REPORT TO:	East Lothian Integration Joint Board
MEETING DATE:	21 September 2023
BY:	Chief Officer
SUBJECT:	East Lothian Inreach Project at Royal Infirmary of Edinburgh

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1 PURPOSE

1.1 To update the IJB on ongoing development and delivery of the Inreach Programme.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Note the positive evaluation of Phase 1 of the Inreach Project and the agreement to continue delivery until March 2024.

3 BACKGROUND

3.1 The East Lothian (EL) Inreach model aims to shape and direct the pathways of all EL residents presenting or admitted to the Royal Infirmary Edinburgh (RIE). The model aims to ensure that residents are identified at the earliest point in their patient journey with a focus on optimising patient journey and reducing length of stay (LOS).

3.2 An enhanced Inreach approach has been implemented with a team of EL therapists based within the RIE, undertaking assessments of EL patients. At the core of this model are the close links with the wider East Lothian Health & Social Care Partnership (ELHSCP) and a commitment to support acute staff in navigating EL discharge pathways. This includes fostering an ethos of Partnership responsibility and transfer of risk to the HSCP, in order to explore all available opportunities to support hospital discharge.

3.3 Phase 1 of the project case managed 347 patients, completing 2300 interventions, and facilitated 320 discharges. The project evidenced mitigated costs of £518,760 achieved through an average of 11 bed days

saved over 120 patients by improvements in the Discharge to Assess pathway.

3.4 Phase 2 (Q1) of the project has case managed a further 382 patients, completing 1795 interventions, and facilitated 166 discharges.

4 ENGAGEMENT

4.1 N/A

5 POLICY IMPLICATIONS

5.1 Development of the Inreach Project supports a number of the IJB's strategic priorities for 2022-2025, including Strategic Objective 1 'Develop services that are sustainable and proportionate to need' and Delivery Priority 'Supporting the acute sector'.

6 INTEGRATED IMPACT ASSESSMENT

6.1 No IIA required at this stage due to this being a time-limited project, this has been discussed and agreed with East Lothian Rehabilitation Services IIA Lead.

7 DIRECTIONS

7.1 ELHSCP are determining the introduction of a direction for this piece of work.

8 RESOURCE IMPLICATIONS

8.1 Financial – Additional funding sourced from repurposed Scottish Government Unscheduled Care funding (£300,000).

8.2 Personnel – this was initially provided through existing resource, however, subsequently some additional recruitment was completed and at the beginning of Phase 2 the staff was as shown in the table below.

Description	Band	WTE	Cost (£K)
Occupational Therapy Team Lead	7	1	£63,468
Advanced Practice Occupational Therapist	7	1	£63,468
Physiotherapy Team Lead	7	1	£63,468
Occupational Therapist	6	1	£57,267
Occupational Therapist	5	2	£46,558 x2 = £93,116
Occupational Therapy Assistant Practitioner	4	1	£33,908
Total			**£374,695**

8.3 Other – Nil

9 BACKGROUND PAPERS

9.1 East Lothian RIE Inreach Final Report (Oct 22-Mar 23)

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East Lothian RIE Inreach

November 2022

–

March 2023

Rebecca Knipe – Clinical Lead Occupational Therapist

Laura Rowlinson – Clinical Lead Physiotherapist and Digital & Informatics Lead

East Lothian Rehabilitation Service

Introduction & Background

The current health and social care system has been under unprecedented and sustained extreme pressures and is no longer sustainable in its current model of service delivery. There is a global shortage of health and social care workforce (Crooks, 2023), significant increase in waiting lists (with 1 in 9 people on a waiting list in Scotland) and a limited hospital and care resource (Carey-Whitehead, 2023).

A fundamental change in service delivery and existing pathways is essential to meet the requirements of the Scottish population.

The challenges outlined above are reflected within NHS Lothian and in planning for Winter 22/23 all Partnerships were asked to review what they could do, to support their residents and ease pressure on the acute hospitals. An enhanced Health and Social Care Partnership (HSCP) approach was required where Partnerships assist in the navigation of discharge pathways and with this the intention to transfer responsibility, and therefore risk to the HSCP for seeking all available opportunities to support early hospital discharge.

Allied Health Professionals (AHPs) are well-placed to address some of the challenges around unscheduled care, assessing and using high clinical reasoning skills to identify patients who can be discharged home directly from the front door or at the earliest point within the patient journey. It is estimated that 70% of patients referred to Occupational Therapists (OTs) at the front door can be discharged directly home (James, 2017).

East Lothian Health and Social Care Partnership (ELHSCP) has a reputation for developing home first pathways and having an agile workforce able to adapt to meet the changing needs of the population, ensuring people receive the right care, at the right time. ELHSCP residents admitted to acute sites, particularly those over 65, are often known to local services, where it was identified that comprehensive Partnership assessment could positively influence the discharge plan at an early point, utilising local knowledge, expertise and integrated team working. Furthermore, the East Lothian Hub and Flow Team identified an increasing prevalence of Request for Service's (RFS's) from acute clinicians were lacking in essential information, consideration of alternative options and limited or poor family communication. (See Appendix 1 for additional challenges identified).

ELHSCP proposed an enhanced Partnership model with daily Activity Huddles chaired by Senior Managers and an Inreach model based at the Royal Infirmary of Edinburgh (RIE) to allow East Lothian AHPs to complete comprehensive assessments and rehabilitation of East Lothian Residents. The Inreach would be delivered by the East Lothian Rehabilitation Services (ELRS) with continual collaboration with all the ELHSCP services.

The RIE Inreach model supports the priorities of the NHS Lothian USC programme focused on Discharge without Delay and is in accordance with the refreshed National Framework for Unscheduled Care (Scottish Government, 2022). This collaborative approach would improve pathways through hospital settings and reduce length of stay by optimising flow and aligning capacity and demand. Working with patients, families and/or carers, it will ensure patients are treated in their home where appropriate.

Executive Comments

Calum Campbell, Chief Executive of NHS Lothian

"As we continue to see the increasing challenges on demand, we need to respond differently looking at alternative and novel systems of approach. The activities undertaken by East Lothian's AHP service, are a fantastic example of how they can show their support to the wider HSCP system, by developing and delivering an alternative approach to assessment.

It not only challenged risk using local knowledge, but also improved the performance, creating capacity and importantly delivered better outcomes for patients. It was clearly an incredible team effort, worthy of praise and recognition."

Alison Macdonald, NHS Lothian Executive Director of Nursing, Midwifery and Allied Health Professionals

"In delivering this project East Lothian has used their well-established AHP team to access the full range of services available across the community to meet the needs of our patients. It is through these kinds of project that we can see the true value of integration across our professional groups. East Lothian's approach benefits from the knowledge Partnerships bring, to how our patients live day to day. I'd like to commend them on this patient centred approach to care."

Fiona Wilson, Chief Officer of East Lothian Health and Social Care Partnership

"East Lothian HSCP has a strong history of developing innovative pathways to prevent admission and support discharge. This project has looked at opportunities for improvement, by incorporating AHP Inreach at the front end and a strong skilled multi-agency team working alongside them, to support the best pathway for patients. Not only was this development balanced on risk, it also focused on delivering an asset based approach. Our commitment is to strengthen this development further, identifying opportunities to improve performance, with the potential to cultivate wider system change."

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East Lothian Rehabilitation Services

East Lothian Rehabilitation Services (ELRS) was well positioned to respond to this request. ELRS at design is an agile, integrated, and collaborative team. With an innovative and data-driven ethos, the service was able to reallocate workforce within existing resources to support East Lothian therapists to clinically work within the RIE to provide comprehensive assessment and discharge planning of East Lothian (EL) residents.

ELRS work across multiple sites within East Lothian and have a high level of remote and virtual communication and time management skills. There is a strong ethos of auditable practice with bi-annual notes and outcome measure audits completed. In addition, there is a comprehensive training, supervision, and Continual Professional Development structure. All these factors supported ELRS to be able to respond to this new requirement not only in a timely manner, however with professionalism and enthusiasm.

The impact of moving resource was identified, with the expected increased community waiting lists and potential for reduced Discharge to Assess (D2A) capacity. Priority "RAG (Red-Amber-Green)" rating was implemented on existing workstreams, and the Single Point of Contact Phoneline cover was provided by Band 7 / 8a's to increase clinical capacity within the community, ensuring the continual delivery of a flexible service to respond to facilitating discharge requests.

ELRS has a collaborative and visible management structure, which allows for quick decision making and provides a supportive staffing structure. Furthermore, ELRS AHPs already had close links with the EL Hub / Flow Team and Social Work teams, across both inpatient and community. These elements provide essential foundations to develop and implement the Inreach model on.

'ELRS is a successful service due to its ethos of evidence-based and data-driven service design and adhering to and implementing operational policies, auditable practice, and comprehensive training within all service pathways.

The Inreach model could be described as the 'arrow point' of ELRS, and the service was able to implement this model due to the multi-agency and collaborative approach utilised within ELHSCP.

Innovation is a key priority within ELRS and there is active development of enhancing digital choice options available and utilising current and emerging technologies.

I am very proud to be the General Manager of this innovative service.'

Lesley Berry, General Manager East Lothian Rehab Service and Chief AHP.

The Inreach Model & Aims

The East Lothian Inreach model aims to shape and direct the pathways of all EL residents presenting or admitted to the acute hospitals (RIE and Western General Hospital (WGH)). Ensuring patients are identified at the earliest point in their journey with a focus on optimising their journey and reducing length of stay (LOS).

