Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	6 September 2016
Officer	Harry Capron Assistant Director, Adult Care
Subject of Report	Delayed Transfers of Care
Executive Summary	Delayed Transfers of Care (DToC) are a key area of concern across the health and social care community in Dorset. The reasons for delays are numerous and can change on a daily and weekly basis, as can the number of individuals delayed. Most of the individuals delayed require ongoing health and/or social care input upon discharge from hospital. Monthly reporting on Dorset's performance places Dorset into the bottom quartile with high numbers of days delayed in both acute and non-acute hospitals. The current data for Dorset County Council shows that for all delays, the top three attributable reasons for a delay are: • awaiting packages in own home • awaiting nursing home placement • awaiting further non-acute NHS care The recently published High Impact Change Model focuses on eight high impact changes that can support health and care systems to reduce delayed transfers of care. In response to this the System Resilience Group (SRG) have agreed a PAN Dorset Delayed Transfer of Care Plan based around these eight High Impact Changes. Reporting directly to the Dorset SRG there are three Health and Social Care Accountable Care Partnerships. These partnerships

	are responsible for the delivery and update of the DTOC action plan for their area. Royal Bournemouth Hospital (RBH) Following support from NHS England Royal Bournemouth Hospital and their partners have developed a 42 point action plan. There are already robust processes in place to monitor and agree delayed transfers of care so the action plan focuses on improving patient flow and focusing on the eight High Impact Changes. Three key elements to the plan are the development of a Frailty Unit at RBH which will be operational from the beginning of September. The development of a Hub in Christchurch linked to the Frailty Unit which will support discharge to assess and admission avoidance. This will be operational at the end of August and the bringing together of hospital and social care teams into a discharge hub with Trusted Practitioners underpinning the hub will enable discharges across seven days. Dorset County Hospital (DCH) Dorset County Hospital and their partners are also in the process of developing an action plan through their Accountable Care Partnership. The plan is based around the eight High Impact Changes with a priority to develop an Integrated Discharge Team which will bring together health and social care services into a co-located office within DCH. Poole General Hospital (PGH) Poole Hospital and their partners are currently in the process of developing an action plan which will reflect the RBH plan and focus again on the eight High Impact Changes. In partnership PGH are also currently developing a Discharge Bureau. A Project Initiation Document is currently being drafted and key aims will be to co-locate partners responsible for discharge across the hospital providing a central point for discharge coordination and information. Yeovil District Hospital (YDH) Partnership work is at an early stage with Yeovil. Weekly phone calls have been put in place to discuss delays, and escalation processes have been agreed. Partners recently attended a workshop which highlighted areas across the patient pathway where the partnership will carry out further work.

	Salisbury District Hospital (SDH) There are currently formal processes in place for agreeing delays on a weekly basis, however all partners are involved in the 'Green to Go' work that is looking to improve patient discharges. Dorset Health Care (DHC) There are weekly conference calls with all partners to agree delays and actions needed, and escalation processes are in place for patients delayed over a certain length of time. There has been some valuable learning from these cases which have improved future discharges. Key Priorities DCC will continue to work alongside Accountable Care Partnerships and implementation groups to deliver the agreed local Delayed Transfer of Care plans.
Impact Assessment:	Equalities Impact Assessment: Where there are changes or developments in services EqIA screening tools have been used to establish if full EqIA' s are required. This work has been carried out by the responsible working groups.
	Use of Evidence: There have been many reports and reviews carried out across Dorset on various parts of the patient's journey including reviews from NHS England, Local Government Association, Emergency Care Intensive Support Team and reports from the Kings Fund and the Clinical Services Review. All this evidence gathered is used to inform the work around reducing delayed transfers of care.
	Budget: Increased hospital admissions place demand-related pressures on all partner budgets in terms of higher than predicted levels of activity, for example, needing to set up and resource additional hospital beds through to funding extra domiciliary, residential and nursing care.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as:

	Current Risk: HIGH Residual Risk: MEDIUM Without the rapid changes set out in this report being implemented the local health and social care system will be significantly challenged financially and clinically to meet the demands we expect during the forthcoming winter and Easter period.
	Other Implications: None.
Recommendation	To note and comment on key service demands and priorities to respond to delayed transfers of care in hospitals.
Reason for Recommendation	To support the progression of the key priorities which will improve Delayed Transfer of Care performance
Appendices	Appendix 1 – Dorset CCG – Delayed Transfer of Care Report June 2016
Background Papers	None.
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1. Background

1.1 Delayed Transfers of Care (DToC) is a key area of concern across the health and social care community in Dorset. The reasons for delays are numerous and can change on a daily and weekly basis, as can the number of individuals delayed. Most of these delayed individuals require ongoing health and/or social care input upon discharge from hospital.

