LONDON BOROUGH OF HILLINGDON

HEALTH AND SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

2003/4

Report

REVIEW OF HILLINGDON'S PERFORMANCE: DELAYED DISCHARGE

Members of the Committee

Cllr Catherine Dann (Chairman)
Cllr Janet Gardner
Cllr Lee Griffin
Cllr Shirley Harper O'Neill
Cllr John Major
Cllr Mary O'Connor (Vice Chairman)
Cllr Jill Rhodes

CHAIRMAN'S FOREWORD

This review has involved a significant input from many people, not least of whom are the voluntary organisations who have shared their experiences and expectations with members of the Committee. It is only fitting that before I say anything else that I pay tribute to them - for their support in developing this review, and for many years working in partnership with the Council and other service providers to improve the lives of people within and beyond Hillingdon. I would also like to thank Cllr Andrew Vernazza, who was a member of the Committee in 2002/2003, for his significant contribution to the work of this review.

It was that goal which led the Committee at its very first meeting to identify delayed discharge as a priority topic. It impacts upon the services provided by the Council, the health service and other bodies – but most importantly it impacts upon those who are denied care because appropriate resources are not arranged to meet their needs.

At the conclusion of this review I am pleased to look back upon the last year and the significant work which has been achieved in this area, not least of which has been the creation of the Multi-Agency Project Board addressing this issue,

signature

Councillor Catherine Dann
Chairman Health and Social Care Overview and Scrutiny Committee

REVIEW OF HILLINGDON'S PERFORMANCE : DELAYED DISCHARGE

SUMMARY

The Social Services, Health and Housing Overview and Scrutiny Committee began this review in June 2002 having identified it as a priority issue for review.

The key outcomes identified were :
- To identify the issues leading to delayed transfers of care
- To develop recommendations on actions needed to reduce delayed transfers of care

As part of the review a wide variety of witnesses attended meetings, whose contributions are reflected in the conclusions of the Committee. In addition the Committee considered written representations and reports of officers. Running parallel to this review was an intensive push from all service providers to resolve the problems, which has significantly informed the review.

RECOMMENDATIONS ARISING FROM THE REVIEW

1. Local service providers must continue to work together in pursuit of the aims we have set out in our conclusions.

2. The Cabinet Member for Social Services and Health should receive weekly monitoring reports on progress in implementing the Hillingdon Health Economy Delayed Discharges Action Plan.

3. The Cabinet must receive urgent reports of any serious problems identified in implementing the Action Plan with recommendations on how to address them, and the Committee be made aware of any actions taken.

4. That lessons be learned from the Best Value Review of Accommodation and Residential Care for Adults with Learning Disabilities with respect to the use of sites for combined purposes (e.g. intermediate care, sheltered accommodation and other facilities offering a higher level of care).

BACKGROUND

1. In 2002 Alan Milburn announced that the Department would “penalise councils that fail to tackle ‘bed-blocking’ (delayed discharges)”. This raised the profile of an acknowledged problem: that of elderly patients who once admitted to hospital were not discharged to other care environments when their medical condition would have made that appropriate.

2. According to the Department of Health website (Feb 2003) :
   - Two-thirds of general and acute beds were occupied by people over the age of 65 years
   - People over 65 accounted for more than half the recent growth in emergency admissions
   - In 2000/2001 the average admission period in hospital was 9 nights. However for those aged over 75 this was 16 nights

3. The Department of Health’s definition (April 2001) of delayed discharge was :

   “A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed, but is still occupying such a bed. A patient is ready for transfer when :
   - A clinical decision has been made that the patient in ready for transfer
   - A multi-disciplinary team decision has been made that the patient is ready for transfer
   - The patient is safe to discharge / transfer”

4. The situation reflects interrelationships between the health and social care systems as well as the predominately private sector providers of older person care homes. Accordingly the Committee needed to look not just at what the Council could do, but at how this would affect the other partners within the health economy.

