Item 5.3

Report

Whole System Delays – Recent Trends

Edinburgh Integration Joint Board

24 March 2017

Executive Summary

1. Reducing the number of people whose discharge from hospital is delayed and the length of those delays continues to be a challenge in Edinburgh. The number of delayed discharges at the February 2017 census (excluding people with complex reasons for delay) was 209 a reduction of six on the previous month. The target for Edinburgh Integration Joint Board (EIJB) of reducing the number of delays to no more than 50 delays by the end of April 2017 is now unlikely to be achieved.

2. A review of the Flow Programme, put in place in March 2016, to deliver a number of specific actions to address the high levels of delayed discharge in Edinburgh, will take place at the end of March. The review will be overseen by the Flow Programme Board and include the development of revised targets and related trajectories for approval by the IJB, that are both challenging and realistic.

3. The purpose of this report is to update the Integration Joint Board on:

    - current performance in relation to delayed discharges;
    - actions being taken to reduce the number and length of delays; and
    - proposed future actions to further improve performance.

Recommendations

That the Edinburgh Integration Joint Board is asked to note:

4. the current performance in respect of delayed discharge;

5. the progress made in reducing the length and number of delayed discharges from hospital;

6. the proposed future actions to further improve performance; and

7. that the Flow Programme Board will be undertaking a review of the Flow Programme at the end of March 2017, following which a revised set of indicators and trajectories will be recommended to the Integration Joint Board.

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 has been provided in previous reports. The work streams are:
    - admission avoidance;
    - rehabilitation and recovery;
    - supporting discharge; and
    - mental health

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 management buy in and support for the changes required. The Patient Flow Programme Board is overseeing progress.

Main report

Current performance

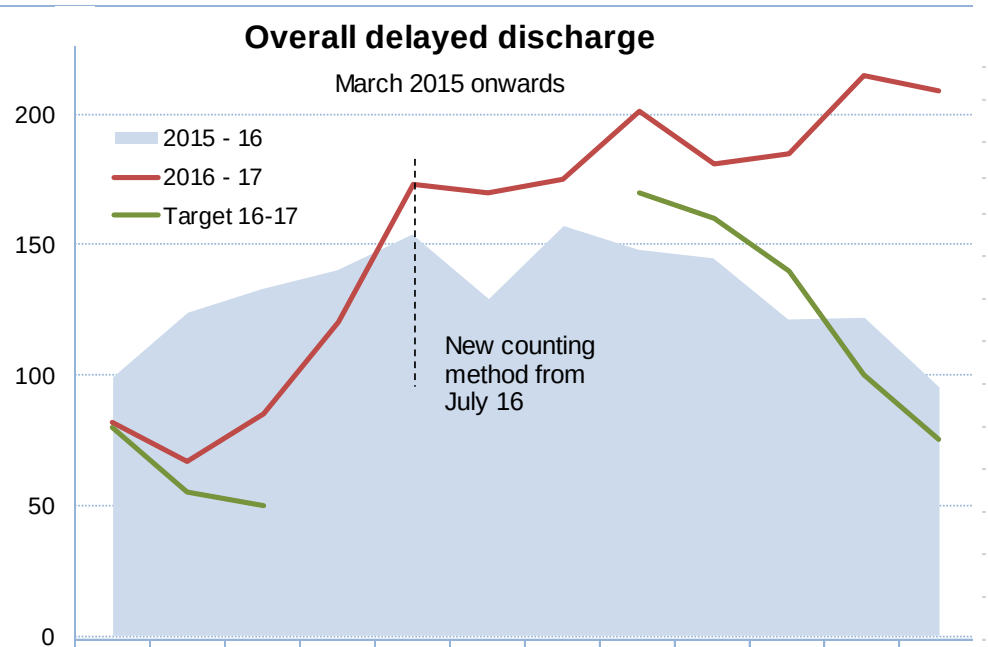
11. Targets for the number of people whose discharge from hospital is delayed were set in October 2016 based on the monthly national census figures. These targets were recognised as being very challenging. In practice, the Edinburgh Health and Social Care Partnership has not been able to deliver in line with the trajectory in order to meet the target of no more than 50 delayed discharges by the end of April 2017. The targets and trajectories to be achieved from April 2017 will be reset by the Flow Programme Board as part

of the programme review later this month and reported to the next meeting of the Integration Joint Board.

12. The total number of people delayed at the February census was 209. This cannot be directly compared to performance before July 2016, due to the change in national reporting methods previously reported to the EIJB.

13. Table 1 below shows the number of Edinburgh residents delayed in hospital over the past two years using the monthly national census data which excludes people with complex reasons for delay. The shaded area shows performance for February 2015 to January 2016 and the red line shows levels for the current year. The target trajectory is shown by the green line.