Additionally, the aim to ensure the appropriate patients are listed for an East Lothian Community Hospital (ELCH) bed in a timely manner and supporting these patients to continue to receive rehabilitation and avoid being "prioritised out".

A primarily remote EL Inreach model was commenced on the 15th August 2022 at the WGH, this was alongside the daily multi-agency flow huddle which commenced 11th July 2022. However, as it became apparent that most of EL patients and delays were within the RIE, the model was reviewed and adapted to be implemented in the RIE. The updated model consisted of a small team of OTs and Physiotherapists (PTs) who would be clinically working at the RIE Monday to Friday, assessing and rehabilitating EL residents.

The Inreach team aim was to work with acute AHPs and the Discharge Hub on:

- Tracking EL patients, from presenting at the front door (A&E).
- Assist and guide acute AHPs on EL Pathways
  - Determining appropriate patients for an ELCH bed or opportunities for innovation (e.g. lifestyle monitoring kits) and utilising 3rd sector organisations, daycentres etc. reducing formal care package requirements where possible.
- Addressing rehabilitation gaps by escalating where people may not be optimised in their treatment goals. Identifying opportunities for Home First at every point.
- Influence risk thresholds, balanced with those applied in ELCH and EL community and grow confidence in the inpatient OT's assurance in the community approach.
- Inform the EL Daily Activity Huddle to ensure optimal length of stay.
- Utilising the proven model of highest skillset being present at the point of triage, the role of the APOT presence at the front door:
  - to support advanced clinical decision making and conversations around direct discharge options to EL.
  - to explore options around Safe Home referral, follow up for EL patients

The Project

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Resource

The project team consists of Occupational Therapists, Physiotherapists and Assistant Practitioners, working Monday – Friday within the RIE. In addition to the clinical staff there was appropriate Clinical Leadership assigned to the project. This was to support the team in a new environment, allowing higher level decisions to be made quickly and support the data gathering and evaluation of the project.

The staffing reallocated to this project from within existing ELRS resource varied throughout the project to be agile to meet the high demand for East Lothian led case management in the RIE. Additional resource was reallocated and student AHP staff were recruited through collaboration with Queen Margaret University and the NHS Lothian Staff Bank to meet the increasing demand.

The current total costing of the clinical team is shown below (as off the end of project March 2023 and costed using Paycost table for 21/22, mid-point +1 and inclusive of employer's costs):

For further details on Staffing throughout the project refer to Appendix 2 – Resource.

Description	Band	WTE	Cost(£k)
Occupational Therapist (Team Lead)	7	1.0	£63,468
Occupational Therapist (APOT)	7	1.0	£63,468
Physiotherapist (Team Lead)	7	1.0	£63,468
Occupational Therapist	6	1.0	£53,855
Occupational Therapist	5	2.0	£86,562
Assistant Practitioner (OT)	4	1.0	£33,908
Total			£364,729

Activity

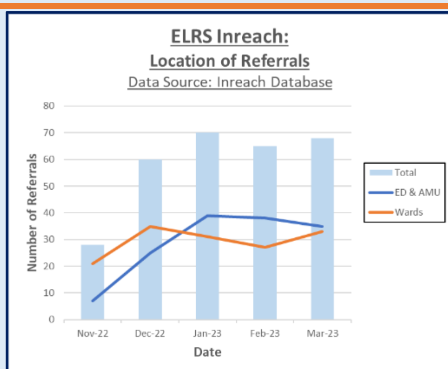
The East Lothian Inreach team case managed 347 patients and completed 2300 interventions. (See Appendix 3 – Additional Graphs). The patient demographics were 88% of patients were 65+ years and 12% <65 years (see Appendix 5 – LAS Project Evaluation for further details). It would be beneficial to have comparative data from the acute of patient demographics and AHP activity.

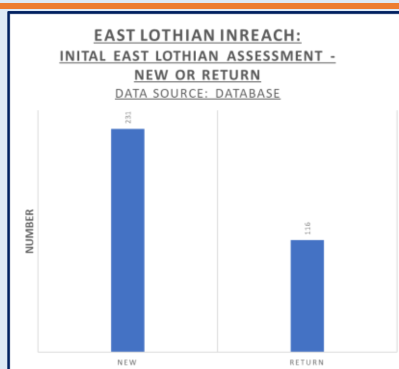
There were 231 patients who had not been assessed by a RIE OT or PT prior to being referred to the Inreach team, these referrals were described as "New". There were 116 patients who had been assessed by a RIE OT or PT prior to being referred to the Inreach team, these referrals were described as "Return".

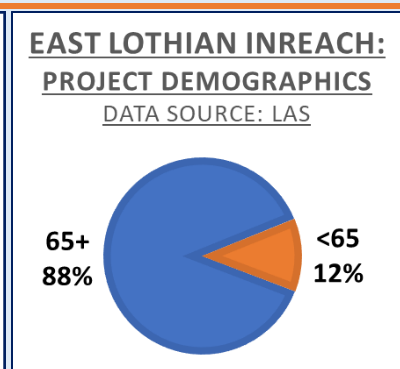
The first graph below summarises the pattern of referrals from A&E compared to the Wards. The first stage of the project focused on the back door and therefore more referrals were from the wards, whereas as the project progressed the requirement for increased presence in A&E was evident and there was an increase in A&E referrals. The team have worked to capacity at times having to decline new referrals.

The team saw patients across 19 different specialties and 35 wards. The patient specialty receiving the largest number of interventions was Medicine of the Elderly (38%). General Medicine and Orthopaedics received the next largest number of interventions (24% and 11% respectively). A further 7% of interventions were completed in A&E.

Occupational Therapy interventions were 54% direct patient contact and 46% non-direct patient contact. Physiotherapy interventions were 65% direct patient contact and 35% non-direct patient contact. (See Appendix 1 – Additional Graphs)







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Discharges

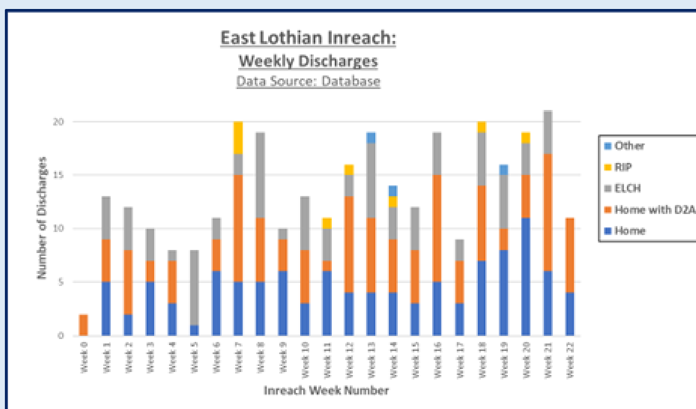
The project facilitated 320 discharges from the RIE. (See Appendix 1 – Additional Graphs).

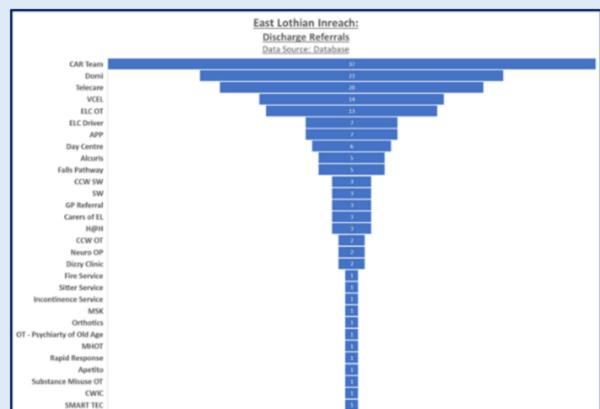
	Number of Discharges	Percentage (%)
ELCH	79	25
Home	110	34
Home with D2A	120	38
Other	3	1
RIP	8	3
Grand Total	**320**	

East Lothian specialist knowledge was utilised to refer to a wide range of EL services to support timely and effective discharge planning avoiding care where possible. The team through high levels of communication across ELHSCP were aware of the worsening situation in the community regarding the availability of care, as per the end of March there was 1,238 hours of unmet care in EL (data provided by ELHSCP).

The project facilitated the discharge of 120 patients with the D2A service. This service can facilitate earlier discharge by supporting patients' home who have ongoing OT or PT assessment and rehabilitation goals. Within the 120 patients 36 patients were referred to additional services at time of discharge, supporting a comprehensive discharge. A total of 64 referrals were made to 24 different services.

Across the project the team utilised 31 different services and completed a total of 296 referrals including 120 D2A referrals. The other 176 referrals included 37 referrals to Care Assessment and Review (CAR) Team, this team review the need for Care when a patient is at home with the aim to reduce care requirements by utilising specialist equipment, digital options and completing rehabilitation. There were also 23 Community Physiotherapy (Domi), 20 Telecare, 14 Volunteer Centre East Lothian (VCEL) and 13 Community Occupational Therapist (ELC OT) referrals completed.





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Discharge To Assess (D2A)

Prior to the Inreach project the average length of stay (LOS) for a patient discharged from the RIE with D2A was 16 days and the RIE discharged on average 5 patients a week with D2A (over the 6-month baseline period). There were 7 patients referred to D2A from A&E during the baseline period. When LOS is reviewed excluding discharges from A&E, average LOS is 17 days.