1.2 In the recent past there have been joint health and social care commissioning partnership plans and initiatives to support transfers of care.

1.3 NHS England Wessex recently commended Dorset health and social care organisations and staff for their clear commitment and transparency in working together with a clear objective of preventing delayed transfers of care.

1.4 The Delayed Discharge Act of 2003 was replaced by the Care Act 2014. One of the aims of the Care Act is to ensure that people do not remain in hospital when they no longer require care that can only be provided in an acute trust. Arrangements for discharging patients who are likely to have on-going care and support needs have

been designed to encourage acute trusts to plan for discharge in advance of the patient no longer requiring acute care.

1.5 Information about delayed transfer of care is collected for acute and non-acute patients, including mental health and community hospital patients on the monthly Delayed Transfers Situation Report (SitRep) return. The focus on the return is to identify patients who are in the wrong care setting for their current level of need and it includes patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay.

1.6 A SitRep delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed. A patient is ready to transfer when:

- A clinical decision has been made that the patient is ready for transfer AND
- A multi-disciplinary team decision has been made that the patient is ready for transfer AND
- The patient is safe to discharge/transfer

1.7 The Care Act brought in some changes which include that every day of the week counts, including weekends and Bank Holidays. Previously delays were only counted during the working week. These changes are in line with the move towards seven day services. For social care delays, reimbursement is no longer mandatory and it is up to the discretion of the local system whether it wants to charge or instead use the resources in a different was to support effective discharge.

1.8 From April 2004 there has been a requirement to return the monthly SitRep report. This identifies all delays in transferring patients from acute and non-acute settings across three broad categories:

- reasons related to social care;
- reasons related to health care (non-acute);
- reasons related to delays in both health and social care.

1.9 When delays are reported they are categorised. Each category has a clear definition that ensures that delays are counted consistently across the country.

1.10 All health and social care delays are required to be reported on a monthly basis, it is common for this to be increased to weekly from October through to April, and sometimes daily. There is a requirement that the return is validated, agreed and signed by the trust and social care. This should be at Executive Director level in the acute trust and the Director of Adult Social Care level in the local authority. Delegation is acceptable as long as there is a process for escalation if there are any disputes.

1.11 From the monthly SitRep there are two specific performance reports, these are known as ASCOF 2C Part 1 and ASCOF 2C Part 2. ASCOF 2C Part 1 is a report on the number of delays at midnight of the last Thursday of the month. ASCOF 2C Part 2 is the number of delays at midnight of the last Thursday of the month that are attributable to social services.

2 Dorset Performance

2.1 The year end outturn for ASCOF 2C Part 1 was **23.5** per 100,000 population compared to 21.31 for 2014-15, against a target of 9.70. ASCOF 2C Part 2 was **9.2** per 100,000 population compared to 7.98 for 2014-15, against a target of 3.10.

2.2 The monthly reporting also produces a 'league table' of all 151 local authorities according to the delayed transfer of care performance. The end of year outturn showed that Dorset is in the bottom quartile for both indicators (146th of 151 authorities for ASCOF 2C Part 1 and 139th for ASCOF 2C Part 2). Data for May 2016 shows Dorset being placed at 141th of 151 authorities for ASCOF 2C part 1 and 135th for ASCOF 2C part 2). A majority of south west authorities and a majority of the Dorset comparator group authorities are also in the bottom two quartiles.

2.3 Delays are categorised by which provider is responsible for discharging the individual, so either health, social care of both. Where the delay is attributable to health the most likely reason is that the person is being assessed for continuing health care or is eligible for continuing health care funding and is awaiting a package of care or a placement.