Table 1: Number of people delayed in hospital March 2016 to Feb 2017 excluding complex cases



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2015 - 16	99	124	133	140	154	129	157	148	145	121	122	95
2016 - 17	82	67	85	120	173	170	175	201	181	185	215	209
Target 16-17	80	55	50					170	160	140	100	75

14. Table 2 below shows the total number of actual delays including people with complex reasons for delay who excluded from the national census and therefore not included in Table 1 above. Delays relating to Guardianship are shown separately.

Table 2: Number of people delayed in hospital March 2016 to Feb 2017 including complex cases

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Total	82	67	85	120	173	170	175	201	181	185	215	209
Excluded cases	33	30	33	27	25	23	24	27	23	18	12	13
Of which, Guardianship	28	25	30	24	23	20	20	22	16	17	11	12
Grand Total	115	97	118	147	198	193	199	228	204	203	227	222

15. Table 3 below shows the number of people delayed in acute hospital sites. The remaining delays are in Liberton Hospital.

Table 3: number of people delayed in acute hospital sites

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Delays in acute sites	74	64	82	112	148	146	143	173	145	136	158	165
Total	82	67	85	120	173	170	175	201	181	185	215	209
% in acute	90%	96%	96%	93%	86%	86%	82%	86%	80%	74%	73%	79%

16. The main reasons for people being delayed in hospital at the census points over the last 12 months are shown in table 4 below.

Table 4: Main reason for people being delayed in hospital

	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
Assessment	27	23	14	20	34	24	43	42	47	32	37	30
Care Home	14	15	26	35	58	59	50	72	64	68	77	69
Domiciliary Care	36	22	40	59	78	76	81	86	69	81	97	107
Legal and Financial	0	2	0	0	0	0	0	0	0	2	2	0
Other	5	5	5	6	3	11	1	1	1	2	2	3
Total	82	67	85	120	173	170	175	201	181	185	215	209
% Domiciliary Care	44%	33%	47%	49%	45%	45%	46%	43%	38%	44%	45%	51%

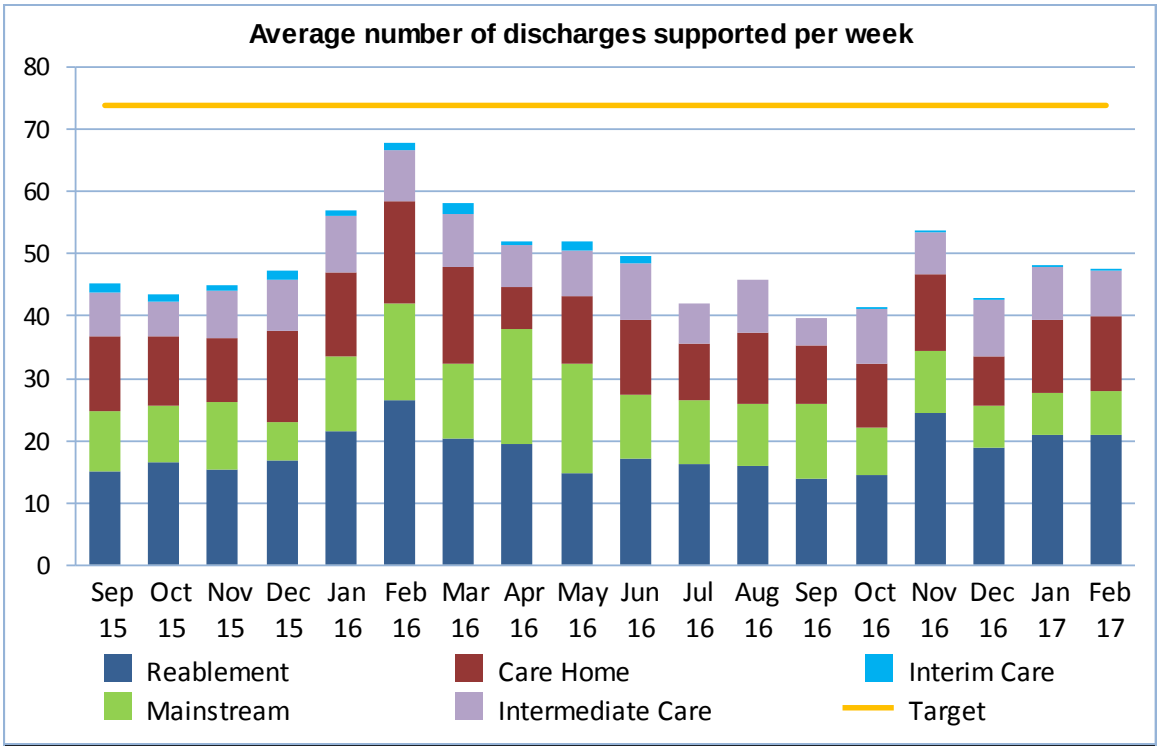
17. Whilst the number of people delayed waiting for an assessment or a care home placement both reduced in February, the number of people waiting for domiciliary care increased from 97 to 107 and accounted for 51% of all delays.