CURRENT POSITION

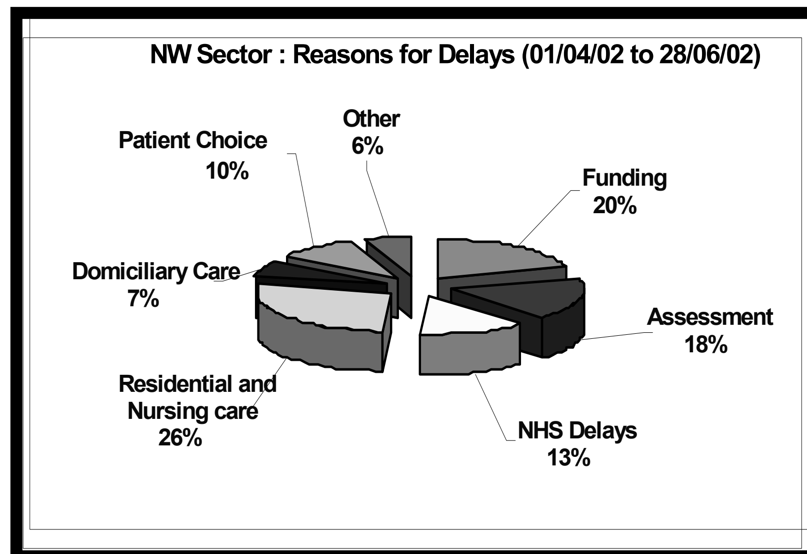
5. On 29th August 2002 the Committee received information on the local situation regarding delayed discharge, in particular from a one week survey of 42 patients aged 65 or over in hospital waiting for alternative accommodation, the results of which are set out in Table 1.

Table 1 : Performance In Hillingdon

	Total	Percentage
	42	100%
Reason for delay		
Waiting for assessment and identifying appropriate care setting	12	29%
Awaiting funding from social services	6	14%
Awaiting further NHS Care	0	0%
Awaiting nursing home placement	20	48%
Awaiting domiciliary package, inc equipment and adaptations.	0	0%
Patient and/or carer exercising right to chose.	2	5%
Other reasons	2	5%

6. Looking over the local region the following reasons were identified as causing delays in discharging patients across the North West London Sector (including Hillingdon)

Reason for Delays – North West London Sector



7. The Committee was also informed of another review, of inpatient stay, which found that 3 out of 11 patients could have been diverted from hospital admission - 2 by better medical intervention and 1 by combined medical or psychiatric and social care.

STEPS ALREADY BEING TAKEN

8. On 6th March 2003 the Committee reviewed actions already taken by officers to address the issue of delayed discharge, including the 'Hillingdon Health Economy Delayed Discharge Action Plan' which is attached at Appendix 2 to this report. The Action Plan was developed by Dorian Leatham (Chief Executive of the London Borough of Hillingdon), Graeme Betts (Chief Executive of the Hillingdon Primary Care Trust), David McVittie (Chief Executive of Hillingdon NHS Trust) and Jim Wilson (Interim Director of Social Services).

9. The Committee following consideration of the Action Plan agreed to welcome the information received, expressed concern at the spiralling cost of placements, welcomed the move towards sheltered accommodation in the Borough and recommended that there should be learning from the Best Value Review of Accommodation and Residential Care for Adults with Learning Disabilities in respect to the use of sites for combined purposes (e.g. sheltered accommodation and facilities offering a higher level of care).

10. As of 6th March 2003 the Committee heard from Jim Wilson that a range of measures had already been implemented :

- Extra funding for older people's service to increase the purchase of residential and nursing home provision – several beds purchased on a block contract in Feltham and Rickmansworth
- Development of community based service so that people can return from hospital to their own home, with appropriate domiciliary care
- Increase the amount paid to purchase beds in order to maintain LB Hillingdon's place in a competitive market
- Social Services would be giving £95,000 to the Hillingdon PCT to open beds in Northwood and Pinner Community Hospital
- Discussions with Housing Services about development of suitable units for sheltered beds

11. In addition to the written evidence presented to the Committee it received evidence from a range of the organisations directly involved in resolving the delayed discharge issue, as well as from groups representing users, listed at Appendix 3.