During the project the RIE therapists continued to discharge on average 4 patients a week with an average LOS of 16 days with D2A. However, in addition to these discharges the project discharged on average 5 patients a week with an average LOS 5 days.

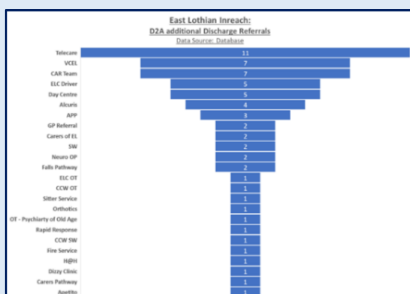
- *Mitigated project costs: 11 bed days saved over 120 patients (£518,760).*
- *Annual mitigated costs supporting increase system capacity: 3,168 bed days (£1,245,024)*

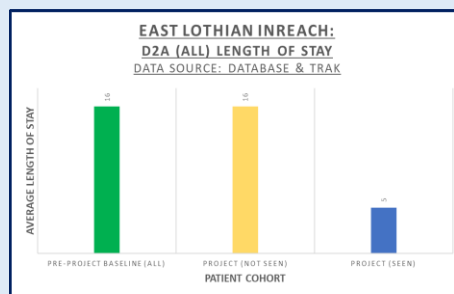
This significant reduction in LOS can be explained by the increase D2A referrals from A&E. During the project 12% of D2A referrals were from A&E compared to the baseline period where only 5% of D2A referrals from the RIE came from A&E. However, it should be noted that during the project D2A referrals from the RIE A&E team have increased to 10% of their referrals however, average LOS has remained 16 days.

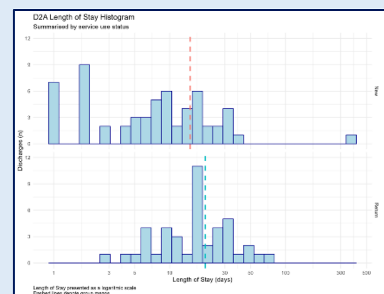
On further review of the D2A data it can be evidenced that if the project team were to complete the initial assessment of the patient, “New”, these D2A patients had an average LOS of 11 days. In comparison to an average LOS of 20 days if the acute therapists completed the first assessment and the project was subsequently referred the patient, “Return”.

This LOS data comparison excludes discharges from A&E. The improvement in LOS, particularly when EL complete the first assessment, evidences the importance of having an EL specialist assessment completed at the earliest stage of a patient’s journey. These patient’s assessment and rehabilitation being overseen by an EL Inreach team results in effective and timely D2A discharge planning.

Baseline data and comparable data is from ELRS Capacity Database, RIE have not been able to provide any comparable data. See Appendix 4 – full D2A statistics and Appendix 5 – LAS.







Accident & Emergency (A&E)

During the project there were 61 assessments in A&E, 35 patients (57%) were discharged directly home from A&E and 45 patients (74%) were discharged home from A&E or Acute Medical Unit (AMU) following Inreach OT or PT assessment.

A further 14 (23%) patients were assessed by Inreach team and discharged or deemed safe for a facilitate

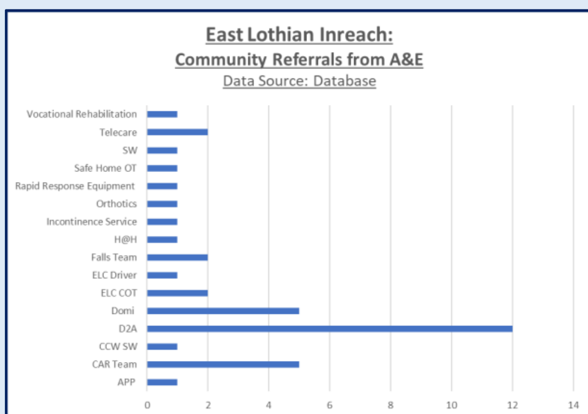
d discharge, however, were admitted. Out of these 14 patients, three were admitted due to transport issues.

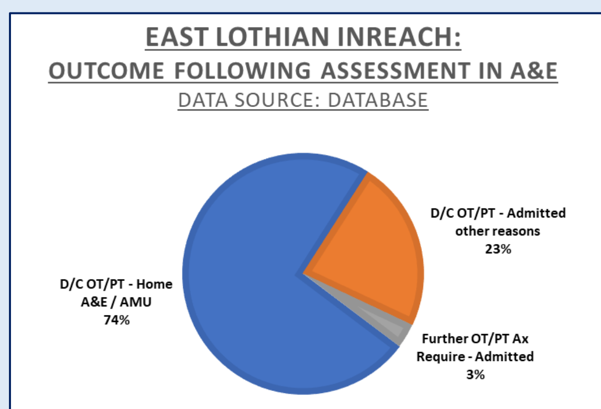
The Inreach team were able to utilise their local expertise to support discharges directly from A&E, there were 38 onward referrals to 16 different EL services, as shown in the graph below. The RIE completed an A&E process map for before the project and this identified they had 7 community services they referred to including D2A, prevention of admissions, package of care, voluntary sector, and community alarm services. Unfortunately, at the time of writing this report the final process map had not been shared by the acute.

Reviewing the 45 patients who were discharged from A&E or AMU the pie chart below displays the discharge destinations. The Inreach team were able to support 31 patients home without requiring D2A, to achieve this local expertise was utilised to refer these patients to 10 different community services (excluding D2A), totalling 21 referrals for these 31 patients.

See Whole System Flow section for HSCP level review.

At time of writing this report Acute Project reports had not been shared to provide further comparable data.





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Feedback

ELHSCP, ELRS and the clinical project team value the importance of feedback from all staff. The staff feedback questionnaire was launched through Jisc on 10th March 2023 and ran until 24th March. It was sent electronically to all OT and PT staff (qualified and non- qualified) and all Consultants and Doctors. In addition, hard copies were provided on the wards to support ward staff to complete.

In total 31 online and 7 paper questionnaires were completed, resulting in a total of 38 responses. Staff feedback came from clinicians working within the specialities that the project had the most clinical input with and referrals from, those being, MOE (36.8%), ED/AMU (15.8%) and Orthopaedics (15.8%). Full summary of the online questionnaire feedback attached in Appendix 6, any identifiable staff information has been removed to maintain anonymity.

Key results:

1. Understood aim of Project –
   Yes (81.6%), No (10.5%), Unsure (7.9%).

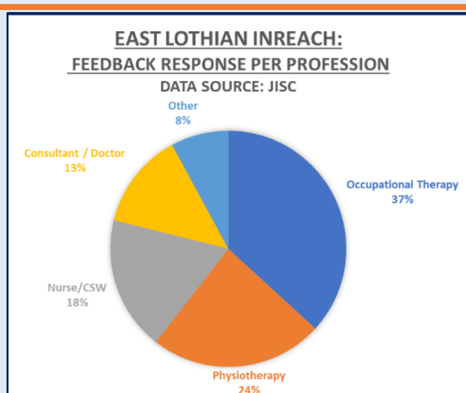
2. Experience with the EL Inreach team

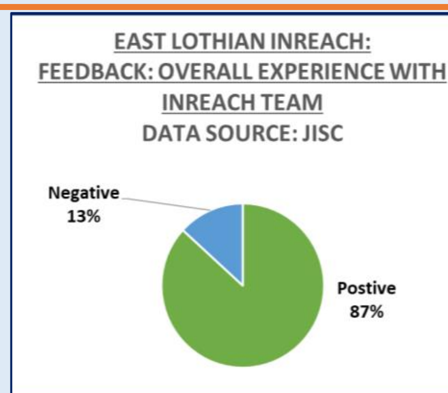
Questions	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree
Approachable	66%	18%	11%	5%	0%
Good Communicators	32%	50%	8%	8%	3%
Knowledgeable of EL Service	71%	26%	3%	0%	0%

"Very friendly and approachable team,

it is so great to have them in the RIE"

3. Key Themes were identified, including the following (for full review see appendix 7)
   - Differing use of Trak
   - Referrals to D2A
   - Initial Introduction of Project and Team
   - Communication between Inreach and acute teams
   - Clinical focus area of project
   - Added capacity vs EL Specific Knowledge
   - Screening of EL Patients





Whole System Flow

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East Lothian Activity in the RIE, ELCH Activity & ELRS Activity

Although the Inreach project is a small resource within a much large health system, over time it is anticipated that the improvements in pathways and outcomes for patients will be reflected in the whole system flow.

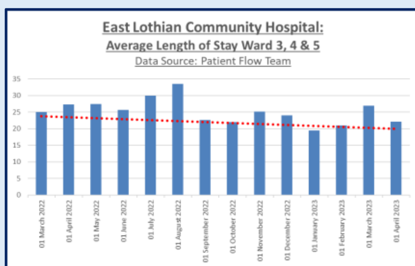
Total Occupied Bed Days (TOBD), delayed discharges and A&E activity has been monitored throughout the project.

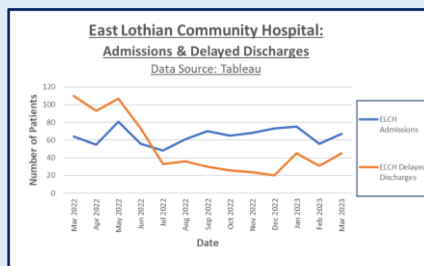
During the project there were 1,595 East Lothian admissions to the RIE – 65+ years, unplanned admissions. (Data Source: Tableau – Activity Trends by Hospital – accessed 11/04/23). Over the project the team case managed 347 patients thus 22% of these admissions.