18. It remains of concern that there are a substantial number of people waiting to move from hospital to a care home place (33% of delays in February) 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 at Liberton hospital for those unable to return home. A reablement approach will be taken in this new facility, to maximise residents' level of independence.

Actions being taken to reduce delays

19. Table 5 below shows the average number of discharges per month supported by the Health and Social Care Partnership over the last 18 months.

Table 5



20. The list of delayed discharges is sent out daily with progress being tracked on a daily basis at a locality level and at weekly meetings to go through each individual case to assess progress. Weekly meetings have also been introduced, chaired by the newly appointed Chief Strategy and Performance Officer and attended by a range of people including the four Locality Managers and the four Hub Managers. Delayed discharge levels and associated activity are being closely scrutinised at these meetings, and any gaps in capacity or problems arising from current processes will be identified and addressed.

21. The Rapid Improvement Team's (RIT) work on the Care at Home contract, which commenced in October 2016, is continuing apace, and has produced the following results since November:

- the contract is currently delivering 27,000 hours per week;
- although the number of people waiting in hospital for a package of care has remained relatively constant , the average time people are waiting for a package of care has reduced from 34 days to 15 days;
- the number of people waiting in the community for a package of care has reduced from 634 to 520 and the average time people in the community are waiting for a package of care has reduced from 168 days to 119 days;

- partner providers have increased their capacity by 1.6% across the city;
- complaints from service users and families regarding delays in being matched to a package of care have reduced by around 60%;
- the successful emergency transfer of 98 service users and 1,100 hours of care, with no safety or publicity issues, and no complaints being received, following the decision to remove a partner provider from the contract (as reported to the EIJB on 20 January 2017); and
- partner providers have agreed to reduce contractual waiting times to accept or decline a referral from the current 7 days to 48 hrs.

22. The number of people waiting in hospital for Guardianship orders has been a significant challenge. However, the deployment of two additional Mental Health Officers (funded jointly by the Scottish Government and NHS Lothian) to focus on these individuals, has seen the number of Guardianship delays in hospital reduce from 28 in April 2016, to 9 at the start of March 2017. The overall success of this initiative represents a resource saving in excess of £1,000,000 per year.

23. Work is also 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 of concern. The approach being developed jointly by colleagues from the Council's Strategy and Insight Team, NHS Lothian's Analytical Services Division and Information Services Division'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 so, the extent to which performance is satisfactory. It can also help identify situations where trends are unpredictable and require further investigation. This work is being overseen by the Flow Programme Board.

Proposed future actions to improve performance

24. The next steps for the Rapid Improvement Team include:
    - working with partner providers and stakeholders to design and implement a time limited whole system approach to increasing the capacity available to discharge people from hospital;
    - continuing to work with partners to:
        - devise and implement a recruitment and retention strategy; and
        - streamline the referral and service matching processes, including the potential introduction of an online process; and
    - the introduction of a further hospital to home discharge team within the contracted providers.

25. Recruitment for care workers in Edinburgh is particularly challenging: two strands of work have begun in this area. At locality level, dynamic recruitment campaigns are being undertaken. At a strategic level a business case is considering the option of increased pay for care workers along with affordable housing options within the care at home contract and beyond to enable competitive recruitment.

26. A new Hospital to Home programme is to begin shortly for 6 months, which will see a whole system approach to delayed discharge including the use of 45 beds in Liberton Hospital being used as “step down” beds (to facilitate removal from acute beds, whilst awaiting programmes of care etc). We also currently offer step down facilities at Gylemuir for people waiting for care home places. These programmes are in addition to the business as usual work going on at locality level.

27. LOOPS Hospital Discharge is a pilot project funded through the Integrated Care Fund. Third sector liaison workers drawn from four organisations are part of an integrated function within the new locality Hubs and acute hospital settings. The aim is for the Third Sector to be better integrated as a trusted partner, more able to respond to referrals quickly and one which can ensure earlier intervention through the team acting as a rapid referral pathway.

28. Work is taking place with innovation contract providers and sheltered homes to create more capacity by providing technology solutions to care at home.

Key risks

29. Whilst there are a range of actions in train seeking to reduce the number of people delayed in hospital and the length of those delays there is a risk that vacancies in the care workforce cannot be filled, limiting available capacity.

Financial implications

30. There are no direct financial implications arising from this report.

Involving people

31. 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

32. The ability of the Edinburgh Health and Social Care Partnership to significantly reduce the number of people currently delayed in hospital and the length of those delays impacts on NHS Lothian and the other three Integration Boards within Lothian. These partners are kept informed of progress by the Chief Officer of the Edinburgh Integration Joint Board through the IJB Chief Officers Acute Interface Group

Background reading/references

None

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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

Delayed Discharge Codes

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