Item 5.3

Report

Whole System Delays – Recent Trends

Edinburgh Integration Joint Board

20 January 2017

Executive Summary

1 Changes to national reporting of delayed discharge, outlined in the May 2016 report to the IJB, were introduced for the July 2016 census. The total now includes people who were discharged within 3 days of the census (formerly excluded from the total). Totals since July 2016 are therefore not directly comparable with earlier figures.

2 The number of people who were ready for discharge from hospital at the November 2016 census was 181. As per national guidance, this total excludes people with complex reasons for delay.

3 The main reasons for delay are shown. Over the last year, people waiting for domiciliary care have accounted for at least 33% of the total, and the proportion in November was 38%. The number of people waiting for a care home place was comparatively high at 64, although lower than the 72 at the October census.

4 Following the flow workshop on 8 March 2016, a range of work streams to address delayed discharge are underway, targeted at key pressure points across the care system. These work streams are overseen by the Patient Flow Programme Board. Details of the work streams are provided in the main report.

5 Targets have been set for the total number of people waiting for discharge, with the objective of achieving 50 by the April 2017 census.

6 In recognition that delayed discharge is symptomatic of pressures and activity in the wider system, work is underway on a phased basis to develop a whole-system overview to enable a greater understanding of pressures and changes within the system, enabling actions to be appropriately targeted. Phase 1 is underway and will provide a city-wide overview across all hospital sites and the scope is A&E through hospital admission, referral for support for discharge and finally, discharge.

Recommendations

7 That the Edinburgh IJB note:

- That there has been a significant increase in delayed discharge since June this year with the increase only partly explained by the changes in reporting which were introduced across Scotland in July.

- That given the complexity of this issue, a self assessment of the current approach in Edinburgh to tackling delays in transfer of care was carried out utilising the best practice guidance contained within the Joint Improvement Team "Self Assessment Tool for Partnerships" (updated 2015) and The National Institute for Health and Care Excellence guidelines (Dec 2015) for "Transition between inpatient hospital settings and community or care home settings for adults with social care needs".

- That a comprehensive range of actions is in place to secure a reduction in the number of people delayed. These focus on: admission avoidance, rehabilitation and recovery and supporting discharge.

Background

8 Recent guidance emphasises the whole system redesign required to ensure smooth transition of care from hospital. In particular this report has referred to Joint Improvement Team "Self Assessment Tool for Partnerships" (updated 2015) and The National Institute for Health and Care Excellence guidelines (Dec 2015) for "Transition between inpatient hospital settings and community or care home settings for adults with social care needs".

9 Taking a whole system approach a range of work streams to address delayed discharge in Edinburgh were initiated at a workshop session on 8 March 2016, details of which were given in previous reports. The work streams are:

- Admission avoidance
- Rehabilitation and recovery
- Supporting discharge

10 Each work stream is being led jointly by a senior officer from both the Health and Social Care Partnership and the acute hospital sites to ensure senior buy in and support for the changes required. The Patient Flow Programme Board is overseeing progress.

11 This report presents the revised target level of delayed discharges which have been set for the monthly censuses between now and April 2017, which has a target of 50. It gives a high level overview of the number of delayed discharges against targets, reasons for delay and trends in the number of people supported by the Edinburgh Health and Social Care Partnership to leave hospital.

12 It also provides an update on work to develop an overview of activity and pressures across the hospital system, which will be reported to the Patient Flow Programme Board.

13 As noted in previous reports, changes to national delayed discharge reporting took place for the July 2016 census and are designed to ensure that published

figures are more complete and comparable across Scotland than at present. These changes have led to an increase in the reporting of the number of people delayed.

Main report

Targets

14 As noted above, targets have been set for each monthly census between October 2016 and April 2017, with the aim of reducing to 50 by the end of this period. These targets are recognised as being challenging and have been rephased since the October report.