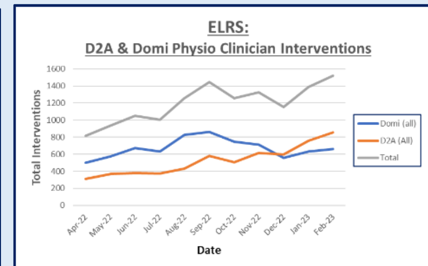
Variable	October	November	December	January	February	March
Mean LOS of Hospital Discharges	8.6	8.6	9.1	9.1	9.6	8.3
Hospital Admissions	254	288	302	264	221	266
Hospital Transfers Out	39	53	51	48	42	43
TOBD	2307	2459	2798	2581	2216	2153
Death	18	17	21	25	13	16

In addition, activity within ELCH has been monitored, including number of transfers in, discharges and LOS. The below graph displays an improving average LOS across Wards 3, 4 and 5.

ELRS activity is shown in the graph below. The reduction in Domi interventions is reflective of the RAG rating being implemented and with this there was an increase in the Domi waiting list, RAG rating was removed in March. However, the graph evidences that the process put into place to support the pressures on the acute sites to facilitate more discharges have been successful in releasing capacity to this workstream and total community interventions have increased during the project.







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Total Occupied Bed Days for Delayed Discharges (TOBD for DD)

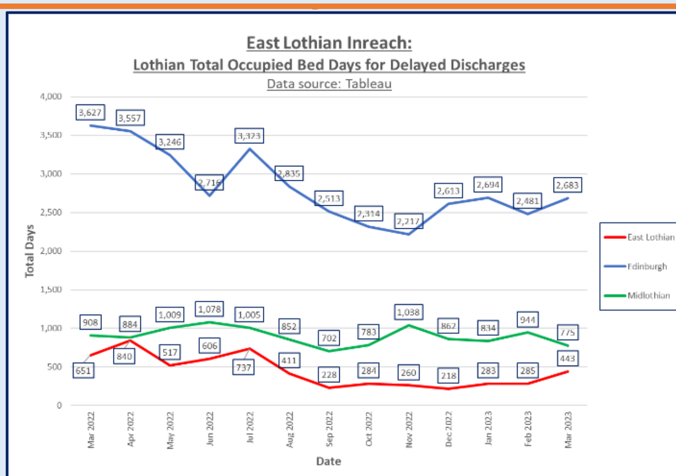
Delayed Discharges is a key area ELHSCP are reviewing and actively working to reduce within the context of a care crisis in the community. All patients recorded as a Delayed Discharge are discussed at the daily integrated Activity Huddle to ensure all avenues have been investigated to facilitate discharges wherever possible. These patients may not be known to the Inreach project team, however, they will often be following the meeting liaise with acute colleagues or actively take on the management of these patients dependent on the daily discussions.

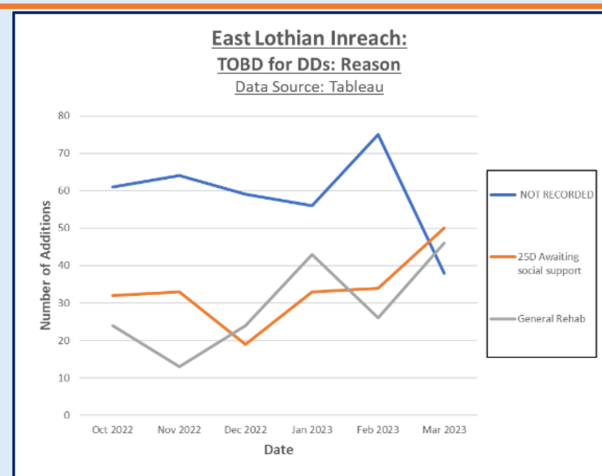
The highest proportion of ELHSCP DDs are "Not recorded", "25D awaiting social support" and "General Rehab". (See Appendix 1 – Additional Graphs)

At the initial phase of the project there was a focus on the "back door" to "pull" patients out utilising the specialist knowledge of the Inreach Team. During this period there was a reduction in TOBD for DDs. As the project progressed capacity was continuously reallocated to meet competing demands from the front door and back door.

Over the final month of the project there was an increase in TOBD for DDs and on reviewing the reasons for DDs there was a large increase in "General Rehab" DDs from 67 in October to 135 in March and a large increase in "25D awaiting social support" from 46 in October to 120 in March. This is reflective of the lack of care provision, the reduction in access to interim beds and reduction in ward 5 beds (8 were closed in March). The Inreach team will continue to ensure patients active to them receive ongoing rehabilitation whilst awaiting transfer, this however, will impact on the teams capacity to accept new referrals.

East Lothian TOBD for DDs remain the lowest when compared to Edinburgh and Midlothian HSCP.





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Accident & Emergency (A&E)

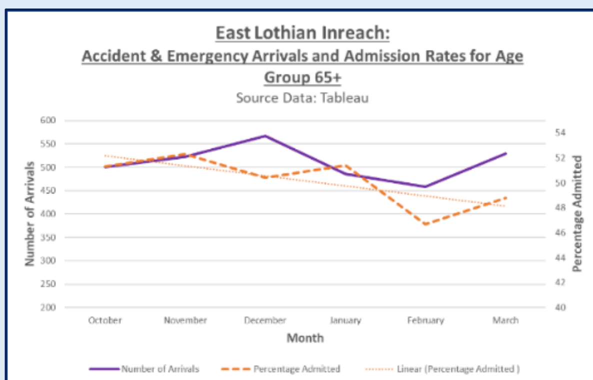
During the project the team have increased their presence in A&E as this is identified as a key area where patients can be supported home with the correct services. This can prevent unnecessary hospital admission, especially as this often results in care packages being lost and lengthy waits for care to be recommenced.

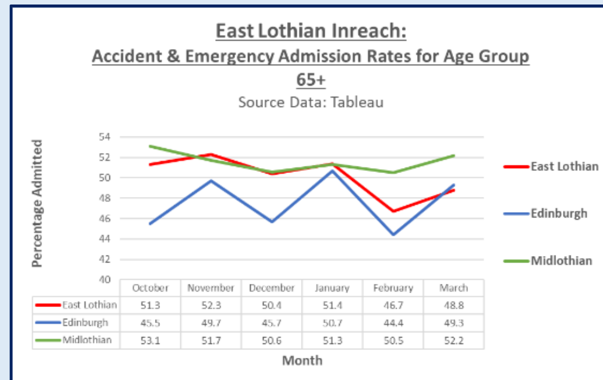
The key data that is being monitored is the number of arrivals to A&E and the percentage of patients 65+ years who are subsequently admitted.

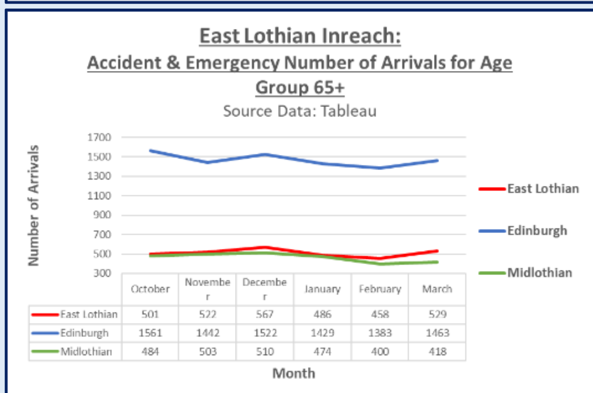
During the project East Lothian arrivals at A&E have ranged from 458 to 529 per month with the highest numbers in December and March. The percentage of patients requiring admission has reduced from 51.3% in October to 48.8.% in in March. It can be seen in the graph below there is a positive trendline in the reduced percentage of patients being admitted even when arrivals at A&E have increased.

See Appendix 3 Additional Graphs for trends from April 2020-March 2023.

East Lothian	October	November	December	January	February	March
Number of Arrivals	501	522	567	486	458	529
Percentage Admitted	51.3	52.3	50.4	51.4	46.7	48.8







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Readmissions

Readmission data review was completed by Lothian Analytic Services (LAS) and a full report can be found in Appendix 5.

Baseline readmission data was reviewed for the specialities of General Medicine and Medicine of the Elderly, and for patients 65+ years following an unplanned admission. These metrics were chosen on review of the demographics of patients seen in the project. This baseline data was reviewed across East Lothian, Edinburgh and Midlothian and at 7 days, 28 days and 90 days percentage readmitted.

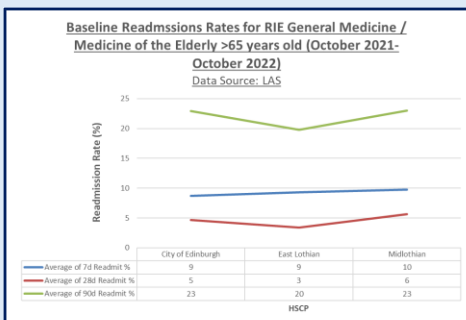
Baseline data evidence that East Lothian has the lowest percentage readmitted across all three categories as shown in the graph below.

