Edinburgh Integration Joint Board

REPORT

Evaluation of Winter 2023/24

Edinburgh Integration Joint Board

20 August 2024

Executive Summary	The purpose of this report is to provide the Edinburgh Integration Joint Board (EIJB) with an update on performance over Winter 2023/24 and make any recommendations for improvement in 2024-2025. In spite of system pressures EHSCP delays in the days before the festive period were 27% lower than the previous year (2023-2024) and the March 2024 data remained 6% lower than March 2023. Our position in March 2024 put Edinburgh in the top 50% of Partnerships for delays at the end of the winter period. In tandem with this our occupied Bed Days (OPDs) have reduced significantly from January onwards in the RIE. The Partnership delivered the highest ever number of interface care /hospital at home interventions over Saturday and Sundays (i.e. 7 days) ensuring more medically unwell people were treated in their own homes.

Recommendations	It is recommended that the Edinburgh Integration Joint Board: 1. Note the evaluation of winter 2023/24 contained in this paper. Planning for Winter 2024 – 2025 will commence in August 2024. 2. A named lead from Strategic Planning should be identified to work with the Head of Service with responsibility for Winter Planning to ensure that future plans are more joined up and learning from Winter is incorporated into Strategic Plans for the coming year.

Directions

Direction to City of Edinburgh Council,	No direction required	✓
	Issue a direction to City of Edinburgh Council NHS Lothian	

NHS Lothian or both organisations	Issue a direction to NHS Lothian	
	Issue a direction to City of Edinburgh Council and NHS Lothian	

Main Report

1. Winter preparedness planning plays a key role in ensuring NHS Boards and Health and Social Care Partnerships (HSCPs) are ready to meet the additional challenges likely to be faced over the winter months as a result of seasonal influenza, norovirus, severe weather, and public holidays. This was again amplified this year by the rising costs of living and the residual impact of the COVID-19 pandemic which is still being felt across the whole system through increasing demand and workforce pressures.

2. The Edinburgh Health and Social Care Partnership (EHSCP) Winter Planning Group leads on the planning, monitoring, and evaluation of preparations for winter. It has multi-agency and pan Lothian-system representation, including acute, community, winter vaccination, unpaid carers, the third sector, resilience, severe weather, and communication leads with monthly meetings scheduled to run throughout the peak winter period.

3. The NHS, Scottish Government and COSLA Winter Resilience Priorities are outlined below:
    a. Where clinically appropriate, ensure people receive care at home, or as close to home as possible
    b. Through clear and consistent messaging, we will have a strong focus on prevention and give people the information and support they need to manage their own health, and that of their families, better
    c. Support delivery of health and social care services that are as safe and sustainable as possible
    d. Maximising capacity and supporting our valuable workforce to meet demand.
    e. Protect planned care with a focus on continuing to reduce long waits
    f. Prioritise care for the most vulnerable in our communities
    g. Work in partnership to deliver this Plan

4. The Scottish Government requested that each NHS Board complete a winter preparedness self-assessment checklist with Health and Social Care Partnerships (HSCP's). The checklist comprised overarching principles, resilience preparedness,

Primary Care, Urgent and Unscheduled Care, Workforce and Seasonal Outbreak. The Whole System Winter Planning Checklist was presented and approved by the NHS Lothian Corporate Management Team (CMT), noting major risks identified:

a. Surges in infectious disease
b. Poor weather
c. Cost of living impacts such as heating and food costs
d. Fragility of the social care system, particularly in the independent care sector
e. Financial limitations making it impossible to action additional interim care beds in the system
f. Financial limitations making it impossible to action additional NHS capacity in the system
g. Reduction in capacity at Royal Infirmary of Edinburgh (RIE) to facilitate fire safety works
h. Recruitment

Financial allocation to support winter pressures

5. The revised criteria for winter proposals for the EHSCP is outlined below:
    a. Reducing attendances (aligned to portfolio 1,2)
    b. Preventing unnecessary presentation at ED (aligned to portfolio 2)
    c. Hospital at Home, including Frailty, Respiratory and Home IV (aligned to portfolio 3)
    d. Front Door Flow 0-72h (aligned to portfolio 4)
    e. Optimising Patient Flow / DwD (aligned to portfolio 5)
    f. 7 Day working and Discharge (aligned to portfolio 5)

6. The previous year's winter funding had been allocated to each area based on an average percentage of funding received in the previous three years. The EHSCP received a total allocation of £170,000 for Winter.

7. Allocation of this funding, along with slippage from previous years, has been based on the Winter Resilience Priorities identified. The proposals were funded for a four-month period and ran from December 2022 to March 2023. A description of the selected areas of work is given in Table 1

Proposal title	**Outline**
Physiotherapy Respiratory	This initiative aimed to: • support people with respiratory conditions beyond COPD with assessment, treatment, and self-management of acute chest infections at home with a focus on prevention of hospital admissions.

	• To optimise the flow of patients with respiratory conditions from hospital to home 7 days a week, • optimising patient flow and supporting the person-centred management of this cohort of in their own homes. Additional funding was approved for one full time temporary Band 7 Advanced Physiotherapy Practitioners (APP) in Community Respiratory Team (CRT) and one full time Band 6 Physiotherapist in the Winter Response Service of Physio at Home. Funding to enhance CRT weekend staffing capacity was included in the costing which included the enhanced pay rates and on-call payment. **The Winter Response Service** was activated during 4 December 2023 to 31 March 2024. A total of 22 new patient referrals were accepted during this period, with the peak demand in December 2023. The referral to treatment time was within 24hours. The majority of referrals came from GP and the most common condition seen was frail, elderly patients with acute respiratory infections. A total of 65 interventions were delivered. The outcome for the majority of patients was positive, with 91% of patients having their respiratory symptoms and rehabilitation managed at home. One patient was admitted to hospital and one patient declined intervention. **The Community Respiratory Team** (CRT) reported an increase in prevention of admission and hospital discharge activity for people with an acute exacerbation of COPD and during the period Dec 23 – Mar 24 received 2,247 referrals. The total number of people living with Bronchiectasis referred to CRT was 7. There was one referral in Jan 2024 made via the early supported hospital discharge pathway for a person with Covid19 on oxygen therapy which CRT successfully facilitated the discharge home and oxygen weaning. The total weekend activity during Dec-March 24 was 356 interventions.
Advance Nurse Practitioner (ANP) to Support Prevention of Admission (PoA)	To support prevention of avoidable admissions for the frail elderly by aligning a Community Advanced Nurse Practitioner (ANP's) with Community Geriatricians and the South West Edinburgh Locality. In total, 57 patients were seen by the community ANPs between January and April with a total of 105 visits undertaken, out of the 57 patients seen, 6 were admitted to hospital. Referrals to the service sourced via the South West Locality Hub, day hospital in South Edinburgh, Hospital at Home via Consultant (city wide), GP referrals via H@H – these referrals were patients who did not require hospital based acute review however required some frailty specialist input. The ANPs also worked closely with