2.4 The Provider Summary part of the monthly SitRep for the end of year shows 60.9% of Dorset's delays are attributable to the NHS. Of the delays attributable to Adult Social Care in Dorset, over half of all delays (54.5%) are in non-acute beds in community hospitals. However, it should be noted that the strict guidelines of formal attribution can deflect from the root cause of delays. For example, all delays for self-funding patients are attributed to the NHS even though the patient may be trying to arrange a package of domiciliary social care that is very difficult to procure, or a residential home placement in a location with very limited availability.

2.5 The monthly SitRep also reports on the number of days people have been delayed. At year end there had been 14,732 days delayed in acute hospitals and 12,654 days delayed in non-acute hospitals.

2.6 The current data for Dorset County Council shows that for all delays, the top three attributable reasons for a delay are:

- awaiting packages in own home
- awaiting nursing home placement
- awaiting further non-acute NHS care

2.7 It is also recognised that in addition to the recorded attributable reason for delay, health and social care partners need to consider the potential for delays in all parts of the system throughout a patient's journey. Such delays are not captured within the delay recording information but add to a patient's length of stay and the potential for further delays to occur once the patient is considered medically ready to leave hospital are defined in 1.6 above.

<u>DTOC Targets NHS England and Better Care Fund (BCF) Targets</u>

2.8 The current NHS England target for delayed transfers of care for all health providers is 3.5% of their occupied bed state, reducing to an ambition of 2.5% by October 2016.

2.9 Dorset SRG has also agreed targets for the achievement of a reduction of DToCs across Dorset:

2.9.1 For NHS acute providers, the target is 3.5% in the number of people whose transfer is delayed by 31 March 2017, with a stretch target of 2.5% (as monitored nationally by NHSE);

2.9.2 For the NHS community provider (physical and mental health), the target is 7.5% in the number of people whose transfer is delayed by 31 March 2017, with a stretch target of 6.5%.

2.10 The Dorset SRG system is not currently achieving a 5% target on delayed transfers of care performance. As part of the BCF planning process, there have been robust discussions between partners regarding the implementation of a risk share for DToC improvement linked to potential protection of social care monies from Dorset CCG.

2.11 All partners have signed up to targets which are stretching for the local system and are committed to meeting these through harmonising efforts. The stretching local targets for the two local HWBs, reflecting the current DToC status, are:

2.11.1 For Dorset, a reduction of 5% of delayed days (all causes) by 31 March 2017 – this is a reduction of 1,298 delayed days compared with 15/16;

2.11.2 For Bournemouth and Poole, a reduction of 3% delayed days (all causes) by 31 March 2017 – this is a reduction of 411 delayed days compared with 15/16.

2.12 As part of the DToC implementation plans, further work will be undertaken to refine these targets, and agree on a cluster basis:

2.12.1 Targets for those areas where the Local Authorities have clear accountability as part of their statutory responsibilities, and

2.12.2 Targets for those areas where there is a joint responsibility for improvement, for example self-funders

3 Improving Performance

3.1 The recently published High Impact Change Model – Managing Transfers of Care, focuses on eight high impact changes that can support local health and care systems to reduce delayed transfers of care. These impacts are:

(a) Early Discharge Planning In elective care, planning should begin before admission. In emergency /unscheduled care, robust systems need to be in place to develop plans for management and discharge, and allow an expected date of discharge to be set within 48 hours.

(b) System to Monitor Patient Flow Robust patient flow models for health and social care, including electronic patient flow systems, enable team to identify and manage problems

(c) Multi-Agency Discharge Teams Including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and

protocols, and on shared and agreed responsibilities promotes effective discharge and good outcomes for patients

(d) Home First/Discharge to Assess Providing short-term care and reablement in people's homes or using 'step-down' beds to close the gap between hospital and home which means that people no longer need to wait unnecessarily for assessments in Hospitals. In turn, this reduces delayed discharges and improves patient flow

(e) Seven-Day Services Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs

(f) Trusted Assessors Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way

(g) Focus on Choice Early engagement with patients, families and carers is vital. A robust protocol underpinned by a fair and transparent escalation process is essential so that people can consider their options. The voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care

(h) Enhancing Health in Care Homes Offering people joined-up, co-ordinated health and care services can help reduce unnecessary admissions to hospital as well as improving hospital discharges.