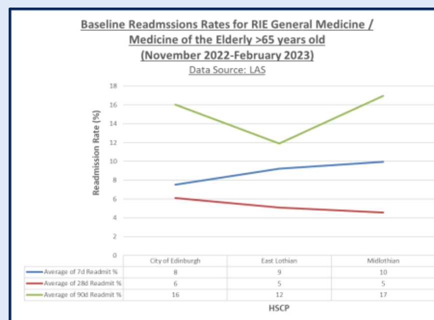
Review of data from the project period evidence that East Lothian has remained consist with percentage readmitted. Edinburgh has a 1% lower average percentage admitted at 7 days and otherwise East Lothian has continued to have the lowest percentage readmitted when reviewed again Edinburgh and Midlothian, across the three categories.

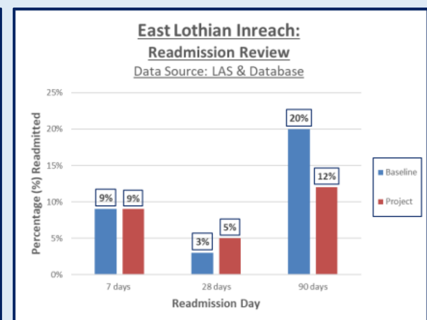
Thus showing, that although there has been an increased number of patients facilitated home at an early point in their journey, with the right support in place these patients have remained home, with no change in percentage of patient being readmitted.

Cohort	7 days	28 days	90 days
Baseline	9%	3%	20%
Project	9%	*5%	*12%

*The current percentage readmitted at 28 days and 90 days is included, however, the analysis will need to be re-run 28 days and 90 days following the last day of the data (28th April and 29th June).







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Case Studies & Patient Feedback

East Lothian Health & Social Care Partnership

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Case Study 1

OUTCOMES

	Barthel
Start:	*55*
End:	*70 (improved)*

Background:

- 88 year old Female
- Admitted to hospital following a fall
  - Resulting in left hip pain
  - Confined to bed for 2 weeks preadmission
- PMH:
  - OA
  - Prediabetes
  - CKD

Key Dates:

Admitted to RIE:	05/01/2023
Referred to EL Inreach Team:	17/01/2023
Desired Discharge Date:	18/01/2023
Actual Discharge Date:	22/01/2023

**Medical Staff kept patient in for TVN review rather than refer to community and daughter not wanting to support over weekend.*

Challenges:

- Consultant unavailable for discussion and junior doctor unable to make decision re discharge plan without discussion with consultant so had to wait until following day to discuss.
- Medical staff reluctant to refer to tissue viability in community therefore remained in hospital to await this.

Successes:

- Prevented unnecessary transfer to ELCH
- Patient straight home without wait for POC assessment
- Prevented further AHP professional involvement through holistic PT approach
- Prevented OT involvement through EL PT being involved, arranging care review and equipment provision.

Situation:

- Handed over patient by MOE PT on 17th Jan
- for maintenance until transfer to ELCH
- last reviewed on 13th.

Input:

- Assessment carried out, patient close to baseline mobility of WZF and supervision
- Discussion with daughter at initial assessment who was keen to take patient home.
- Daughter assists with all ADL's at baseline.
- Medical staff requested patient remained on ward for TVN review
- Liaised with NS and DN's – hospital bed and nimbus mattress ordered on rapid response

Sign posting/ referrals:

- CAR Team referral for assessment of POC in community.
- Domi PT referral to progress outdoor mobility
- CAS referral to allow easy escalation of falls/patient becoming unwell due to history of long period of bed rest following fall.
- Equipment provision with rapid response for hospital bed.

Case Study 2

Key Dates

Admitted to RIE: 06/12/2023
Referred to EL Inreach Team: 06/12/2023
Desired Discharge Date: 06/12/2023
Actual Discharge Date: 06/12/2023

Background:

- 71 year old Female
- Admitted to hospital due to back pain.
- PMH:
  - COPD
  - AF
  - Electrolyte derangement secondary to anorexia
  - Osteoporotic fractures
  - Hereditary haemochromatosis - homozygous C282Y
  - Anorexia Nervosa
  - Chronic hyponatraemia with element of SIADH
  - History of alcohol excess

Situation:

- Lives alone (bungalow);
- Has supportive family however patient beginning to separate herself from them as she feels they are too involved.
- BD POC on admission however patient previously had TDS POC for meal prep due to malnutrition and patients lack of motivation.
- Current input from Domi PT, Alcohol Liaison Nurse and EL POA.

Input:

- Transfer, mobility, strength, ROM and balance assessment completed in ED.
- Pain was limiting factor. Liased with medical staff in ED about H@H follow up.
- Checked Mosaic and TRAK for all services involved.

Sign posting/ referrals:

- Follow up form H@H for pain management
- CAR Team referral to review POC
- Email sent to Domi PT involved
- Increased POC back to its previous level (TDS)

Successes

- Due to EL Inreach Team PT/OT knowing the patient form the community there was a lot of important information already known.
- EL Inreach Team also able to check Mosaic for additional information on input and services.
- Direct contact with Domi PT to ensure suitable follow up available.
- Discharge was successfully supported by H@H and Domi PT, with no readmission.
- Care and Review Team follow up was very appropriate for this lady as her care has been insufficient for some time, it also allowed us to send the patient home to await her care as we knew someone was going in to specifically assess if her care is sufficient.

Challenges

- H@H were initially unable to support with pain management.

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Case Study 3

Background:

- 66 year old Female
- Presented to ED for Biers block post fall.
- Admitted to hospital following reduced mobility secondary to cerebellar ataxia. Has found balance "off" for a number of months with sensation of leaning back regularly.
  - Resulting in left wrist fracture.
- PMH:
  - Cerebellar ataxia

Key Dates

Admitted to RIE:	09/01/2023
Referred to EL Inreach Team:	09/01/2023
Desired Discharge Date:	09/01/2023
Actual Discharge Date :	09/01/2023

Situation:

- Lives with husband
- Husband supports with all transfers and ADL's.
- Carrying out precarious transfers at baseline for long time
- Minimal support in community

Input:

- Assessed in ED
- Mobility assessment – precarious
- Reviewed previous Neuro PT notes to compare assessment to previous function.
- Discussion with patient and husband re risks of admission v risk of discharge with community support.
  - Agreed DC home safest route to establish safe set up in own environment and establish good community support networks

Challenges:

- Difficulty assessing complex patient in ED without normal bed height access.
- Difficulty in busy environment with precarious mobility

Successes:

- Able to pick up on orthotics referral to reduce further falls risk
- Able to be well informed at point of assessment due to awareness of previous input from ELRS.
- Patient able to go home as per wish
- Prevented likely admission due to complexity of mobility and background condition

Sign posting/ referrals

- Referred to D2A
- Referred to orthotics
- Sign posted to carers of East Lothian – declining referral at point of assessment

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Case Study 4

Key Dates

Admitted to RIE: 06/01/2023
Referred to EL Inreach Team: 09/01/2023
Desired Discharge Date: 20/01/2023*
Actual Discharge Date: 25/01/2023*
**delayed discharge – tested positive for COVID Medical team made the decision to delay D/C*

Background:

- 88 year old Female
- De-conditioned, low mood, lost confident become house bound.
- Admitted to hospital following: GP referral - cough + vomiting + reduced PO intake + suprapubic pain, ++ carer stress as family felt patient was not coping at home & required a 4 times per day POC
- PMH:
  - AF, hearing aids, BPPV, NSTEMI, malignant neoplasm of ascending colon right hemicolectomy and anastamosis, diverticulosis, unstable angina, HTN, migraine

Situation:

- Lives alone bungalow
- Family live locally who visit daily for social support, provide shopping and make meals if required ++ daughter stress as they feel mum depends on them a lot
- No PoC
- Lost confidence and developed anxiety after husband pasted away
- Stopped going out for walks or attending local activity groups

Input:

- Meal prep practice in the Kitchen
- Personal Care toileting Practice to promote Independence
- Ongoing mobility practice to build patients confidences
- Washing & Dressing Ax with ongoing practice
- Checked Mosaic and TRAK for all services involved

Sign posting/ referrals

- D2A, Alcuris, Telecare
- Volunteers of East Lothian, Day centre
- Increase POC to OD

Challenges:

- Delayed discharge due to testing positive for COVID
- Family ++ stressed and felt mum was depending on them a lot prior to admission family felt patient would benefit from a 4 x per day POC

Successes:

- Patient progressed to near full independence
- EL Inreach Team knowing what East Lothian services were on offer for patient OTAP was able to refer patient to day centre to start weekly attendance the same week patient was discharged home
- EL Inreach Team also able to check Mosaic for additional information on current input and services.
- Discharge was successfully supported D2A with no readmission
- OTAP knowledge with Alcuris & Telecare enable the family to view and see how mum was managing at home without them having to visit daily

Patient Feedback

The Inreach Team used the ELRS Patient Feedback Questionnaire that has been approved by NHS Lothian Patient Experience Team. All results are hosted through the ELRS digital platform.

Patient feedback was collated by clinicians either face to face with patients or family members at point of discharge or via telephone call if patients had been discharged prior to completion of Patient Feedback Questionnaire. To date clinicians have completed 73 Patient Feedback Questionnaires.

Key Themes:

- Receiving **regular** Physiotherapy and Occupational Therapy input was beneficial
- Input from Physiotherapy and Occupational Therapy made recovery much easier
- Provision of equipment / aids supported timely discharge home
- East Lothian provided a great inpatient service and community follow up
- Good communication re. discharge planning with patient and families

See below for Patient Quotes.