	the IMPACT team with patients referred to IMPACT following ANP review and intervention for continuity of care. This initiative was paused in April due to staff absence and the need to prioritise workload and other clinical commitments. The team faced resilience challenges due to vacancies and recruitment challenges. This initiative did not utilise winter funding.
Hospital at Home MoE Consultant Weekend Rota	To increase weekend admissions to Edinburgh, Mid and East Lothian Hospital @Home (H@H) services by funding a weekend Medicine of the Elderly (MoE) consultant to provide remote clinical decision-making and support to H@H services at the weekend, supporting increased weekend admissions to H@H services during the winter months. The aim was to admit up to 20 patients per weekend, which would result in an 80% increase on weekend admissions to H@H services compared to previous months. The criteria for H@H admission would be the same at the weekend as it is during the week. The number of admissions over a 4-week period was 17 prior to the winter funding implementation, and this increased to 36 admissions. In total, the Hospital at Home had a mean increase of 113% weekend admissions.
Long Term Conditions Programme (LTC) Test of Change	The overarching aim of the Long Term Conditions (LTC) project was to scope multi-agency, strength-based approaches to community support, care and treatment with a view to bringing together the core components that enable collaborative, strength-based models to work in practice. The two tests of change are intended to facilitate action learning to understand and enhance the current system of cross-sector support for: a. people who frequently attend the Emergency Department b. people living with clinical frailty, discharged home from hospital with resolved/resolving delirium. Due to challenges around recruitment and resource to support the tests of change initiation of the projects were severely delayed. With the continuing support of the EHSCP Executive Management Team (EMT) for the advancement of an EHSCP Multiagency approach, it has been agreed that timelines would be revised to spread work required over a longer period (2024/25) with a view to informing pathway development and improvement. Over the coming year a programme of work will be undertaken, inviting representatives from the range of multi-agency models that are utilised across Edinburgh to come together; using a human learning systems approach to build on what's working in some parts of the system to benefit all citizens we work alongside.

Community Resilience Team, Reset.	A Community Resilience Team aiming to reduce unplanned hospital admissions and presentation to statutory services over the winter months for people 60 and over who are impacted by the cost-of-living crisis and at risk of severe decline of all aspects of their health. Comprised of 4 locality-based workers to support clients holistically and link with colleagues to provide tailored advice on local community resources which could be used before or instead of statutory services such as Home Energy Scotland. The team offer vital support to break down barriers which prevent people from coping with life adversities. Reset focusses on enabling people to have more good days by offering support to access things such as health appointments, income maximisation, improvements to their physical environment, food, and energy security. Reset supported 78 clients overall, with 17 of these unable to access essential items to support them over winter. Reset received 77 referrals from hospitals, the source of referral was varied: RIE Front Door 6, WGH 10, RIE wards 10, 32 referrals came from Locality Hubs and 19 other referrals came from additional wards in the RIE, Community hospitals and the Flow Centre. The fund has helped people with food security, white goods, warm clothing, and furniture.

8. Recruitment to key service areas to support reducing admissions/re-admissions and delayed discharges proved to be challenging. The increased demand for staff across the system made it difficult to source suitably qualified candidates. The outcome of this was that planned additional capacity was not available in most service areas, adding significantly to pressures.

9. Additional funding was also made available through the Carers Short Breaks Fund to support the 2023 winter programme for carers. A total of 109 carers benefitted. An update of this work is set out in table 2 below.

Title	**Outline of proposal**
VOCAL – Winter Programme for Carers	A total of 109 carers benefitted. Tickets and vouchers were distributed for a pantomime, Odeon cinema and Mimi's Bakehouse to provide carers with a break from caring. Additionally, food hampers were purchased for carers through Edinburgh Community Food. The majority of carers reported improvements across outcomes around feeling better supported, safer and more confident in carrying out their role, feeling an improvement in their health and wellbeing and better social interaction.

	All carers reported an improvement in the outcome 'more opportunities to enjoy life outside of my caring role'. Carers reported the following benefits of having a break: a. Having some 'time for me' b. Feeling less socially isolated c. Having space to reflect on my caring role and share my story Carers completed Adult Carer Support Plans, with 74% reporting an improvement in their health and wellbeing. As well as this, carers reported the following improvements: a. 76% felt more financially secure b. 82% felt more informed c. 100% felt more confident in their caring role d. 62% reported an improvement in actively shaping their caring role e. 83% noted an improvement in feeling like they have a life of their own

Vaccination Programme

10. The Edinburgh Autumn Winter (A/W) vaccination campaign ran from 4th September 2023 to 31st December 2023. Permanent vaccination sites continue to deliver vaccinations. A total of 230,824 vaccinations were administered on Edinburgh sites and selected community pharmacies during the period of the A/W Programme 2023/24. The Edinburgh overall achievement is best reported as c. 58%.

11. A total of 230,824 vaccinations were administered during the Winter 2023-24. In total, 126,497 flu vaccinations and 104,317 covid vaccinations were delivered to all eligible groups by end of December 2023. The total Covid booster uptake for all cohorts was 95,498 (58%).