12. Common themes that the Committee identified as coming from the presentations were :

- the need for more support in the community to avoid unnecessary admissions and to enable people to return to their own home, with appropriate care, following a stay in hospital
- the need for the earliest possible planning around discharge

- difficulties with the recruitment and retention of front line staff (e.g. Occupational Therapists, District Nurses) exacerbate the problem of delayed discharge
- the importance of liaison between the services to ensure a coherent ‘whole systems’ / partnership approach

INTERMEDIATE CARE

13. Intermediate care seems to be a key provision in solving the Delayed Discharges conundrum. It can act as a buffer between full residential care home care. But crucially it gives time for difficult, life changing decisions to be made in a careful and balanced way. It is vital that patients and their relatives are given the necessary information to make informed decisions about their care.

OUR CONCLUSIONS

1. Delayed discharge from hospital is a serious problem for all concerned – patients and their relatives – and medical, care and other service providers. We believe that the aim should be for a whole systems approach that achieves the following

- prevent unnecessary admission to hospital
- facilitate early but planned discharge from hospital
- provide a fast effective response to referrals
- give service users a breathing-space period in an enabling, non-acute setting (intermediate care)
- prevent long term admission into residential or nursing home where not appropriate
- more sheltered accommodation (homes for life) built for low dependency service users
- assistance to carers in making the right choices for their loved ones and also for themselves
- involving service users and their families fully in choice of care home or package of home care.

2. It is essential that the Hillingdon Health Economy Delayed Discharges Action Plan works. If it does not, there will be severe consequences

- for patients themselves and their relatives through the distress caused
- for other local services if the Department of Health’s financial penalties are triggered.

Appendix 1

HILLINGDON HEALTH ECONOMY DELAYED DISCHARGES ACTION PLAN

This plan pulls together a number of action plans that have been written over the last 4 months by organisations across the Hillingdon Health Economy and presents an up to date list of current actions, resources and responsible organisations. In terms of immediate priorities (to be implemented by the end of March 2003) these actions are unshaded. Those actions that are considered to be medium and long term objectives (i.e. after the 31st March 2003) are shaded in grey.

Source of information:
WSAP = Whole Systems Action Plan.
COAP = Chief Officers Action Plan of October 2002
DW = Discharge Workshops – Craig Williams:

Accountability for the plan is as set out in action points 1& 2 and as covered in the meeting between Graeme Betts, David McVittie and Jim Wilson.

Objective 1: Develop partnership working

	Action Proposed	Source	Start date	**Extra investment £**	**Intended impact upon numbers of people classified as 'delayed discharge'**	**Progress**	**Accountability**	**Lead(s)**
1	Establish multi-agency project board to oversee joint agency action plan.	WSAP & DW	Jan 03	Nil	Will ensure chief officer oversight and assistance to achieve whole system action. In particular, the remit of this group will be to focus on: The reduction in delayed transfers of care; The development of admission prevention and discharge planning; The implementation of the single assessment process The development of intermediate care	The board has been established and meetings arranged	Graeme Betts, David McVittie and Jim Wilson	**Elaine House** Lesley Perkin John Doran Hannah Coffey Keith Skerman Simon Weldon

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
2	Establish operational sub-group of the Board	DW	Jan 03	Cost neutral	To support the work of the Project Board in delivering implementation of: • An agreed capacity plan for achieving reduction in delayed transfers of care. • Reimbursement • Auditing progress	Meetings arranged	Elaine House Lesley Perkin John Doran	Elaine House Lesley Perkin Keith Skerman Sue Pascoe Simon Weldon Hannah Coffey Craig Williams
3	Maintain the multi-agency project group developed through the whole economy workshops on admission and discharge planning.	DW	Jan 03	Four days of Craig Williams £1250 per agency	Improve discharge planning process with consequent impact upon performance through more timely and co-ordinated discharges.	Has been established, met once and meetings arranged	Elaine House Lesley Perkin John Doran	Sue Pascoe Simon Weldon Craig Williams