'Seen by OTAP one day and got home the next day, very happy as I wanted to get home ASAP'

'Great service and follow up that East Lothian offer'

'Kept me up to date with discharge planning and provided me and my husband with all relevant info which led to fast discharge and got me home to my dogs quickly'

'Waited on RIE PT Team to review me for 2days before I could be discharged home'

'East Lothian OT Team have been great, got me home quickly after my fall'

'Well set up going home'

'OTs and PTs were very patient and caring'

'Reassurance given at each stage was beneficial'

'Great follow up service with D2A'

'My POC was held whilst I had a short stay in the RIE'

'Everything has been wonderful, PT was very knowledgeable and helped me progress my walking and hand movement'

'Got home quickly from RIE with follow up, rather than going to ELCH for rehab'

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Summary & Recommendations

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Summary

East Lothian Rehabilitation Service has been able to successfully respond to the request from the acute to support the extreme and sustained pressures facing the acute sites. ELRS was able to be responsive due to their core values, robust structures, and data-driven approach to service delivery across multiple existing pathways.

The Inreach model was implemented in conjunction with the existing Multi-agency Daily Activity Huddles and existing effective and efficient methods of information sharing within ELHSCP including third sector.

Within existing resources ELRS was able to reallocate a small resource of staff to the RIE. Workstreams were revised to enhance capacity for facilitating earlier discharges from the acute and ELCH to support whole system flow. Urgent work was prioritised, and routine work was monitored via RAG rating between December - March.

The Inreach project case managed 347 patients, which equated to 22% of EL unplanned 65+ admissions to the RIE. They worked across 19 different specialities, 35 wards and supported 320 discharges. The project referred to 31 different EL services on discharge and completed a total of 296 onward referrals.

During the project an average of 9 patients were discharged per week with D2A compared to 5 patients during the baseline period. In addition, the average LOS improved from 16 days from the baseline period to 5 days for patients seen by the Inreach team. This equates to annual mitigated costs of £1,245,024.

The Inreach team completed 61 assessments in A&E and 74% were discharged home from A&E or AMU. These patients were referred on to 16 different services, totally 38 onward referrals. Without the acute providing comparative data, finalised process pathways and project reports conclusion cannot be drawn. However, from a shared draft pathway it was reported the acute A&E team refer to 7 EL services.

Feedback received from RIE staff reported 87% of staff had a positive experience with the Inreach team. On reviewing the comments, the team were well received in the acute. However, other comments highlighted perceived issues, for example with communication and the use of Trak as the primary method. This alongside other feedback highlighted significant differences in culture.

Whole system flow is being monitored and at this early-stage readmissions rate has remained at 9%. Although initially there was an improvement in TOBD for DDs, March saw this number increase, in conjunction with bed closures in ELCH, reduced interim beds and reduced care availability. A further period is required to continue to review this data and the impact of Inreach model.

To meet the demand within the acute site for EL led case management the Inreach team has provided an agile and flexible service across the whole of the RIE. This approach has been adopted to best meet the needs of EL patients however, due to the small Inreach resource this influences the ability to measure the impact of the project.

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Recommendations

It is recommended that additional funding (£297, 638.50 – from EL Unscheduled Care Funding) is used to allow the continual delivery of this test of change for one further year. This would allow for further data evaluation and impact to be measured and reported, and resource returned to ELRS inpatient and community teams.

At the end of the additional year one of the two Outcomes proposed below will be agreed by senior management within the Acute, ELHSCP and senior NHS Lothian management.

Outcome 1:

- The Inreach project demonstrates successful outcomes for EL patients and positive impact on whole system flow therefore, resource would be transferred from the acute / set-aside to EL.
- Within the year the Inreach project will develop the following.
    - Enhanced EL model in A&E.
    - Agreement of all pathways and processes for EL and RIE staff.
    - Process implementation in line with EL capacity and working patterns.

Outcome 2:

- The RIE will evidence how they can meet the identified needs of the EL population – Inreach project will cease.
- The RIE will be able to evidence the following.
    - Use of a full range of EL discharge pathways and services.
    - Attendance at daily multi-agency activity huddle.
    - Improved pathways within D2A and EL whole system flow.

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Appendixes

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Appendix 1: Challenges Identified by Flow Team

It was identified from the flow huddle that frequently:

- People are added as a health or social delay without discussion with EL, where earlier intervention could have prevented the delay.
- Planned date of discharge (PDD) is not always used to provide clarity on the ready for discharge date from an early point.
- People are prioritised out from receiving rehabilitation when they are listed for a rehabiltation bed, which results in deconditioning and a longer length of stay overall.
- Activity meetings have highlighted discrepancies in acute MDT feedback regarding patients function and need for ELCH bed.
- There were opportunities to support earlier conversations around a multi-disciplinary PDD. Similarly, conversations around risk management, 'moving on' and community options could be more effective if supported by teams with ELHSCP specific knowledge who will often know the patient and their family.
  - AHP/SW assessment could be brought forward in the patient journey.
  - Acute teams are not clear on the options within EL, resulting in a different assessment of need, and threshold for managing risk.
  - Patients are listed for OT/PT when there may be no clear indication of need, resulting in delayed discharges awaiting AHP input that may not be required.

Appendix 2 – Resource

Initial SBAR (August 2022) presenting the ELHSCP In-Reach Plus RIE model proposed a staffing compliment (from existing resource) off 1x Advanced Practitioner OT, 1x Team Lead OT, 1x B6 OT, 1x B6 PT and 1x B4 Assistant Practitioner, costing £268,554 (costed using 21/22 Payscale).

The project commenced in October 2022 with the following staffing, 1x Clinical Lead OT, 0.4x Clinical Lead PT, 1x Team Lead OT, 1x B6 OT, 1x B6 PT and 1x B4 Assistant Practitioner, costing £298,908.40. The decision to change the staffing compliment, increasing senior management was to support the team in a new and potentially challenging environment and to allow higher level decisions to be made quickly and to support the data gathering and evaluation of the project. (From existing resource and costed on 21/22 Payscale).

In the second month of the project capacity was increased further as clinical demand was not being met. ELRS Inpatient Team Lead OT was moved to the project (0.6 WTE) and the Staffbank was utilised to employ OT and PT students as B4 Assistant Practitioners, 2.45WTE B4 Assistant Practitioners. Annual costing would be a further £121,155.40. (21/22 payscale used.) Please note 0.45WTE Assistant Practitioner PT worked with team for one month only and the 2.0WTE B4 Assistant Practitioners are now on the Staffbank as Band 5 OTs and continue to work within the project. Staffbank employees have been funded through existing vacancy monies.

The increased capacity allowed the In-reach team to have more of a presence at ED/AMU, data available at the end of this report. The use of students from Staffbank allowed the continuation of outcome measurement completion and gathering of Patient Feedback, alongside increased rehab capacity at backdoor for EL patients. As staffing resource was moved to allow the RIE Inreach to commence, ELRS community and inpatient teams have been negatively impacted, this was expected to happen when the project was undertaken using existing resource. Initial SBAR (August 2022) presenting the ELHSCP Inreach Plus RIE model proposed a staffing compliment off. (From existing resource and costed using 21/22 Payscale):

Description	Band	WTE	Cost (£K)
Occupational Therapists (Team Lead and APOT	7	2.0	£63,468 x 2 = £126,936
Occupational Therapist	6	1.0	£53,855
Physiotherapist	6	1.0	£53,855
Assistant Practitioner	4	1.0	£33,908
Total			**£268,554**

The project commenced in October 2022 with the staffing shown in the table below. (From existing resource and costed on 21/22 Payscale)

Description	Band	WTE	Cost(£k)
Clinical Lead Occupational Therapist	8a	1.0	£67,016
Clinical Lead Physiotherapist	8a	0.4	£26,806.40
Occupational Therapist (Team Lead)	7	1.0	£63,468
Occupational Therapist	6	1.0	£53,855
Physiotherapist	6	1.0	£53,855
Assistant Practitioner (OT)	4	1.0	£33,908
Total			**£298,908.40**

In the second month of the project, capacity was increased further as clinical demand was not being met. Inpatient Team Lead OT was moved to the project and the Staffbank was utilised to employ OT and PT students. Costing below, 21/22 payscale used. Please note Assistant Practitioner PT worked with team for one month only and the Staffbank employees were funded through existing vacancy monies.

Description	Band	WTE	Cost (£K)
Occupational Therapist (Team Lead)	7	0.6	£38,080.80
Assistant Practitioner (OT)	4	2.0	£33,908 x 2 = £67,816
Assistant Practitioner (PT)	4	0.45	£15,258.60
Total			**£121,155.40**

To enable the project to continue, maintaining the level of delivery and improvement for 1 more year and to return staffing resource back to the ELRS inpatient and community teams in which resource was taken within the first 6months, the following is a breakdown of how funding would be used. (Costed using Paycost table for 22/23, mid-point +1 and inclusive of employers costs).

Description	Band	WTE	Cost (£K)
Occupational Therapist	6	1.0	£57,267
Occupational Therapist	5	2.0	£93,116 (£46,558 x2)
Occupational Therapist	4	1.0	£36,853
Physiotherapist	7	1.0	£8,565 (difference between B6 point 2 - B7 point 1)
Physiotherapist	5	1.0	£46,558
Physiotherapist	4	2.0	£55,279.50 (£36,853 + £18,426.50) (1.0 for 6months only)
Total			**£297,638.50**

This would be achieved through utilising current recruitment cycles where possible. While these people would be recruited permanently, we would use natural staff turnover to support any cost pressure if the project was not funded after 1 year. Within this, there is an opportunity to permanently recruit 2 newly qualified OTs (currently working within Inreach project through Staff bank), recruit B4 OTA from recent interviews (person identified), recruit a B6 OT from upcoming B6 OT interviews, fund 1 B5 PT over-established from recent interviews and act up current B6 PT to B7 to provide PT Team leadership for Inreach team. Evaluation will continue throughout the next year, discussing if the In-reach project continues and annual costs this would incur.