12. During the programme, 7 vaccination sites across EHSCP were utilised, 3 of these main sites within Ocean Terminal shopping centre, Waverley Mall centre and Gyle Shopping Centre. The Gyle vaccination clinic was continued in 2023 but a larger unit is still required to make the site fit for long term use. 4 additional local clinics within GP practices and Health Centres across the partnership on weekends.
13. 14 Community Pharmacies across Edinburgh provided access to those unable to travel to other vaccination sites. They delivered 6,022 during the A/W campaign. Pharmacies in Oxgangs and Morningside delivered the most vaccines accounting for 20% of all Community Pharmacy vaccinations.

14. A dedicated team of registered, non-registered vaccinators, and admin staff organised for housebound patients and Care Home residents to be visited early in the programme, administering a total of 13,472 vaccinations. The majority of care home patients were offered vaccinations in the first 20 days of the A/W programme, and the majority of housebound patients were vaccinated in October and November.

15. All over 75s were scheduled by the national team and were given appointments to attend clinics. The clinically at risk and 50-64 (not at risk) cohort were invited via letter/digital reminder to book an appointment via the national portal.

EHSCP Communications

16. The EHSCP communications team employed a comprehensive strategy across multiple platforms to amplify the reach of our winter campaign. The main objectives were to support the Edinburgh community during winter through signposting them to help available and highlight to staff the importance of vaccinations. In addition to spotlight the EHSCP's vital role in supporting people through winter.

17. In consultation with members of the winter planning group to better understand our target audience's needs, further adjustments were made accordingly. Winter communication topics therefore included:
    a. Winter vaccination programme
    b. Staff winter vaccination programme
    c. Mental health support
    d. Referral pathways to Home Energy Scotland and other organisations
    e. Sharing the national right care right place messaging
    f. Recruitment drives to ease winter pressures
    g. Providing advice on a variety of topics such as adverse weather conditions

18. The communications team prioritised accessibility by using clear, straightforward language, ensuring all communications were as accessible as possible. Additionally, the decision to use icons as part of the EHSCP brand was based on research with service users. People understood icons better than photography, particularly people living with dementia. Using EHSCP icons and plain English in the winter campaign meant it had the highest possible reach.
19. Communications with frontline workers who in turn spread winter advice to the people they support, providing a more reliable and trusted way for the message to reach service users.

Strategic Priorities

Strategic Priorities	✓	Key points within report that address strategic priorities
Prevention and Early Intervention	✓	Paragraph 3 and 8 of the report reflect prevention and early intervention strategic priorities.
Tackling Inequalities		
Person Centred Care	✓	Paragraph 3 and 8 of the report reflect prevention and early intervention strategic priorities.
Managing our resources effectively		
Making best use of capacity across the system	✓	Paragraph 3, 19 and 21 of the report reflect the intention to make best use of the capacity across the system.
Right care, right place, right time	✓	Paragraph 3,8,17,22 and 24 of the report reflect the intention to ensure that care is delivered in the right place and the right time.

National Performance Indicators

Please note which national performance indicator your report aligns to			✓
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	✓	6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	✓
2. People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	✓	7. People who use health and social care services are safe from harm.	
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	✓	8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care, and treatment they provide.	
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.		9. Resources are used effectively and efficiently in the provision of health and social care services.	✓
5. Health and social care services contribute to reducing health inequalities.			

Implications for Edinburgh Integration Joint Board

Financial

20. NHS Lothian was allocated a total of £1.452M to support the costs of ensuring health and social care services were prepared for winter 2023/24.

21. A total of £171,000 was allocated to Edinburgh HSCP based on the average percentage of funding received in the previous three years.

Risk, legal, policy, compliance, governance, and community impact

22. Ability to recruit, not only to short-term posts required for surge capacity, but permanent posts will continue to be challenging due to system-wide pressures and the competitiveness of the local recruitment market. In future there will be a need to weigh up the recruitment timescale and training costs involved against the potential benefits accrued by some of these posts.

Equality and Poverty Impact

23. An integrated impact assessment was undertaken in February 2024 to consider potential impacts on people with protected characteristics and other groups of winter plans.

Environment, climate, and sustainability impacts

24. Improvements to public safety through identification of vulnerable people living in the community and ensuring appropriate support is in place, for example through ATEC24 or Technology Enabled Care; protecting their vital interests during periods of severe weather or where there are concerns for their safety and improving infection control through care management at home.

25. Improving physical environment through improved links with ATEC24 to provide equipment as required.

Quality of care

26. Winter planning continues to enable safe and effective care for people using services and ensuring there is sufficient capacity to meet the expected surge in demand. It focuses on providing care close to home, avoiding unnecessary admissions and re-admissions where possible and facilitating the early supported discharge where admission is needed.

27. During the period, there was city wide Social Work cover in acute sites with one hub manager on call. A festive preparedness on call rota for 2023-24 was prepared with

executive team and senior management on call rota for acute and community teams, as well as a resilience festive roster for major incidents or significant disruptions.

Consultation

28. Preparing for winter is done in close consultation with key stakeholders through the Winter Planning Group, which includes multidisciplinary representation not only from the Partnership but also acute services and the third sector.

29. The Partnership is also represented on the NHS Lothian Unscheduled Care Tactical Committee which has oversight of Lothian-wide planning for winter.

Reflections / Recommendations

Reflections:

In spite of system pressures the number of delays were managed and Occupied Bed Days (OBDs) reduced significantly from January onwards in the RIE.

The Partnership delivered the highest ever number of interface care /hospital at home interventions over Saturday and Sundays (i.e. 7 days) ensuring more medically unwell people were treated in their own homes.

The types of pressures that historically only occurred in Winter now occur all year round, with the exception of influenza and in tandem with that it has now become almost impossible to recruit to additional capacity non-recurringly for the four month period.