Table 1. Delayed discharge targets: December 2016 to April 2017

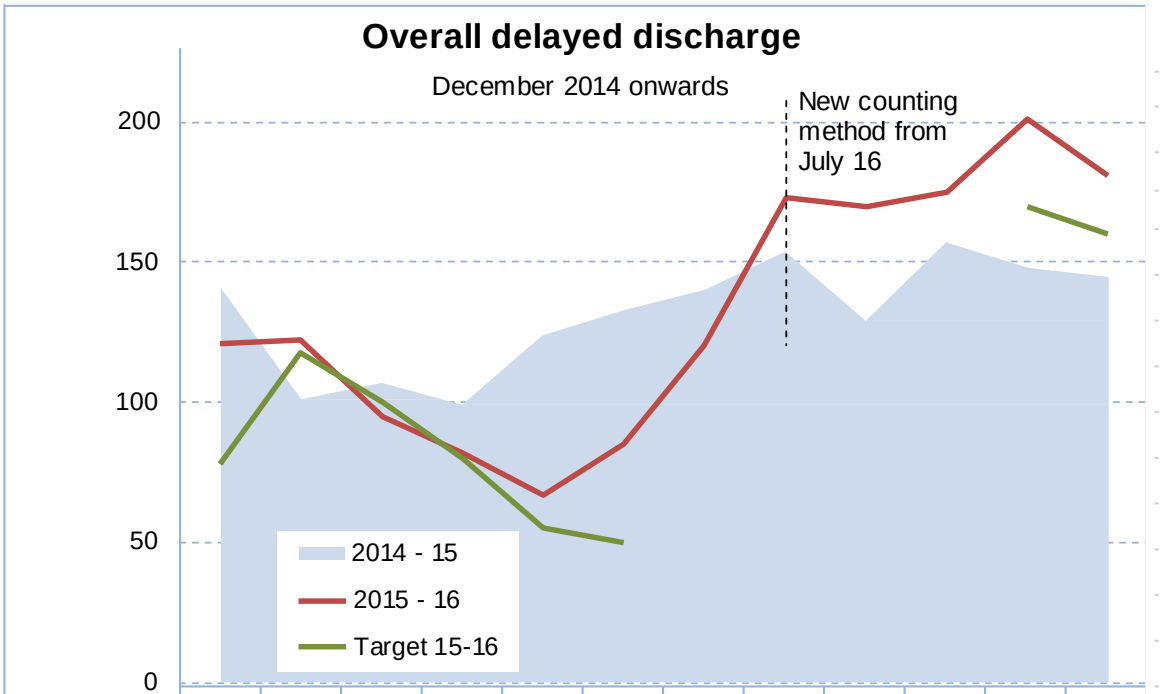
December 2016	158
January 2017	132
February 2017	110
March 2017	74
April 2017	50

Total number of people delayed

15 The total number of Edinburgh residents who were delayed in hospital over the past two years **as at the monthly official census** is illustrated in the graph below. The shaded area shows performance for December 2014 – November 2015 and the red line shows levels for the current year. Target levels are shown by the green line.

16 The total number of people delayed at the November census was 181. This cannot be directly compared with earlier figures, as noted above. Whilst there is an impact of the reporting on the figures there is a significant increase in numbers from June which is not attributable to the change in methodology.

Chart 1



	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
2014 - 15	141	101	107	99	124	133	140	154	129	157	148	145
2015 - 16	121	122	95	82	67	85	120	173	170	175	201	181
Target 15-16	78	118	100	80	55	50					170	160

Reasons for delay, 2015-16

17 The main reasons for delay at the census points over the last 12 months are shown in the table below. The most common reason across this period has been waiting for domiciliary care, which peaked in October 2016 at 86 and then reduced to 69 in November.

Table 2

	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
Assessment	26	30	26	27	23	14	20	34	24	43	42	47
Care Home	26	26	16	14	15	26	35	58	59	50	72	64
Domiciliary Care	64	59	49	36	22	40	59	78	76	81	86	69
Legal and Financial	0	0	0	0	2	0	0	0	0	0	0	0
Other	5	7	4	5	5	5	6	3	11	1	1	1
Total	121	122	95	82	67	85	120	173	170	175	201	181
% Domiciliary Care	53%	48%	52%	44%	33%	47%	49%	45%	45%	46%	43%	38%

18 Increases in the number of people delayed over the year were apparent across most reasons for delay i.e. ongoing assessment, waiting for care home placements and for packages of care at home. The number of people waiting for

a care home place remains comparatively high at 64. Difficulties within the care homes continued to have a bearing into the early part of this month. However successful recruitment has now allowed 8 vacancies in our own homes to be matched to people waiting. Additionally, we have seen an increase in the number of people matched to vacancies be declined on assessment by the care home due to complexity of need. Norovirus has also had an impact on the flow of placements through Gylemuir House which lasted for 10 days. Despite these factors the number of people delayed while waiting for a care home place has reduced on last month's figure of 72.