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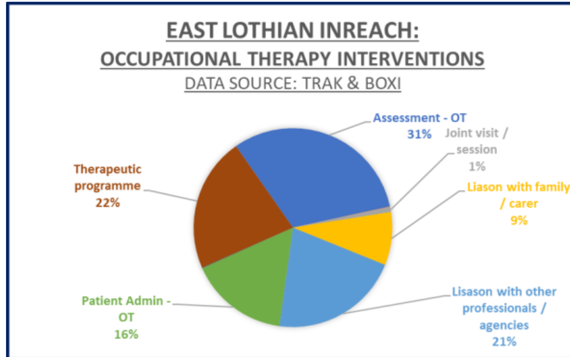
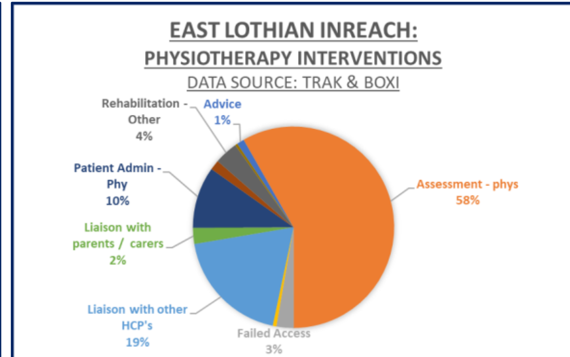
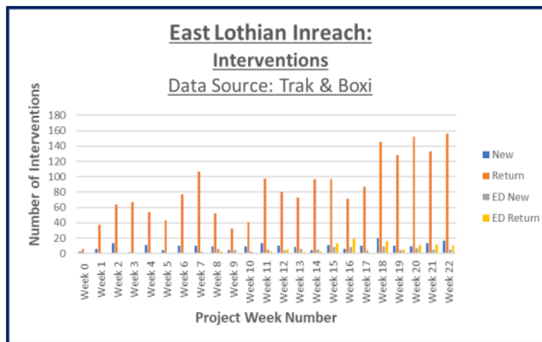
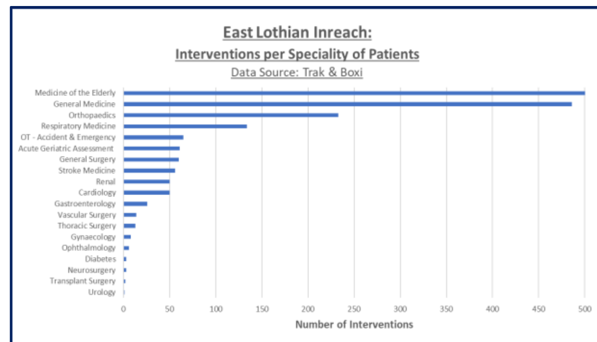
Appendix 3: Additional Graphs

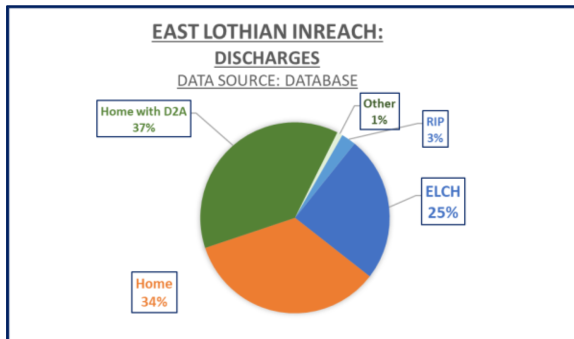
The main body of this report was not able to include all relevant graphs, therefore additional key graphs can be reviewed in this section, which support the discussions within the main body of the report.

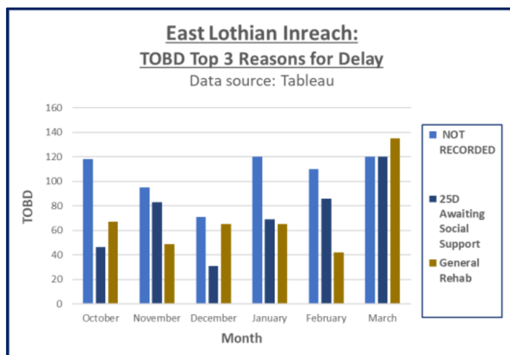


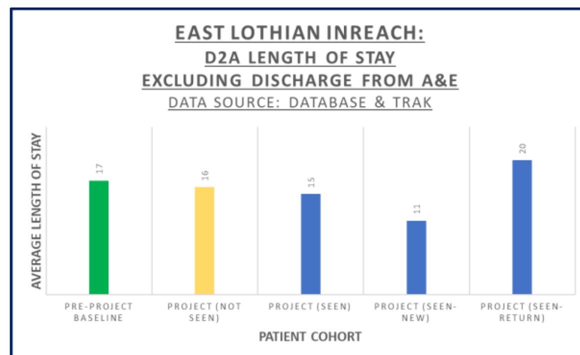


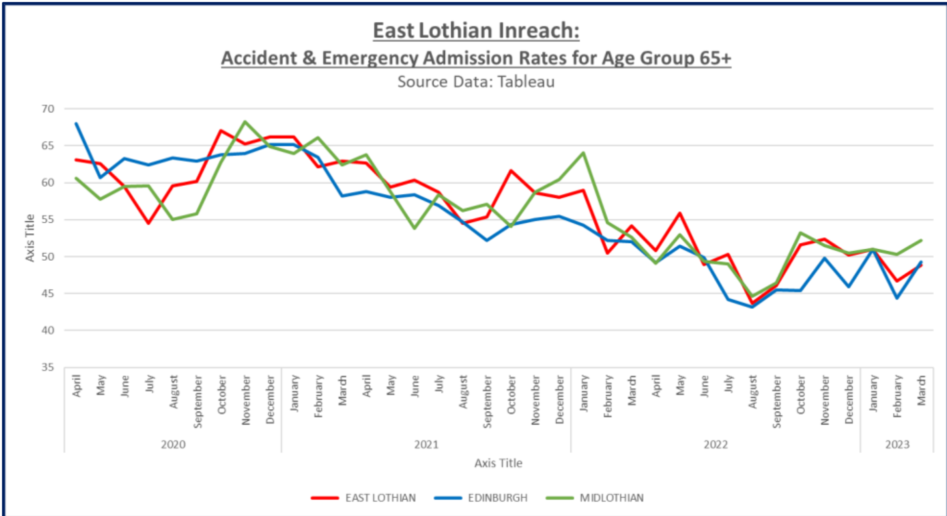


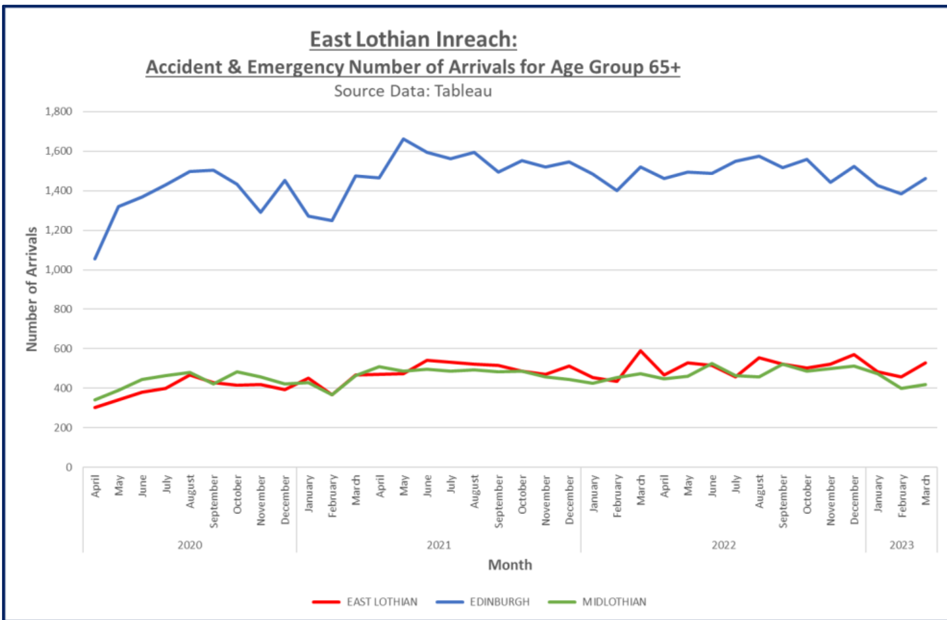









East Lothian Inreach:
Accident & Emergency Admission Rates for Age Group 65+
Source Data: Tableau
Axis Title
70
65
60
55
50
45
40
35
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March
2020
2021
2022
2023
Axis Title
EAST LOTHIAN
EDINBURGH
MIDLOTHIAN


East Lothian Inreach:
Accident & Emergency Number of Arrivals for Age Group 65+
Source Data: Tableau
Number of Arrivals
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March
2020
2021
2022
2023
Month
EAST LOTHIAN
EDINBURGH
MIDLOTHIAN

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Appendix 4: D2A data

The table below displays full D2A LOS analysis for Baseline and Project period cohorts of patients.