Recommendations

Given that system pressures exist all year around and some of the solutions to these pressures are only activated through the winter months and then stopped, we need to reflect on the ongoing logic of some of the winter planning cycle and convert impactful activities to business as usual.

To enable that to happen it is recommended that a named lead from Strategic Planning is identified to work with the Head of Service in Home First, Community Rehabilitation & Reablement to ensure that winter planning is more joined up and learning is incorporated into year round, system wide planning.

Report Author

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Background reading / external references

Appendices

Appendix 1	Winter Evaluation of Performance 23-24 – Final
Appendix 2	EHSCP Performance Report from November 2023 – March 2024

Evaluation of Edinburgh HSCP Performance – Winter 2023-24

Overall commentary

Overall, our performance over winter 2023/24 has stayed similar to that seen over winter 2022/23. While we remain below the high levels of delays seen in previous winters, delay numbers are remaining higher than we would like. Over winter our delays were on the rise, with delays in March 18% higher than in December, a seasonality trend similar to pre-pandemic years. We have seen a decrease in delays over March 2024 following an increase from historically low levels (excluding the pandemic) seen in December 2023. Delays were 27% lower in the days before the festive period than in 2022 and the March data remains 6% lower than March 2023. Nationally figures followed the same trend, with an increase between December and February then a decrease in March. This is likely linked to increasing admissions in December and January being ready for discharge approximately 6 weeks after admissions.

This winter we have seen increases or enduring high levels of delays for those waiting for care at home and nursing or dementia home placements. Care home placements for those with complex needs has been a challenging area in Edinburgh for some time and we are constrained by limited availability of care within our external market. Currently the only beds available for people requiring a nursing or dementia care home bed are at prices significantly higher than the national care home rate, making them unaffordable, particularly within the current financial climate. While the external care at home market continues to be responsive to our demands and prioritises support for those in hospital, there continues to be some instability within the external market with a small number of our commissioned care at home providers currently suspended, subject to enhanced monitoring and/or controlled growth, which is affecting our waitlist figures.

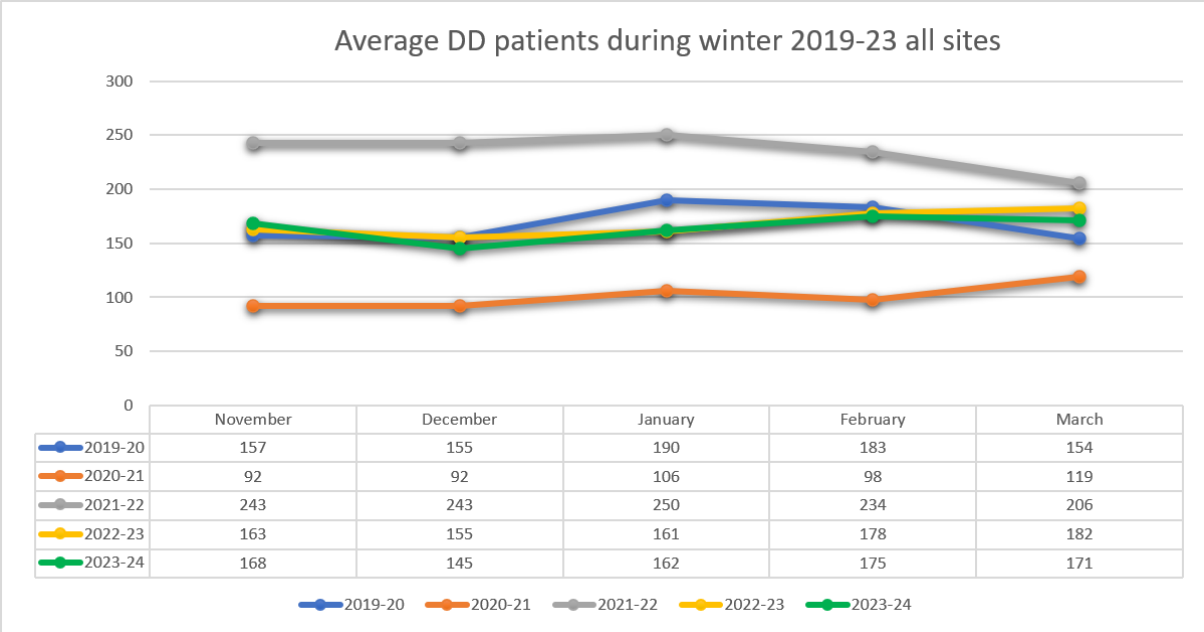
These issues are long-standing and intractable, and will take significant shifts within the system to fully resolve, however some of the actions we are taking to support this include:

- Implemented minimum of twice weekly huddles to review the position of each of our services to support discharges (daily over the winter period).
- Implemented a brokerage team to facilitate flow to packages of care at home.
- Implemented a nursing model at three of our internal care homes to provide for residents with more complex needs.
- Undertaking a strategic review of care home services in Edinburgh.
- Moving our internal service to a reablement model to support more people to live as independently as possible.
- Shifting our external care at home market from competitive, shorter term commissioning models to long term collaboration and partnership commissioning.