3.2 In response to this model the System Resilience Group (SRG) agreed a PAN Dorset Delayed Transfer of Care Action (DTOC) Plan. There have been improvements to many of the processes which may cause delayed transfers of care but merely doing more of the same is unlikely to give ongoing sufficient capacity and flow.

3.3 Transforming the unplanned care pathway to improve patient flow is a key system wide priority, overseen by the Dorset System Resilience Group (SRG). All health and social care partners of the SRG are committed to achieve this transformation to reduce avoidable admissions, provide alternative pathways and ensure that there are robust processes to manage patients effectively through the continuum of the unplanned care pathway, including timely and safe discharge.

3.4 The overarching SRG DTOC action plan supports and addresses the recommendations of two external reviews into the Dorset health and social care system. It references national best practice as set out in the eight High Impact Interventions detailed above and describes a clear governance structure, with a Senior Responsible Officer at director level and reporting and assurance measures.

3.5 Reporting directly to the Dorset SRG are three Health and Social Care Accountable Care Partnerships based on West, Mid and East Dorset. These partnerships are responsible for the delivery and update of the DTOC action plan for their area.

3.6 It should also be noted that a recent NHS England communication in relation to improving Accident & Emergency (A&E) waiting time performance requires SRG's to transform into A&E delivery boards with five initiatives to drive improvements in the streaming, flow and discharge of patients. Further guidance is awaited but it is

anticipated that DTOC plans will need to be updated to incorporate additional actions adopted in order to deliver against the five initiatives defined as follows:

- Streaming at the front door – to ambulatory and primary care;
- NHS 111 – increasing the number of calls transferred for clinical advice;
- Ambulances – aim to decrease conveyance to hospital and an increase in 'hear and treat' and 'see and treat' to divert patients away from Emergency Departments;
- Improved flow – a set of must do's that each trust will need to implement to enhance patient flow;
- Discharge – mandating 'Discharge to assess' and 'trusted assessor' type models.

Royal Bournemouth Hospital (RBH)

3.7 There are already robust processes in place to communicate and respond to actual and forthcoming delayed transfers of care on a daily basis and also to monitor and agree delayed transfers of care, with weekly meetings held to agree the position and agree any further actions required for those that are delayed.

3.8 Following support from NHS England Royal Bournemouth Hospital and their partners have developed a 42 point action plan. There are already robust processes in place to monitor and agree delayed transfers of care so the action plan focuses on improving patient flow and on the eight High Impact Changes detailed in 3.1 above.

3.9 Three key elements to the plan are:

- the development of a Frailty Unit at RBH which will be operational from the beginning of September

- the development of a Hub in Christchurch linked to the Frailty Unit which will support discharge to assess and admission avoidance. This will be operational at the end of August

- the bringing together of hospital and social care teams into a discharge hub with Trusted Practitioners underpinning the hub will enable discharges across seven days

3.10 RBH Frailty Unit - in advance of the operational "go live" date of 7th September when the Frailty Unit will take direct admission to Older Person Medicine, there have been some trial days where direct admissions have been taken from GPs and Emergency Departments. A generic initial assessment form (OPAL) is being used and tested and increased Local Authority presence at whiteboard rounds (ward rounds) is supporting increased Multi-Disciplinary Teams' knowledge and enabling joint decisions to be made about appropriate actions and pathways with each patient.

3.11 Christchurch Locality Hub Project - The project is a joint initiative between RBH, Dorset County Council locality and hospital teams, Dorset Hospital University Foundation Trust and Tricuro and aims to support patients (who are predominately older people) to manage their medical, rehabilitation and ongoing care needs within the Christchurch locality. The hub should provide an alternative to hospital admission or to enable timely discharge from RBH. It is hoped that the locality hub will provide the ability to progress the model for 'Discharge to Assess' (D2A) at scale and enable further integration of the RBH interim care service with community based services

such as Intermediate Care, Day Hospital and Reablement using a trusted assessor framework for patients remaining at or returning home. RBH and partners are also undertaking some work to consider the model required for interim care provision, including, for example, the use of step-up beds within community hospitals and locality based interim step-down beds for patients presenting with moderate to severe frailty. At present, the hub is planned to commence on 29th August to support discharge and 12th September to support both discharge and admission avoidance.