Patient Cohort	Exclude ED D/C	Number of Patients	Duration (weeks)	Average per Week	Mean LOS	Median LOS
Pre-Project Baseline (All)		138	26	5	16	12
Pre-Project Baseline (ED only)		7	26	0	0	0
Pre-Project Baseline	Exclude ED D/C	131	26	5	17	12
Project (NOT Seen)	Exclude ED D/C	81	22	4	16	10
Project (Seen)		120	22	5	5	4
Project (Seen-New)		74	22	3	3	2
Project (Seen-Return)		46	22	2	7	4
Project (Seen)	Exclude ED D/C	103	22	5	15	11
Project (Seen-New)	Exclude ED D/C	57	22	3	11	10
Project (Seen-Return)	Exclude ED D/C	46	22	2	20	11
Project (Seen-ED)		14	22	1	0	0

Appendix 5: LAS Project Evaluation

Lothian Analytic Services completed a comprehensive evaluation of LOS and D2A. The LAS report compliments this report and it is recommended that is it reviewed alongside this report.

East Lothian Inreach Project Analytical Rep

Appendix 6: Staff Feedback

To review full staff feedback access document here.

Questionnaire Feedback - 38 (1).pd

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Appendix 7: Staff Feedback Key Themes

Within the main body of the presentation there was discussion around the key themes from the staff feedback form. Further detail and ELRS responses have been included here for review.

1. Trak – within the feedback it was noted that EL Inreach team use Trak as a 'notice board' and that this is 'not communication'.
    a. From an EL perspective, this is what Trak should be utilised for, Trak is a safe and timely way of sharing confidential patient information across MDT members, it is more effective and time efficient way of communication as it means everyone involved in the patients care has access to the same information and it is not information that is passed through word of mouth that can be altered/misinterpreted. EL complete regular audits of all clinician notes to ensure high quality of notes are documented and also to ensure staff are meeting clinical governance standards. Documentation of notes is part of HCPC adherence for all AHPs.
    b. The EL Inreach team use Trak but have also been happy to update any AHP handovers or Nursing handovers e.g. the brain on Trak with updates so that those attending MDTs / Rapid Rundowns have access to the most up to date EL Inreach team information. To be time efficient, as the Inreach team cover all wards and specialities across the RIE they do not attend MDTs or Rapid Rundowns, unless specifically requested or beneficial due to discussion for example around a complex patient.
2. Referrals to D2A – feedback suggested the feeling that EL Inreach team referrals were being accepted over RIE therapists, and a 'lack of trust' in the assessment of RIE therapists.
    a. From data captured by EL, there is no evidence that higher numbers of RIE referrals were declined, prior to Inreach commencement the average RIE D2A referrals were 5 per week, this has remained similar throughout the project with the average RIE D2A referrals being 4 per week. Further D2A data is included in the main body of this report. From data collated by EL D2A throughout the duration of the project only one D2A was declined in December due to capacity, with other referrals being signposted to other EL services if did not meet D2A criteria.
    b. Further comment on D2A referrals advised the feeling that EL D2A was harder to refer too than other localities – EL have worked with RIE clinicians closely, providing the referral forms showing the info that will be asked and also doing education on the EL service structures. EL follow a 'true' D2A model, in which assessment is completed by OT and/or PT on day of discharge (or within 24hours of discharge), the patient has clear outstanding assessment and goals to achieve on discharge and therefore the team are very much facilitating the discharge. The reason EL work this way is to ensure the best use of finite resource, e.g. by information gathering we can ensure the right clinician follows the patient up at the right time. EL have structures in place such as Community OT and Domi PT pathways which are more appropriate for patients requiring follow up but not on day of discharge.
3. Initial introduction of team and aim of project not shared
    a. Unfortunately there was a delay on the acute side in sharing of information at the start of the project, the EL Inreach Team had completed an SBAR and had a clear evaluation matrix prior to starting the project which had been shared.

4. Communication
    a. Unfortunately when the EL Inreach Team started there was no dedicated office space allocated, this made communication difficult for the team but also for those trying to reach the team. This took 3months to be resolved, during this time the Inreach team worked hard to maintain communication, sharing work phone numbers etc but this was difficult to manage with A/L or sickness etc. Bleeps were ordered but took time to arrive. Now the team have a dedicated space, office phone and bleeps communication is much easier.
5. 'Just added capacity' – feedback that EL Inreach Team provided additional capacity only.
    a. From the gathering of data that the team undertook throughout the project the evidence shows that with specific EL knowledge, onwards referrals were made to 31 different EL pathways, whereas when the RIE completed an A&E process map for before the project and this identified they had 7 community services they referred to including D2A, prevention of admissions, package of care, voluntary sector, and community alarm services. Furthermore, the LOS savings EL Inreach Team incurred by using D2A at an earlier stage also highlights benefits of EL knowledge of community pathways and patients.
6. ED/AMU focus more so than back door wards
    a. Initially the team focused (in October and November) on the back door delays, this was due to EL patients being 'prioritised out', due to staff capacity. As with any test of change the focus changed during the project to allow for evaluation of impact at ED/AMU, with the aim of using EL knowledge to turn pts around before they became a delay. Due to Inreach Team being small, capacity shifted to ED/AMU but the Inreach Team did maintain a presence at backdoor, supporting where possible.
7. Picking up pts 'who were ready to go', 'already had RIE AHP input' or handing patients back when Ao2
    a. The Inreach Team generally only took on patients from back door who were referred by the acute AHPs or those raised at the 930 Activity Huddles as being prioritised out due to RIE AHP capacity but requiring OT/PT. Also, due to capacity the ED pts and majority of AMU patients picked up by the Inreach Team were via referral. However, an agreement was in place from RIE Senior Management at the start of the project that if EL Inreach Team screened a patient they could pick up as they felt appropriate, all picking up of EL patients via the Inreach Team was done with clear communication with AHPs in that area and documented clearly on Trak.
    b. The Inreach team were unable to get involved with many patients who were assistance of 2 due to capacity, but if the team did become involved no patients were handed back to RIE therapists due to being Ao2. There was acknowledgement that the team would benefit from extra PT capacity and this has been actioned by recruitment of a B5 PT going forward and with future plans for a B4 PTA. Where capacity allowed the OTs in the Inreach Team tried to provide input to patients who were Ao2 still with PT, with the aim of identifying earlier those requiring further rehab at ELCH or who may get home direct from the RIE, this is something that RIE therapists did not have capacity to do.
8. Screening duplication
    a. Screening of EL patients was done as capacity allowed, often the priority was using time effectively by prioritising clinical. Going forward the team would be keen to put processes in place, allowing EL therapists to screen EL patients at certain points (within the working day each week). Due to working hours and no weekend cover, this would need to be done jointly and with agreement from the RIE acute therapists.

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Appendix 8 – Data Source Information

To ensure transparency and reproducibility of data the following table provides detailed description of data source and additional information.

Graph Title	Data Source	Dashboard (if applicable)	Filters (if applicable)	Date data accessed
TOBD Top 3 Reasons for Delay	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE HSCP: East Lothian Show Me TOBD by Reason and Month	
TOBD for Delayed Discharges	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: TOBD by HSCP and Month	
TOBD for Delayed Discharges **Specialty - General Medicine & Medicine of the Elderly**	Tableau	Delayed Discharges	Months: October 2022 – March 2023 Hospital: RIE Speciality: General Medicine or Medicine of the Elderly HSCP: East Lothian, Edinburgh and Midlothian Show Me: TOBD by HSCP and Month	
Accident & Emergency Arrivals and Admission Rates for Age Group 65+	Tableau	Activity Trends for A&E	April 2020 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: Percentage Admitted by Month and HSCP	
Accident & Emergency Number of Arrivals for Age Group 65+	Tableau	Activity Trends for A&E	pril 2020 – March 2023 Hospital: RIE HSCP: East Lothian, Edinburgh and Midlothian Show Me: Number of Arrivals by Month and HSCP	
Baseline Readmission Rates for RIE General Medicine / Medicine of the Elderly >65 years old	LAS		East Lothian HSCP Specialty: General Medicine and Medicine of the Elderly 65 years and older	

Appendix 9 – SBAR and Evaluation Matrix

SBAR - ELHSCP In-Reach Plus RIE V4

Core Evalutation Matrix.docx

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Acknowledgements, References & Additional Information

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Additional Information

Data within this report may differ from data presented in previous Inreach Project reports. This is due to the development and improvement in datasets throughout the project. Only data included within this report should be referenced.

This report utilises an average bed day cost of £393 in line with Acute reports. This differs from average bed day cost utilised in previous reports that used the cost of £545 as provided by the Finance team. This figure was agreed with the Acute Management team 28th February 2023.

The Royal Infirmary of Edinburgh Occupational Therapy and Physiotherapy services have limited comparable datasets due to reported poor compliance of staff to complete Contacts Processing within TrakCare or limited access to up to date and accurate data. The acute teams collate limited paper statistics and instead collate increased data during specific projects to complete their project evaluations as not robust baseline data. At the time of writing this report the specific project reports which had been agreed to be shared from the acute had not been shared. Therefore, this report was not able to complete comparable analysis.

All Graphs within this report are in picture format and therefore not editable. If further information is required on any area of this report, please contact the authors. No part of this report should be repurposed without consent from the authors and ELHSCP Management Team.