Objective 2: Reduction in delayed transfers of care

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
4	Increase purchase of residential and nursing home provision	WSAP & COAP	Jan 03	Potential full year cost £750k - £1 million	Increase by a minimum of 46 (agreed at Sitrep meeting of 3rd Feb 03) placements above current quantum of 590 SSD placements: 5 at Rickmansworth, 30 at Feltham, 6 at Northwood and Pinner, and 5 in Mt Vernon. Spot purchases will be unpredictable and might rise if possible	25 beds purchased on a block contract basis for 3 years. 20 in Feltham (available end of 04/03) and 5 in Rickmansworth	Jim Wilson	**K Skerman** N Ellender

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
5	Increase placement price paid.		Dec 02	Dependent upon admission rate but full year cost in future years +10% estimated	Essential requirement to maintain place in competitive market as the shortfall in places and cross charging increase competition. Estimations are that 30% of placements	Price ceilings raised from Dec 02.	Jim Wilson	K. Skerman S Morris N Ellender

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
					become available in a year but these are all potentially at risk of being taken by other local authorities.			
6	Increase availability of sheltered housing: two clusters of five units. Increase the supply of intensive home care support.		Feb 03	Main FYE impact to be costed - £20k SSI grant this year.	10 places available for short-term intensive rehab. Prevent hospital admissions for those 'at risk' and early discharge through sheltered housing	2 units have been identified and are being commissioned. Further 2 planned for next 3 weeks	Jim Wilson	**K Skerman** N Ellender
7	Current usage of Hayes Cottage to be investigated to free up beds for winter pressures	COAP	Nov 02	£95k per annum.	Hayes Cottage not fully utilised (12 beds).		Elaine House John Doran	Penny Thorpe
8	Northwood & Pinner to	COAP	Nov 02	£95k social services for	Northwood & Pinner six beds to open; 2 on the 10th	2 beds have been opened	Elaine House	**Penny Thorpe**

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
	be investigated to free up beds for winter pressures			full-year.	Feb and a further 4 at the beginning of March. SS to fund	4 in March	John Doran	
9	Increase the capacity of the hospital social work team by 2 WTE posts.	WSAP	Dec 03	£35k SSI grant	Reduce 'awaiting assessment' under 7 days figures to maximum of 2 and speed up discharge plans	Extra capacity in place. STEIS at 17th Feb 03 is 12 patients awaiting assessment > 7 days.	Keith Skerman	Nick Ellender

Objective 3: The development of admission prevention and discharge planning

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
	Admission Prevention							
10	Age Concern – develop befriending scheme to support unaccompanied older people in A&E.	WSAP	Apr 03	£46k FYE Joint	Reduce hospital admissions by 2 admissions per day from when the scheme is operational	Recruitment to the scheme will take place in March 03. Projected start date for the scheme is Nov 03	John Doran Elaine House	C Comerford
11	Age Concern – extended the Home	WSAP	Jun 03	PCT/SSD funds	This scheme will provide five	This scheme will be phase 2 of the A&E	John Doran Elaine	C Comerford

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Lead(s)
	from Hospital Scheme to the south of the borough.				discharges per day.	scheme and is expected to start in April 04.	House	
12	Provide more hours of the flexible respite in the home service	WSAP & COAP	Feb03	£10k SSI grant	Prevention of admissions of older people in crisis by 4 at any one time.	Targets need further definition	Keith Skerman	N Ellender

Discharge Planning								
13	Establish Discharge Co-ordination Team	WSAP & DW	Feb 03	£50k identified and a further £100k would be needed – source to be determined.	Immediate establishment of a Discharge Liaison Team to operate 7 days a week. Team to be a nurse, social worker and therapist. Team will be using current staff and will backfill these posts. The rotation will start to influence behaviour across all staff groups and teams. To be agreed at next Operations Sub-Group meeting	Project specification is currently being prepared and will be available by end Feb 03.	To be agreed at next Operations Sub-Group Meeting	To be agreed at next Operations Sub-Group Meeting
14	Simple / complex discharge groups to implement agreed cross agency protocols on discharge planning	WSAP & COAP	Current	-	Timely and appropriate assessment of patients will be completed in a standard time frame.	Draft pathways have been prepared. Implementation plan by each group is now required and will be available by mid Mar 03	Keith Skerman	Nick Ellender Margaret Radu **Simon Weldon**
15	Training for all hospital staff will be provided on their roles in the discharge process and Single Assessment	WSAP	Jan 03	£4k	All ward and social care staff have clearly identified roles and responsibilities in the discharge process and are able to carry these out.	Implementation plan will be drafted by simple / complex discharge groups and	Lesley Perkin, Sue Greenslade	Susan LaBrooy Simon Weldon **Sue Greenslade**