19 It remains of concern that there are a substantial number of people waiting to move from hospital to a care home place (35% of current delays) which means that individuals are being expected to decide on moving to permanent care home places whilst in an acute hospital setting. Capacity is being developed on an interim basis in a non-acute setting at Liberton for those unable to return home. A reablement approach will be taken in this new facility, to maximise residents' level of independence.

20 The increase in people waiting for domiciliary care since April will have been caused by a range of pressures in Care at Home. The new Care at Home contracts aim to address these issues. A workshop to identify and address challenges experienced in implementing the contract has been held (7 December 2016) and a range of actions agreed relating to processes (e.g. matching packages), data quality, recruitment and unmet need. Full details of the actions will be provided in a report to the January Flow Board.

21 The number and proportion of delays in acute sites is shown below:

Table 3

	Dec 15	**Jan 16**	**Feb 16**	**Mar 16**	**Apr 16**	**May 16**	**Jun 16**	**Jul 16**	**Aug 16**	**Sep 16**	**Oct 16**	**Nov 16**
Delays in acute sites	106	117	80	74	64	82	112	148	146	143	173	145
Total	121	122	95	82	67	85	120	173	170	175	201	181
% in acute	88%	96%	84%	90%	96%	96%	93%	86%	86%	82%	86%	80%

22 The numbers of people excluded from the total (X codes and people who are unwell) are given below. Of the X-codes, those which relate to Guardianship (e.g. 16 of the 23 in November 2016) are shown separately.

23 The *grand total* row shows the number of people delayed, including those who are excluded from the national count.

Table 4

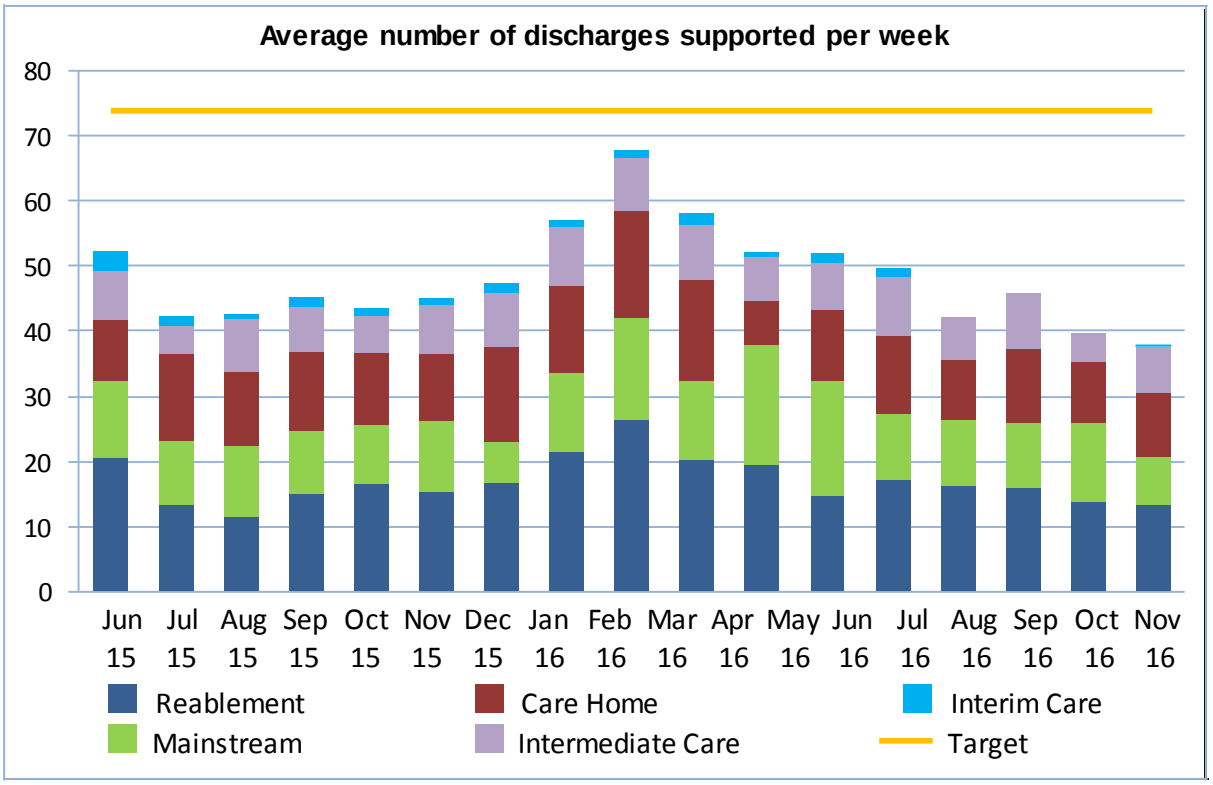
	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
Total	121	122	95	82	67	85	120	173	170	175	201	181
Excluded cases	27	35	29	33	30	33	27	25	23	24	27	23
Of which, Guardianship	24	23	21	28	25	30	24	23	20	20	22	16
Grand Total	148	157	124	115	97	118	147	198	193	199	228	204