3.12 Integrated Discharge Service Proposal - RBH and partners are currently progressing a proposal to develop a co-located discharge hub. The shared ambition between RBH, DCC and Bournemouth Borough Council (BBC) is to provide an equitable Discharge to Assess service utilising trusted professional models. The discharge hub will develop clear aims and objectives across all agencies and promote joint/integrated working required to:

- improve patient experience and outcomes
- support a reduction in unnecessary admission
- support timely discharge with increased patient flow and reduced delayed transfers of care

The proposal is in draft for agreement by all organisations with an initial implementation plan to follow.

Poole General Hospital (PGH)

3.13 There are already robust processes in place to communicate and respond to actual and forthcoming delayed transfers of care on a daily basis and also to monitor and agree delayed transfers of care, with weekly meetings held to agree the position and agree any further actions required for those that are delayed.

3.14 Poole Hospital and their partners are currently in the process of developing an action plan which will reflect the RBH plan and again focus on the eight High Impact Changes.

3.15 Poole Hospital alongside Dorset County Council, Poole Borough Council, Dorset Clinical Commissioning Group and Dorset Hospital University Foundation Trust are also currently developing a Discharge Bureau. A Project Initiation Document is currently being drafted but key aims will be to co-locate partners responsible for discharge across the hospital, providing a central point for discharge coordination and information. It is anticipated that the Discharge Bureau will strengthen and provide opportunities for development of integrated working, deliver some efficiencies around discharge planning processes and provide opportunities to develop trusted assessor and discharge to assess models. The mid-Dorset Accountable Care Partnership has identified these as key priorities for delivery.

Dorset County Hospital (DCH)

3.16 Dorset County Hospital (DCH) and their partners are also in the process of developing an action plan through their Accountable Care Partnership. The plan is based around the eight High Impact Changes and will focus on an Integrated Discharge Team and the development of a Mid Cluster Hub.

3.17 The integrated Discharge Team will bring together the Acute Hospital at Home service, the Discharge Team and the Hospital Social Care Team. The focus will be on developing the Discharge to Assess model linked with the various Hubs that are developing around the hospital. DCH have invested in resources to support this including the Roaming Nights and additional Social Care resource. DCH have also identified space within the hospital to bring the teams together which should be available from October.

Yeovil District Hospital (YDH)

3.18 There have not been robust processes in place previously for agreeing Dorset's delays with Yeovil Hospital. However following recent discussions there are now weekly meetings on a Thursday with all partners to go through the actions required for any delayed patients and to agree the number of delays. There are also escalation plans in place for when patients have been delayed over a certain length of time.

3.19 Dorset County Council does not have any fixed presence at the hospital and Dorset's referrals go through Somerset County Council. Dorset County Council is now committed to providing a presence at the hospital with support coming from the Social Care Team based at Dorset County Hospital. Recruitment is about to commence for an experienced Social Worker to support the discharge team at Yeovil. With the Yeovil social worker working alongside the acute hospital locality team at Dorset County Hospital, further work will take place around direct referral to Dorset County Council, ensuring prompt referral and response for Dorset patients in Yeovil. Once in place, there are identified areas for development to strengthen Multi-Disciplinary Team working and improving patient experience and discharge pathways.

3.20 On Friday 5 August 2016 a workshop took place at YDH to discuss current pathways, issues with CHC and improving communication. This workshop also contained a detailed case study which has produced some lessons learned by all parties involved. During this workshop a commitment was made by Dorset County Council that there would be a presence at YDG from 1 September 2016 at least half a day a week. When this takes place the current arrangement with Somerset County Council will end and the Adult Access Team will receive referrals directly from YDH. This workshop has also highlighted areas across the patient's pathway where further work will be carried out within the partnership that has formed to improve a patient's journey.