						training will be delivered in June 03		**Maureen Wilcox**
16	Copy of the discharge policy and information about the range of services is given to patients on admission	WSAP	Feb 03	-	Patients will clearly understand the roles of the different agencies in their care and the requirement to manage the acute bed pool.	This action will be taken forward by the PALS service. PALS link nurses to wards now being established.	Sue Greenslade	**Angela Hyde** Faizal Mohomed-Hossen
17	Implement agreed protocol on patients leaving hospital	WSAP	Jan 03	-	This will ensure that patients make a 2nd and 3rd choice of care home that will provide a temporary placement.	Protocol has been agreed and will be implemented from 1st Mar 03	Lesley Perkin Keith Skerman	Nick Ellender, Simon Weldon
18	Achieve consistent standard of the drug information provided on discharge, with the aim of providing this electronically.	DW	Jan 03	Cost neutral, although may be some medium term IT support costs	It has been agreed to pilot this at Mount Vernon, by Martin Sweatman	Group is in the process of drafting an operational protocol.	Lesley Perkin	**Martin Sweatman** Simon Weldon
19	Develop current multi-disciplinary	WSAP	Curr ent	-	This will ensure that all discharge decisions are made in	The project team arising	Lesley Perkin Sue	Nick Ellender Simon

	team structures as operational leads to plan discharge				a multi-disciplinary context, supported by the Discharge Team. Social workers and therapists will detail what they expect from consultants in terms of support, multi-disciplinary working, decision making etc. and the consultants will do the same	from the admissions / discharges workshop will progress this action during Feb and March 03.	Greenslade Keith Skerman	Weldon Clinical Directors

Objective 4: The implementation of the single assessment process

	Action Proposed	Source	Start date	**Extra investment £**	**Intended impact upon numbers of people classified as 'delayed discharge'**	**Progress**	**Accountability**	**Leads**
20	To employ a full time worker as a change and service development person, co-coordinating the operational roll out of the single assessment process, which underpins the joint working on prevention of admission and accelerated discharge from Hospital.	WSAP	Jan 03	£35k is currently with SS for a project manager for single assessment (Performance Fund)	One Qualified Social Worker Level 4 or Health Service equivalent 36 hours. Introduce SAP to hospital and community to improve quality and efficiency of assessment and care management process To ensure the joint and integrated roll out of the SAP across health and social care agencies	J.D. completed. Post to be advertised shortly as a secondment opportunity for PCT or SSD staff. Next Operational Group meeting needs to check how current project architecture can be used to introduce SAP	Keith Skerman Penny Thorpe Lesley Perkin	**Nick Ellender** Sue Pascoe Simon Weldon

21	To pilot the single assessment process on the Hillingdon Hospital site	WSAP	Feb 03	Cost neutral	To implement a unified system of documentation between the acute elderly wards and the hospital social work team. Pilot sites to be Stroke Unit, OP Day unit, at Hillingdon and Day Hospital and rehab unit at Mt. Vernon	Pilot sites	Keith Skerman Penny Thorpe Lesley Perkin	Nick Ellender **Martin Sweatman** Simon Weldon

Objective 5: The development of intermediate care

	Action Proposed	Source	Start date	**Extra investment £**	**Intended impact upon numbers of people classified as 'delayed discharge'**	**Progress**	**Accountability**	**Leads**
22	Implement weekend working and transfer home in the Rapid Response Service	WSAP & COAP	Jan 03	£90K	This will enable additional discharges (2 per day) and prevent inappropriate admissions through A&E (2 per day).	A&E working has commenced, assessment of 2 patients per day in place.	Lesley Perkin Joan Veysey	**Simon Weldon**