People supported to leave hospital

24 Targets for the total number of people supported each week have been revised with the objective of achieving the target of 50 people delayed by April 2017. This is detailed in Appendix 1.

25 The graph below shows the average number of discharges per week supported by Health and Social Care, for each month during 2015-16. It shows an increased number during February and March 2016. Figures for provision exclude the number of packages of care that are estimated to re-start each week.

Chart 2



26 Tables 5 and 6 in Appendix 1 show targets and performance against these for the number of people supported each week to leave hospital.

Other work streams to address delayed discharge

27 Current activity in the three key work streams which are underway and are being overseen by the Patient Flow Programme Board is summarised below.

28 Admission avoidance: work is progressing in the falls pathway with a stakeholder event having taken place on 21st November. The outputs form this are being used to inform a local improvement project charter. Work is also progressing to provide GPs with support and guidance in relation to anticipatory care planning, as well as specific work to develop a structured approach to improving anticipatory care planning with 3 care homes within North Edinburgh.

29 Rehabilitation and recovery: work is proceeding on phase 2: work is underway to analyse the data to explore the volumes and causes of reablement clients who are not eligible based on the existing criteria. Arrangements continue to develop the bridging service through a staff training programme.

30 Supporting discharge: the current focus is on increasing capacity and flow with Elderly Care Assessment Teams now working within all specialties including surgery and orthopaedics, as well as frailty teams in place within the Emergency Department which include Assistant Nurse Practitioners and which has increased the date of direct discharge home. The Rapid Improvement Team, which was put in place on 1 November 2016, continues to have an impact. Its focus has been on working with localities and partner providers to support partnership working, streamline referral processes, introduce joint workforce planning to build city-wide capacity, and improve communications and data quality. The team works with the Service Matching Unit (SMU) to eliminate the backlog of referrals and streamline referral processes. This work has already resulted in an in-principle agreement to reduce referral response from 7 days to 48 hours for Locality Partners, a reduction of 47% in the backlog of SMU referrals and a reduction in the waiting list for packages of care of over 100 people (17%).

31 In addition, the roll out of the Locality Hubs and Multi Agency Triage Teams (MATTs) is continuing, which the objectives of identifying people who can be supported to leave hospital early and to prevent hospital admission.

Whole system flow

32 As noted above, work is underway to develop a whole system overview, to enable a better understanding of activity and pressures within the system and to provide a way of identifying areas within the system which are of concern.

33 The approach being developed jointly by colleagues from the Council's Strategy and Insight Service, NHS Lothian's Analytical Services Division and ISD's LIST team is to apply statistical process control (SPC) principles to weekly data. The technique allows an assessment to be made on whether an area of performance is delivering predictably and if that is so, the extent to which performance is

satisfactory. It can also help identify where to look in situations where trends are unpredictable.

34 Two operational managers (one Locality Manager and one hospital based manager) have been nominated to become part of the project team. They will identify the performance information they need to enable them to identify and address issues and these will be built into the suite of measures.