Salisbury District Hospital (SDH)

3.21 There are currently formal processes in place for agreeing delays on a weekly basis, with Salisbury Hospital using their right to invoice Dorset County Council for reimbursable days.

3.22 Dorset County Council do not currently have a presence at Salisbury Hospital however they would like to address this and want to explore different uses of funding to make this happen.

3.23 Currently, Dorset Clinical Commissioning Group and Dorset County Council receive daily reports on DTOC at SDH and liaise with each other if any action needs to be escalated. It is also planned that there will be a weekly meeting similar to that introduced at Yeovil where actions around those delayed and the number of delays can be agreed. All partners are also involved in the 'Green to Go' work that is taking place with the SDH discharge team and Wiltshire Clinical Commissioning Group.

3.24 Dorset County Council are currently undertaking work with locality teams to improve the communication and reporting of discharge progress and any delayed transfers of care. Dorset County Council are also planning workshop sessions with SDH staff to increase understanding and knowledge of discharge options for Dorset residents but it is recognised there is further development work required.

Dorset Health Care (DHC)

3.25 Dorset HealthCare has been very active in analysing the reasons for delays from its Community Hospitals and Mental Health Inpatient Units. A working group has been introduced and through this very good progress has been made across the Trust to identify and break down the barriers to safe and prompt discharge.

3.26 The links between Community Hospital and Adult Social Care staff have been strengthened through weekly conference calls where all delayed patients are discussed with the Community Hospital Matron, managers within Dorset HealthCare and Social Care managers. Where delays persist a multi-agency Case Conference approach has been implemented in each Community Hospital. This is chaired by Dorset CCG with senior decision makers in each organisation in attendance to formally review all delayed patients and those with a length of stay greater than 60 days. From their statistical analysis Dorset HealthCare have identified that the 10% frailest patients with the longest stays will represent a disproportionately high number of delayed discharge patients, and thus it is vital to arrange for discharge to coincide with the patient's readiness to leave hospital, or risk the patient becoming unwell again.

3.27 Where the Case Conference concludes that discharge processes could have been improved, this learning is shared between organisations and internally within them. Also, where common themes have emerged, these have been shared, and improvements made where possible. However, a high proportion of delays are caused by lack of capacity in domiciliary social care provision (particularly for multiple double-up visits per day) and lack of available residential placements in some areas of Dorset, and these issues are not easily resolved.

3.28 As a result of these discussions a range of actions are in train. These focus on two main themes: improved communication and pro-active planning. Actions include:

- more formalised reporting of admissions and ready-for-discharge dates
- more consistent attendance by Social Care at MDT meetings
- more pro-active discharge planning
- sensitive but assertive use of the 'Dorset Leaving Hospital Policy (2016)'
- identification of escalation routes for when barriers to discharge occur

All these actions support the principles of the 'High Impact Change Model' noted above.

3.29 Dorset Health Care have developed and implemented training for Community Hospital staff on effective discharge planning and are working with DCC on a programme of joint training which will promote better joint working practices.

3.30 However, although these actions will continue to improve discharge planning processes, root causes of delays such as lack of capacity in domiciliary care and residential placements in some areas will continue to cause delays in Community Hospital discharges and delay admissions from acute hospitals trying to discharge their patients into Community Hospital beds.

4 Key priorities

4.1 DCC will continue to work alongside Accountable Care Partnerships and implementation groups to deliver the agreed local DTOC plans. Key priorities include:

- Improved presence and integrated working with Salisbury District Hospital and Yeovil District Hospital on discharge processes and pathways and on accuracy of reporting of delayed transfers of care
- Joint workshops/training with Dorset Community Hospital Multi-Disciplinary Teams, aimed at improving MDT function and problem solving, thereby influencing patient length of stay and delayed transfers of care and introducing more robust sign off processes for delayed transfers of care
- Design and delivery of a discharge to assess model which can function at scale and deliver as required through NHS A&E boards
- Continuation of work to date on development of a trusted assessor framework, accepted by all partners to be developed – October 2016
- Progression of Self funders proposal – implementation prior to Winter 2016
- Continuation of work on integrated working practices through discharge hub/bureau models defined above
- Implementation of updated choice policy.

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August 2016