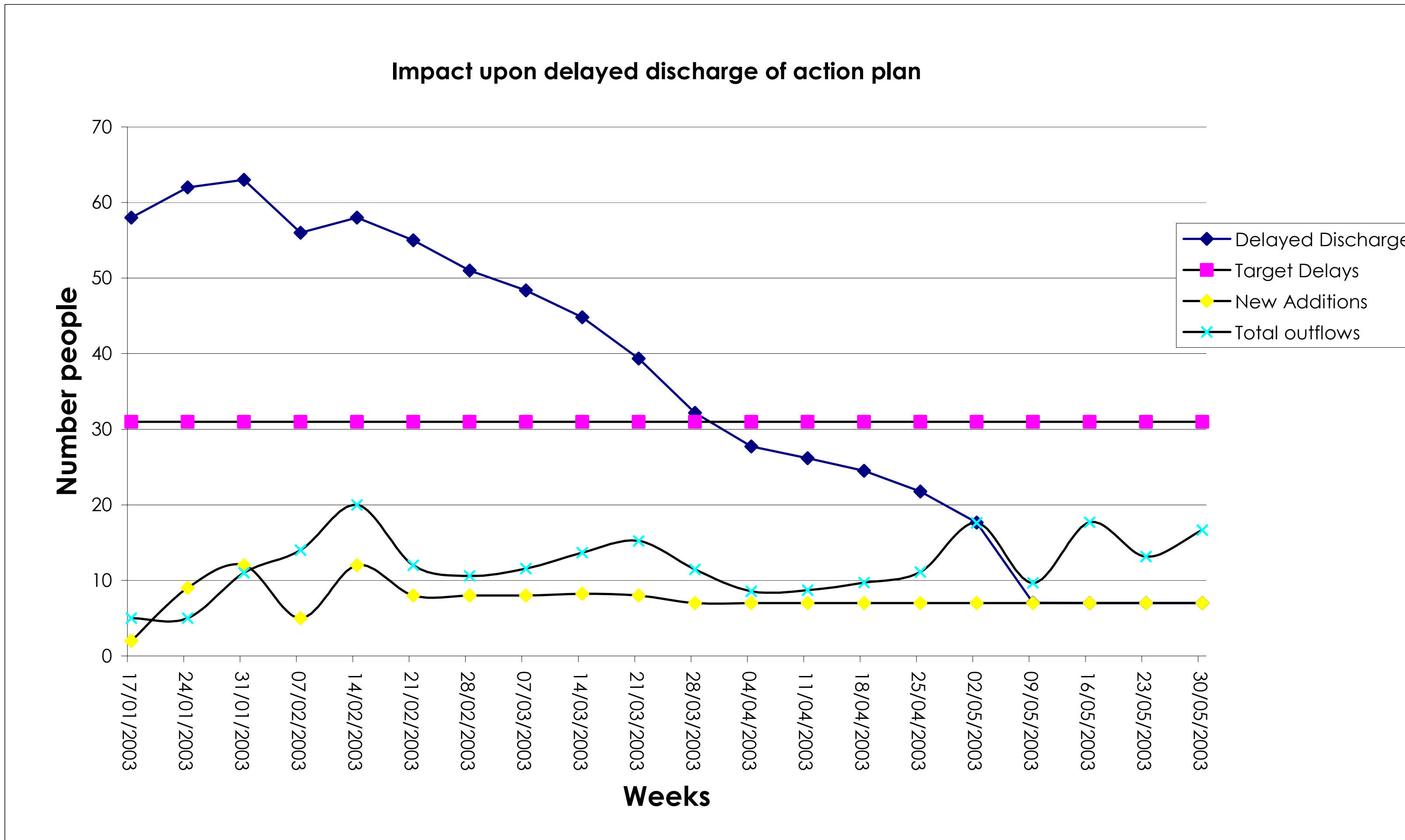
	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Leads
23	Whitby Dene residential home intermediate care facility (10 beds) - improve and extend capacity of the service through greater therapies provision.	WSAP	Nov 02	£45K to be funded by health Funding expires July '03 for rehab. Future funding to be identified	Physiotherapist at senior 1 level for 18 hours a week. Assistant Physiotherapist for 18 hours a week. Occupational Therapist for 36 hours a week. Ensure 10 beds have rehab operate at capacity in provision of early discharges from budgets.	Completed. SW to check	Keith Skerman Joan Veysey	D Ellison
24	Two Rehabilitation Assistants trained to undertake community based rehabilitation work.	WSAP	Jan 03	£58,000 Performance Fund	Employ 2 WTE assistants to focus on admission prevention and facilitate early discharges	Being recruited. Working from where?	Keith Skerman	D Ellison
25	Four senior home care workers (18 hours each) trained to undertake community based rehabilitation work.	WSAP	Dec 02	£46,000 Performance Fund	Increase numbers of people receiving rehab at home – earlier discharges. 36 hours dedicated rehabilitation contact time/week	To use 4 in house staff working 18 hours each. To start in March 03	Keith Skerman	S Morris
26	Pump prime an Admiral Nurse scheme in partnership with	WSAP	Jan 03	£30,000 Performance Fund + £100k charitable	The employment of two RMN posts (G and H grades) on permanent contracts to provide a	Agreement in place with the Dementia Relief trust and the	Keith Skerman Lesley Perkin	N Ellender **M Skelton-Robinson**