35 In the short term, the current weekly operational report, which has been provided to senior managers over the last two years or so, is being reformatted to show the data in the SPC format. A summary sheet will be developed to draw attention to areas trends in performance or activity differ from expected patterns.

36 Progress with this work stream is being overseen by the Flow Board.

Key risks

37 That the additional non-recurring Scottish Government funding has been used to underpin support services and that the reductions in delayed discharge levels will not be sustainable unless alternative approaches or funding sources are identified.

38 That vacancies in the care workforce cannot be filled, limiting available capacity.

Financial implications

39 As noted above, the Scottish Government funding is temporary and is being used to underpin support services. Alternative funding sources or approaches to providing care will need to be considered.

Involving people

40 As we move towards the locality model and develop the locality hubs, there will be engagement with local communities and other partners to inform the further development of the model.

Impact on plans of other parties

41 This report outlines progress of the Edinburgh Health and Social Care Partnership in addressing the pressures within acute services as developed at an event involving key stakeholders from across the system.

Background reading/references

Memorandum of Understanding Reducing Delayed Discharges in Edinburgh

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Links to priorities in the strategic plan

Priority 4	Providing the right care in the right place at the right time
Priority 6	Managing our resources effectively

Appendix 1

People supported to be discharged from hospital: actual against target

Table 5 Discharges per week and month

	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16
Discharges in calendar month	193	209	236	272	258	223	230	213	186	203	170	168
Monthly Target	317	328	328	307	328	317	328	317	328	328	328	328
Average discharges per week	45	47.2	57	68	58.3	52	51.9	49.7	42	45.8	39.7	37.9
Av Weekly Target	74	74	74	74	74	74	74	74	74	74	74	74

Table 6. Provision of packages of care by type

	Care at Home			Care Homes			Intermediate Care			Reablement			Mainstream			Total (1)			Est	Total (2)		
Week Ending	Traj.	Actual	Diff.	Traj.	Actual	Diff.	Traj.	Actual	Diff.	Traj.	Actual	Diff.	Traj.	Actual	Diff.	Traj.	Actual	Diff.	Restart	Traj.	Actual	Diff.
09/10/2016	10	11	1	10	14	4	6	10	4	13	16	3	2	1	-1	41	52	11	14	55	66	11
16/10/2016	11	11	0	10	15	5	7	7	0	14	10	-4	2	0	-2	44	43	-1	14	58	57	-1
23/10/2016	12	5	-7	10	6	-4	8	8	0	15	15	0	2	0	-2	47	34	-13	14	61	48	-13
30/10/2016	14	4	-10	10	9	-1	8	10	2	16	20	4	2	1	-1	50	44	-6	14	64	58	-6
06/11/2016	16	7	-9	10	10	0	9	9	0	18	28	10	3	2	-1	56	56	0	14	70	70	0
13/11/2016	18	4	-14	10	8	-2	10	10	0	18	24	6	3	0	-3	59	46	-13	14	73	60	-13
20/11/2016	18	12	-6	10	13	3	10	6	-4	18	21	3	4	5	1	60	57	-3	14	74	71	-3
27/11/2016	18	5	-13	10	15	5	10	5	-5	18	23	5	4	3	-1	60	51	-9	14	74	65	-9
04/12/2016	18	5	-13	10	9	-1	10	5	-5	18	21	3	4	6	2	60	46	-14	14	74	60	-14
11/12/2016	18	6	-12	10	6	-4	10	11	1	18	23	5	4	4	0	60	50	-10	14	74	64	-10
18/12/2016	18	2	-16	10	4	-6	10	11	1	18	21	3	4	3	-1	60	41	-19	14	74	55	-19
25/12/2016	18	4	-14	10	13	3	10	12	2	18	24	6	4	3	-1	60	56	-4	14	74	70	-4
01/01/2017	18	0	-18	10	12	2	10	5	-5	18	9	-9	4	0	-4	60	26	-34	14	74	40	-34
08/01/2017	18			10			10			18			4			60			14	74		
15/01/2017	18			10			10			18			4			60			14	74		
22/01/2017	18			10			10			18			4			60			14	74		
29/01/2017	18			10			10			18			4			60			14	74		
05/02/2017	18			10			10			18			4			60			14	74		
12/02/2017	18			10			10			18			4			60			14	74		
19/02/2017	18			10			10			18			4			60			14	74		
26/02/2017	18			10			10			18			4			60			14	74		
05/03/2017	18			10			10			18			4			60			14	74		
12/03/2017	18			10			10			18			4			60			14	74		
19/03/2017	18			10			10			18			4			60			14	74		
26/03/2017	18			10			10			18			4			60			14	74		
02/04/2017	18			10			10			18			4			60			14	74		