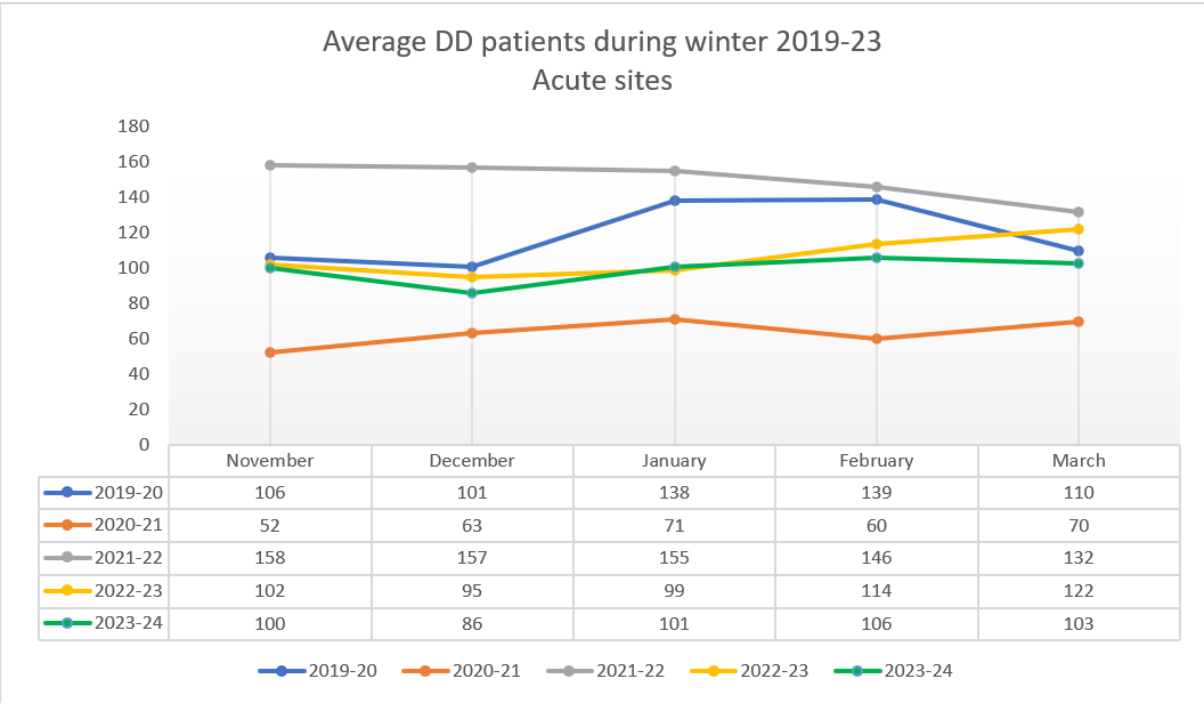
1.0 Delayed Discharge

1.1 Average number of delay discharge* (DD) patients by month during the winter period

Figures for number of delayed discharge patients for the winter months across for Edinburgh residents across Lothian's acute and non-acute sites has shown similar figures in comparison to previous winter 2022-23. When looking at the same metrics for acute sites only (WGH, RIE and SJGH) data shows an improvement to last winter with a 9.48% improvement during the month of December 2023 in comparison to the December 2022.



	November	December	January	February	March
2019-20	157	155	190	183	154
2020-21	92	92	106	98	119
2021-22	243	243	250	234	206
2022-23	163	155	161	178	182
2023-24	168	145	162	175	171

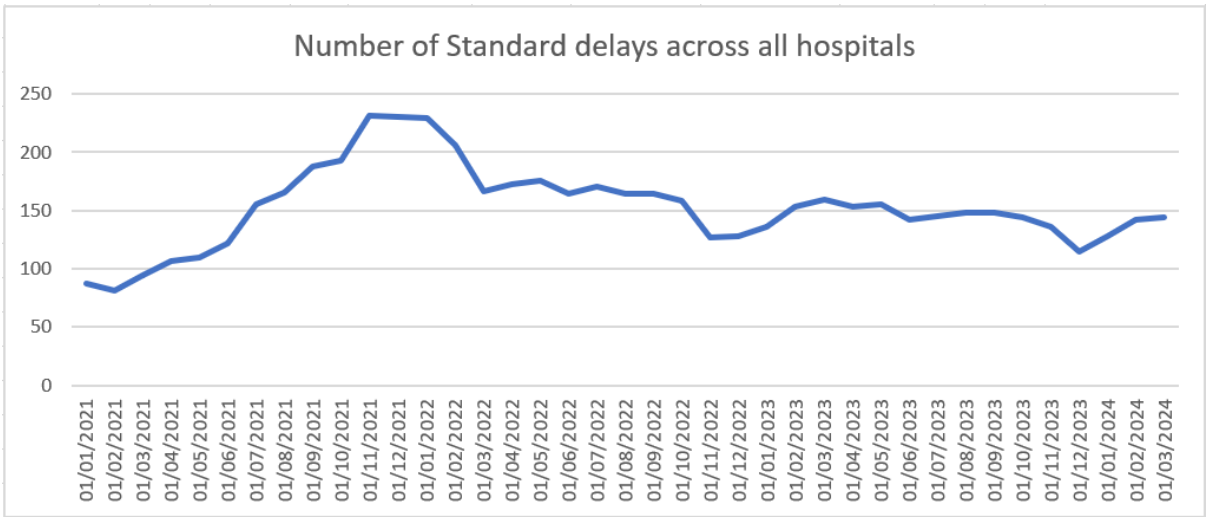


	November	December	January	February	March
2019-20	106	101	138	139	110
2020-21	52	63	71	60	70
2021-22	158	157	155	146	132
2022-23	102	95	99	114	122
2023-24	100	86	101	106	103