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Leads
	the Mental Health Services for older people and the Dementia Relief Trust			funding	service to the carers of people with dementia and prevent inappropriate admissions to Hospital or other forms of institutional care. 40 users & families to be supported.	Mental Health Services for Older People (Hillingdon Hosp.) Post to advert, early Feb 03.		
27	To extend dedicated palliative home team to prevent delayed discharges	Whole Systems- Action Plan & COAP	Nov 02	Cost met by SS in current year Service to be commissioned and funded by health in 2003/04	To prevent closure of scheme supporting those wishing to live at home with terminal illnesses as alternatives to hospital admissions	Service now commissioned with "Specialist Care", an independent provider.	Keith Skerman	S Morris
28	To confirm commissioning arrangements for NHS continuing care for 2003/04	Social Services	Mar 03		Clarification of impact of revised continuing care criteria	Workshop set up for early Mar 03	Sue Pascoe	Keith Skerman Simon Weldon
29	Establish single gateway for access to intermediate care services	COAP	Nov 02	Cost neutral	Initially a neutral effect for capacity. Should result in medium term benefits when the system beds in, resulting from more efficient use of capacity	Single access pilot scheme now in operation that signposts referrals to the appropriate I.C. service.	Joan Veysey	**Intermediate Care Managers**

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Leads
30	Primary care / SS liaison scheme to proactively identify older people at risk of admission to hospital or residential care.	COAP	Nov 02	-	Currently scheme is rolled out in Hayes & Harlington, but only sporadically in the other two localities	Limited progress, but work being done through joint D.Nurse SSD meetings.	Penny Thorpe Keith Skerman	Angie Cowan
31	Amalgamate and distribute SS and PCT bed stocks on a weekly basis to all organisations	COAP	Nov 02	-	To ensure that beds are fully utilised throughout the health economy. Information dispersal currently ad hoc, but has been addressed w/b 13/01/03	Completed. SSD now acting as co-ordinating point and distributing on a weekly basis.	Keith Skerman Elaine House	Margaret Johnston Stephanie Jones Margaret Radu
32	Mapping out of hours services	DW	Jan 03	-	Some work will be undertaken to understand fully how out of hours services fit into capacity planning	A mapping exercise will be commissioned by the Project Team working on admissions and discharges.	Keith Skerman Lesley Perkin Elaine House	Nick Ellender Sue Pascoe Simon Weldon

Objective 6: Project & Audit Review

	Action Proposed	Source	Start date	Extra investment £	Intended impact upon numbers of people classified as 'delayed discharge'	Progress	Accountability	Leads
33	Develop Measures of success and methods for tracking/evaluating success	WSAP & COAP	Mar 03	to be determined	Ensures we can quantify impact of actions on delayed discharges (see below)	To be discussed at next Operational Sub-Group Meeting	Lesley Perkin	To be agreed