Week Ending	Care at Home	Reablement	Mainstream	Intermediate	Care homes	Restarts (est)	Total
04/12/2016	18	18	4	10	10	14	74
11/12/2016	18	18	4	10	10	14	74
18/12/2016	18	18	4	10	10	14	74
25/12/2016	18	18	4	10	10	14	74
01/01/2017	18	18	4	10	10	14	74
08/01/2017	18	18	4	10	10	14	74
15/01/2017	18	18	4	10	10	14	74
22/01/2017	18	18	4	10	10	14	74
29/01/2017	18	18	4	10	10	14	74
05/02/2017	18	18	4	10	10	14	74
12/02/2017	18	18	4	10	10	14	74
19/02/2017	18	18	4	10	10	14	74
26/02/2017	18	18	4	10	10	14	74
05/03/2017	18	18	4	10	10	14	74
12/03/2017	18	18	4	10	10	14	74
19/03/2017	18	18	4	10	10	14	74
26/03/2017	18	18	4	10	10	14	74
02/04/2017	18	18	4	10	10	14	74
09/04/2017	18	18	4	10	10	14	74
16/04/2017	18	18	4	10	10	14	74

Appendix 2 Delayed discharge codes (from July 2016)

Health and Social Care Reasons		
Assessment	11A	Awaiting commencement of post-hospital HSC assessment (including transfer to another area team). HSC includes home care and social work OT
	11B	Awaiting completion of post-hospital HSC assessment (including transfer to another area team). Social care includes home care and social work OT
Funding	23C	Non-availability of statutory funding to purchase Care Home Place
	23D	Non-availability of statutory funding to purchase any Other Care Package
Place Availability	24A	Awaiting place availability in Local Authority Residential Home
	24B	Awaiting place availability in Independent Residential Home
	24C	Awaiting place availability in Nursing Home
	24D	Awaiting place in Specialist Residential Facility for younger age groups (<65)
	24DX*	Awaiting place in Specialist Facility for high level younger age groups (<65) which is not currently available and no interim option is appropriate
	24E	Awaiting place in Specialist Residential Facility for older age groups (65+)
	24EX*	Awaiting place in Specialist Facility for high level older age groups (65+) which is not currently available and an interim option is not appropriate
	24F	Awaiting place availability in care home (EMI/Dementia bed required)
	26X*	Care Home/facility closed
	27A	Awaiting place availability in an Intermediate Care facility
	46X*	Ward closed – patient well but cannot be discharged due to closure
Care Arrangements	25A	Awaiting completion of arrangements for Care Home placement
	25D	Awaiting completion of arrangements - in order to live in their own home – awaiting social support (non-availability of services)
	25E	Awaiting completion of arrangements - in order to live in their own home – awaiting procurement/delivery of equipment/adaptations fitted
	25F	Awaiting completion of arrangements - Re-housing provision (including sheltered housing and homeless patients)
	25X	Awaiting completion of complex care arrangements to live in their own home
Parent / Carer / Family Related Reasons		
Legal / Financial	51	Legal issues (including intervention by patient's lawyer) - e.g. informed consent and/or adult protection issues
	51X*	Adults with Incapacity Act
	52	Financial and personal assets problem - e.g. confirming financial assessment
Disagreements	61	Internal family dispute issues (including dispute between patient and carer)
	67	Disagreement between patient/carer/family and health and social care
Other	71	Patient exercising statutory right of choice
	71X*	Patient exercising statutory right of choice – interim placement is not possible or reasonable
	72	Patient does not qualify for care
	73	Family/relatives arranging care
	74	Other patient/carer/family-related reason
Other reasons		
Complex Needs	9	Code 9 should be used with the following secondary codes: 24DX, 24EX, 25X, 26X, 46X, 51X, 71X. All code 9 delays should have a secondary reason code.
Code 100	100	Reprovisioning / Recommissioning