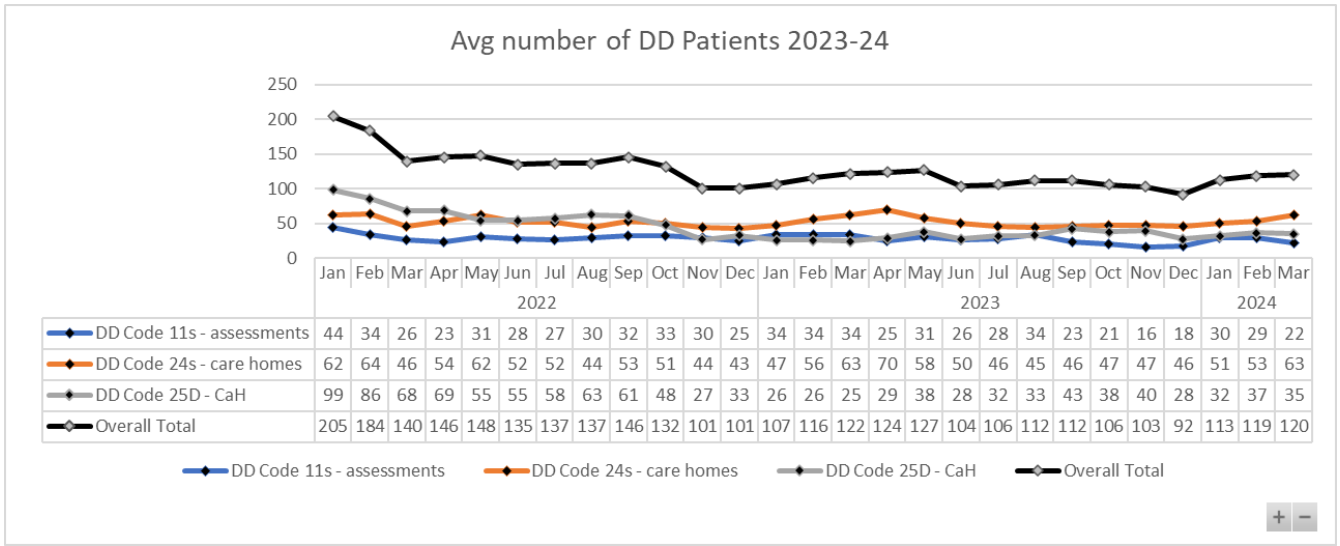
*Standard delays exclude health delays and codes 100 this definition matches the nationally reported delay figures

1.2 Average Standard Delayed Discharges Edinburgh 2021-23 and reasons

The below graph shows the trends on Edinburgh delayed discharge patients during September 2021 and March 2024 across all hospitals in Lothian. There remain high levels of people delayed in hospital although there was improvement in December 2023 where delays reduced before increasing again from January 2024 onwards. This is likely due to seasonal fluctuations due to the Christmas break and as more people are ready for discharge following a period in hospital over winter.



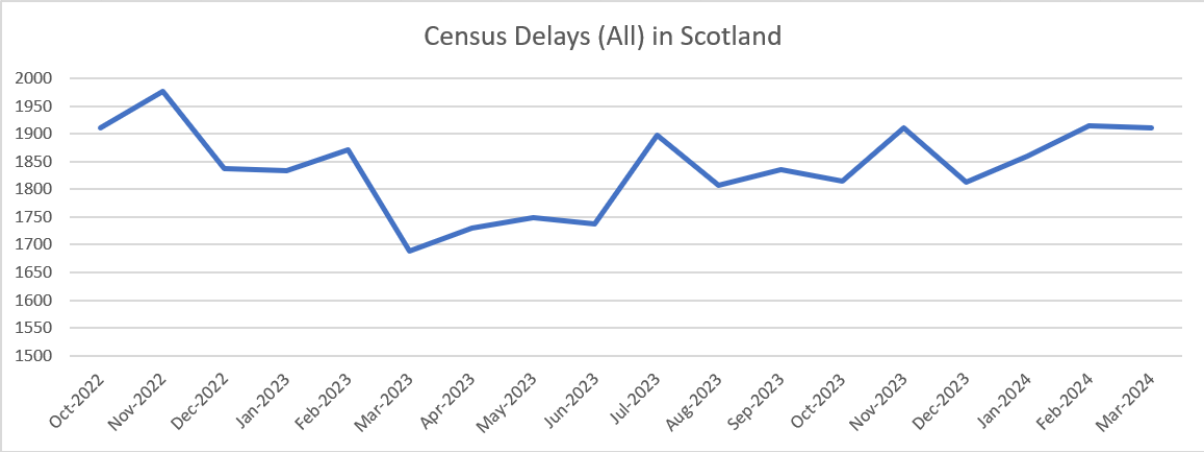
The below graph shows the trends on Edinburgh delayed discharge patients for key delay codes during 2022 up to March 2024 across all hospitals in Lothian. There remain high levels of people delayed in hospital although there has been improvement since the beginning of 2022. One of the main reasons for continued delays include those awaiting a placement in a nursing home, including those with dementia, which changes in staffing in our internal care homes to allow them to admit patients with nursing needs has supported. There have been decreases in code 11s (social work assessments) and code 25Ds (people waiting for care at home) over the last two years but 25Ds are slightly higher than the same time last year.



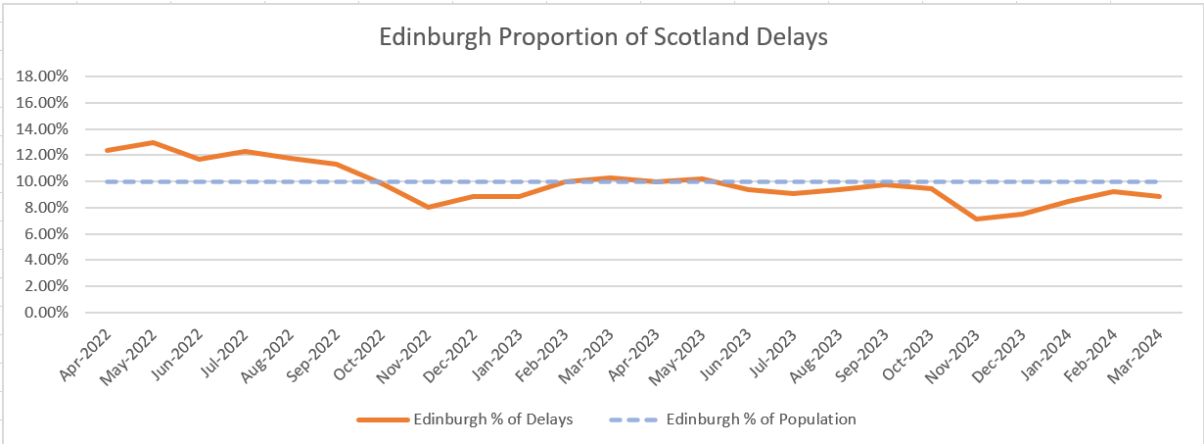
	Jan 2022	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2023	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2024	Feb	Mar
DD Code 11s - assessments	44	34	26	23	31	28	27	30	32	33	30	25	34	34	34	25	31	26	28	34	23	21	16	18	30	29	22
DD Code 24s - care homes	62	64	46	54	62	52	52	44	53	51	44	43	47	56	63	70	58	50	46	45	46	47	47	46	51	53	63
DD Code 25D - CaH	99	86	68	69	55	55	58	63	61	48	27	33	26	26	25	29	38	28	32	33	43	38	40	28	32	37	35
Overall Total	205	184	140	146	148	135	137	137	146	132	101	101	107	116	122	124	127	104	106	112	112	106	103	92	113	119	120

National trend

The following graph shows the position at national level and the total level of delays between October 2022 and March 2024. This shows partnerships across Scotland continue to see pressure on their delay figures.