Impact upon delayed discharge of action plan
Number people
70
60
50
40
30
20
10
0
Delayed Discharge
Target Delays
New Additions
Total outflows
17/01/2003
24/01/2003
31/01/2003
07/02/2003
14/02/2003
21/02/2003
28/02/2003
07/03/2003
14/03/2003
21/03/2003
28/03/2003
04/04/2003
11/04/2003
18/04/2003
25/04/2003
02/05/2003
09/05/2003
16/05/2003
23/05/2003
30/05/2003
Weeks

Delayed Discharge Model

					Week Ending											
REASONS FOR DELAY	**17-Jan-03**	**24-Jan-03**	**31-Jan-03**	**7-Feb-03**	**14-Feb-03**	**21-Feb-03**	**28-Feb-03**	**7-Mar-03**	**14-Mar-03**	**21-Mar-03**	**28-Mar-03**	**4-Apr-03**	**11-Apr-03**	**18-Apr-03**	**25-Apr-03**	**2-May-03**
Awaiting Completion of assessment (<7 days)	2	8	10	4	5	5										
Awaiting Completion of assessment (>7 days)	21	9	10	18	12	8										
Awaiting Public Funding	4	4	3	3	6	4										
Awaiting Further (non acute) NHS Care	3	1	1	2	1	1										
Awaiting Residential/Nursing Home Placemen	10	16	10	9	14	15										
Awaiting Domiciliary Package	0	1	0	0	0	0										
Patient or Family Choice	7	9	15	8	8	9										
Other Reason	11	14	14	12	12	13										
TOTAL DELAYED DISCHARGES	58	62	63	56	58	55	51	48	45	39	32	28	26	24	22	18
TARGET FOR DELAYED TRANSFERS (	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31
FLOW OF PATIENTS																
Deaths	1	1	5	4	3	3	3	4	3	3	3	3	3	3	3	3
Placed in Homes	2	3	4	7	9	6	4	4	6	7	4	2	2	2	3	10
Discharged Home	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Removed due to Illness	1	0	1	3	0	0	1	1	1	1	1	0	0	1	1	1
Discharged with Packages of Care	0	0	0	0	6	3	2	2	3	3	3	2	3	3	3	3
Other outflows	1	1	1	0	2	0	1	1	1	1	1	1	1	1	1	1
Total Outflows	5	5	11	14	20	12	11	12	14	15	11	9	9	10	11	18
New Additions	2	9	12	5	12	8	8	8	8	8	7	7	7	7	7	7
NET FLOW	-3	4	1	-9	-8	-4	-3	-4	-5	-7	-4	-2	-2	-3	-4	-11
CUMULATIVE EFFECT	-3	1	2	-7	-15	-19	-22	-25	-31	-38	-42	-44	-46	-48	-52	-63
								Two sheltered acomodation units open	Plus 4 beds Northwood & Pinner	Plus 3 beds Rickmansworth						Block Contract Part 1

Notes: Projected data from 21 Feb 03 is moving average.

Exceptions:

'Placed in homes' total is made more variable with extra capacity being shown plus estimated variations due to supply.

New additions' total is reduced to reflect extra diversion activity and increased Rapid Response Team capacity and scope

Also note:

Work with 'choice' patients will need to ensure they are ready to leave in timescale but some will probably register as 'delays'
Some delays 'awaiting assessment < 7 days likely.

Model assumes that capacity is used for patients delayed not people waiting in other locations.

Appendix 2

Evidence Received From :

Name	Position in Organisation	Body
Jim Wilson	Interim Director Social Services	London Borough of Hillingdon
Graeme Betts	Chief Executive	Hillingdon PCT
David McVittie	Chief Executive	Hillingdon Hospital NHS Trust
Elaine House	Executive Director Performance and Commissioning	Hillingdon PCT
John Doran	Head of Commissioning and Performance Management	LB Hillingdon Social Services
Claire Thomas		Hillingdon Carers
Angela Wegener	Chief Officer	Disablement Association Hillingdon (DASH)
Keith Sherman	Head of Community Care	LB Hillingdon Social Services
Chris Commerford		Age Concern, Hillingdon
Carol Coventry		Hillingdon Association of Voluntary Services
Dr Susan La Brooy	Consultant Physician and Associate Medical Director	Hillingdon Hospital NHS Trust
Marueen Wilcox	Hospital Social Work Team	Hillingdon Hospital