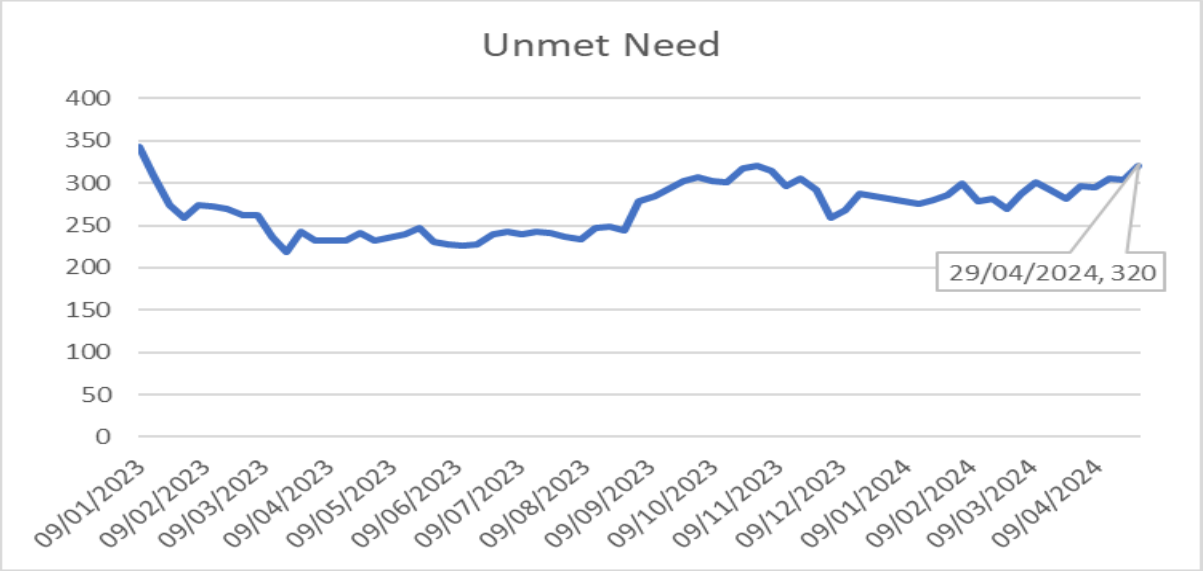
The graph below shows Edinburgh's delays as a proportion of all delays in Scotland and shows that this has been improving in the last few years and has stayed below our proportion of the national population this winter. There has been a slight increase from December 2023 to February 2024 however remained below the national proportion of the national population and started to decrease again in March 2024. This position will be affected by changes within other partnerships as well as those seen in Edinburgh.



On benchmarking Edinburgh against other Health and Social Care Partnerships in Scotland, Edinburgh ranked 11th, ten places better than the Scottish average, in December 2023. By March 2024, our ranking was 13th and we were five place above the Scottish figure so we were not performing as well as in December but better than March 2023 when we were ranked 14th. Our position in March 2024 puts Edinburgh in the top 50% of partnerships for delays at the end of this winter period.

Number of people awaiting a POC in community and hospital

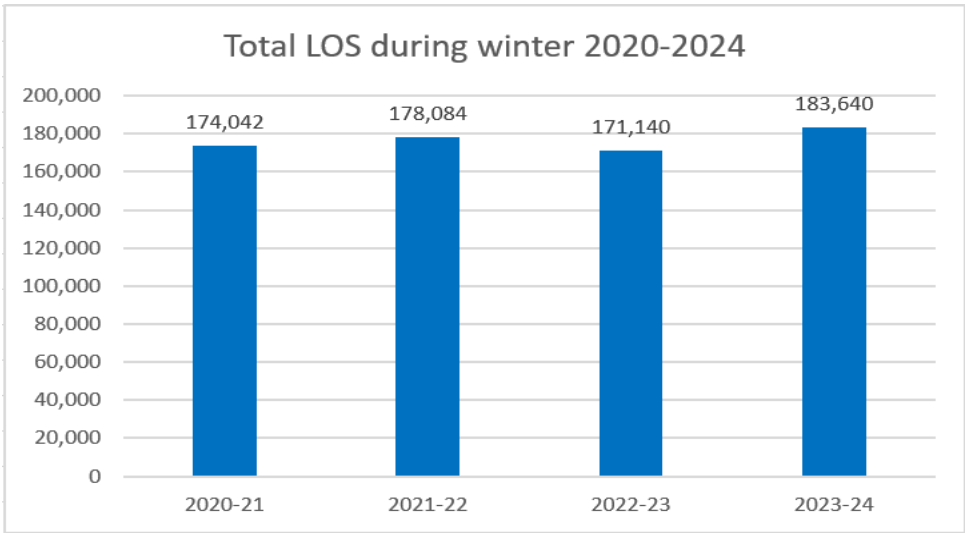
The number of people waiting for a package of care has increased over winter 2023/24. The majority of those waiting are within the community where more people are waiting for care than are doing so in a hospital setting, with around 60-70 people in hospital waiting for a package of care at any one time. While the external market continues to be responsive to our demands, there continues to be some instability within the external market with a small number of our commissioned care at home providers currently suspended, subject to enhanced monitoring and/or controlled growth, which is affecting our waitlist figures.



Source: City of Edinburgh Council local data. Note: Figures exclude blocking reablement and reprovisioning, in line with definitions set by Scottish Government.

2.1 Length of Stay in Hospital – Winter Months

The graph below shows a four-year comparison of Length of Stay (days)* for Edinburgh residents in Lothian acute and community settings. The length of stay (LOS) in hospital increased this winter by **7%**. LOS days for the winter 2023-24 is showing the highest level since the 2019-20 winter.



*LOS of Trak discharges

EHSCP Performance Report from November 2023- March 2024

1. Overall, our performance over winter 2023/24 has stayed similar to that seen over winter 2022/23. While we remain below the high levels of delays seen in previous winters, delay numbers are remaining higher than we would like. Over winter our delays were on the rise, with delays in March 18% higher than in December, a seasonality trend similar to pre-pandemic years. We have seen a decrease in delays over March 2024 following an increase from historically low levels (excluding the pandemic) seen in December 2023. Delays were 27% lower in the days before the festive period than in 2022 and the March data remains 6% lower than March 2023. Nationally figures followed the same trend, with an increase between December and February then a decrease in March. This is likely linked to increasing admissions in December and January being ready for discharge approximately 6 weeks after admissions.

2. Community hospital bed provision in Edinburgh continued to deliver inpatient rehabilitation (intermediate care) and HBCCC over the winter months in Liberton Hospital, Findlay House, Ellen's Glen, and Ferryfield Hospital. There was no capacity to provide any additional winter beds over this time due to the strategic direction around the reprovision of services away from Liberton and the lack of staffing.

3. An additional community step up bed was identified from within the Intermediate Care footprint to support pathways avoiding acute admission.

4. The implementation of Planned date of discharge (PDD) and the adoption of the principles of Discharge without Delay (DwD) in Intermediate Care wards at Liberton and Findlay House is complete and has been highly successful. Significant improvement has been demonstrated across all areas with a third more admissions in 2023 compared with 2022. Median length of stay has reduced by 10 days over the same time frame, and time to admission has reduced by 3 days. Alongside these improvements, the outcome measures collected are also showing improved outcomes for patients.

5. HBCCC wards are undergoing significant redesign through the Liberton reprovision project. A number of inpatient audits have taken place to understand the reasons behind delays in this area.

6. Financial investment has supported Edinburgh Hospital at Home (H@H) to enhance and expand their service thereby increasing the number of patients managed at home. In the last year capacity has increased by 46%. The total patients managed per month now average 180, therefore reducing pressures on attendances and admissions to secondary care services. The average length of stay for a H@H patient has remained

stable averaging 5.73 days in January 2024. It should be noted that the average length of stay for a frail patient admitted to an acute site is currently 18 days.

7. The establishment of an Emergency Department (ED) frailty team has resulted in increased referrals to H@H services. Weekend admissions to Edinburgh H@H increased from 17 in Nov 2023 to an average of 36 per month up to end of March 2024 an average increase of 113% from baseline. This was possible due to allocation of winter funding. Referral criteria have been the same across the week supported by the MoE consultants. Feedback has been very positive. Discussions are ongoing how best to develop sustainable weekend cover.

8. Home First Edinburgh continues to build on the work undertaken to date including the Early Supported Discharge (ESD) pathway which was established as a test of change within the RIE and commenced in December 2023, focusing on patients within the Medical Admissions Unit (AMU) with a length of stay of less than 72 hours. To improve the identification of sufficient numbers of patients with the potential to benefit from this pathway, the team have followed patients beyond the first 72 hours including when boarded from AMU. Between January and April 2024, 155 AMU patients were identified as having potential for ESD and all of these patients were screened by the Home First team onsite. The team subsequently organised 168 pathway services to support these patients to be discharged into the community. Data shows there were 21 new/ increased packages of care arranged. The skill mix of the team which now includes allied health professional leadership to support the home first coordinators is facilitating timely access to various partnership services to support discharge.

9. Home First programme in collaboration with NHS Lothian continues to embed the DwD programme which introduced Planned date of Discharge (PDD) supported by Home First social care staff and Home First coordinators on selected DwD wards at the WGH. The positive results from phase one highlighted the successful collaboration between the EHSCP and NHS Lothian and having been chosen from over eighty applications, the results were presented at the NHS Scotland Event in June 2024.

10. Due to the funding situation, the current DwD workforce at WGH consists of two Home First coordinators supporting MoE DwD wards 50 & 74 and three Home First Social Worker supporting 50, 51,73,74 wards, with one Hospital Social Worker to supports cover as required.

11. The Home First team continues to work with acute colleagues to deliver improvements in LOS for those individuals who have the longest lengths of stay across both the RIE and WGH for all wards. The meetings continue to take place weekly at the WGH for those patients with over 50, 40 and 30 days of LOS and over 30 days LOS for patients at the RIE.
12. The Home First coordinator located at the front door of acute sites continues to provide a dedicated focus to prevent unnecessary admission where possible by

facilitating community alternatives. A single point of access via the Flow Centre provides a professional response to requests from healthcare professionals for people who require urgent therapy and/or urgent social care interventions. Through the Home First navigators, the Flow Centre has developed a greater understanding of alternative urgent therapy and care pathways and is better equipped to recommend alternative options with the ability to highlight potential social admission requests.

13. The Discharge to Assess pathway (D2A) continues to be well utilised across the city with over 3300 referrals received in the last financial year, which represents an increase of over 800 referrals on the previous year.

14. The district nursing IV pathway, working with Outpatient Antimicrobial Therapy (OPAT) at the WGH, has supported 6 patients from February to March to receive IV antibiotic therapy at home. The service is available to patients who are unable to attend OPAT daily.

15. Hospital to Home have offered a bridging service for patients where a package has been matched to commence at a later data and the patient is clinical stable for discharge. The team has grown, and they are supporting greater numbers of patient's home. H2H data suggests the team have been saving over 150 occupied bed days each month in 2024 by supporting patients in the community.