Agenda Item No. 7

Dudley Clinical Commissioning Group

Report of the Director of Adult, Community and Housing Services and the Chief Accountable Officer, Dudley CCG

Quality Transfers of Care between Hospital and community settings

Purpose of Report

1. To advise the Health Scrutiny Committee on issues relating to:
   - quality transfers of care between hospital and other settings,
   - work being done in the health and social care economy to continually improve our services and people's experience of transfer of care between hospital and other settings
   - specific issues relating to delayed transfers of care.

Background

Quality transfers of care between hospital and other settings

2. Admission to hospital can be an anxiety-provoking experience for anyone requiring treatment or physical investigation as well as those who actively care or are concerned about them.

3. It is a priority for organisations working in the health and social care economy in Dudley to ensure that when people develop care needs, the support they receive is appropriate and takes place in the most appropriate setting depending on their circumstances.

4. All health and care agencies are committed to upholding best practice by treating people with dignity, respect and ensuring a quality service is provided. Promoting the independence of people and acknowledging the strengths they bring to their own situation are key underpinning practices which support a quality service. Amongst other mechanisms for these practices, health and care agencies bring together their agency commitment to quality and dignity in service provision through their partnership as members of the Dudley Safeguarding Adults Board.

5. The overwhelming majority of people who are admitted to hospital and are discharged back home to the care of their GP do so with support from their family or friends. The care and concern of their family or friends generally gives people the best chance of making a full recovery and regaining independence as soon as possible.

6. A smaller number of people require support and care from health and social care services on the transfer of their care from the hospital to other settings in community, residential or nursing care homes. These instances can range from fairly straight-forward arrangements such as re-starting a package of care which a person had before their admission to hospital to more complex arrangements in starting a new service or admission to a care home environment.

Work being done in the health and social care economy to continually improve services and people's experience of transfer of care between hospital and other settings

7. Work being done in the health and social care economy to improve services and people's experience is influenced by factors, amongst others, which include:

    - More people living longer
    - More people living with long-term conditions
    - Rising public expectations
    - Improved medical and care technologies
    - Need for greater efficiency in context of reduced resources
    - policy to promote independence, choice and support informal carers;
    - Specific policies aimed at addressing avoidable hospital admissions i.e. the Better Care Fund

8. People whose care needs are more complex need staff from different agencies to work together as partners serving the same person in the hospital setting. For example, Dudley Adult Social Care provide:
    - A Hospital Access Team of four Social Workers and a five Community Care Supervisors. One Social Worker and one Community Care Supervisor work in the Emergency Department to support attempts to divert people from Hospital care where appropriate. The remainder of the team work on the Wards. This team works across a time-span from 08:00 - 22:00 with support from other parts of Adult Social Care such as care staff who respond to emergencies in community settings

    - A seven-day service has been provided since January 2014

    - Specialist Safeguarding Social Workers for safeguarding work for people admitted to Hospital. The thresholds for adult safeguarding are actively monitored by the team to ensure that best use is made of expensive hospital beds.

9. Dudley CCG staff are also in attendance at the Hospital to support assessments for Intermediate Care or Continuing Health Care. On a Tuesday, Thursday, Saturday and Sunday, the Intermediate Care work is covered by the Council's Hospital Access Team.

10. Voluntary organisations also contribute e.g. the Red Cross Society work with some people on discharge from Hospital

11. Private organisations such as "Care Home Select" have been commissioned by the Hospital to support transfers to care homes.

12. Within the hospital, a "Discharge Impact Team" meeting of a multi-disciplinary team meet twice daily to discuss the latest situation of the patients on their list. The status for each patient should be agreed at this meeting and it is recorded on a database called the "Disco" (Discharge Co-ordinators) database. This database is important because its output is used for reporting Dudley's performance to national systems.

13. To avoid hospital admission where possible, a broad range of activity is being undertaken under the heading of the Better Care Fund to support people to stay in the place where they live – at home or in a care environment such as a care home – rather than be admitted to hospital where avoidable and safe to do so. Actions include:

- Development of a Community Rapid Response Team under clinical oversight to strengthen options for alternatives to admission to hospital, including dialogue with West Midlands Ambulance Service;

- The development of a new Urgent Care Centre based at the Hospital will support work to "triage" patients more effectively, supporting efforts to avoid hospital admission as appropriate

- Promoting a more locality-based approach through more integrated working with GP practices and other services e.g. mental health and adult social care;

- Broadening of preventative services still further so that people respond to the need to maximise their own health and well-being

- Re-organisation of adult social care services on a "Customer Journey" model to reflect the way in which people generally may need support and care;

- Working with West Midlands Care Home Association to up-date protocols for discharge from hospital back to the care home environment

- A "Discharge To Assess" model which creates three "pathways" for people to (1) return home where safe to do so; (2) reablement; (3) provision of continuing healthcare.

- The commissioning of work to resolve long-standing challenges about management information system which inform the analysis and decision-making process used to show the activities of all partners relating to hospital discharges.

14. A separate report is on the Agenda for the Committee's consideration but in the context of this Report, the Committee may wish to be reminded that the reduction in emergency admissions to hospital is now the sole determinant of access to the performance element of the Better Care Fund.

15. With regard to the experience of transfer of care between hospital and other settings, a legal framework was set for this through the *Community Care (Delayed Discharges etc.) Act 2003* which was enacted in 2004 and has been updated as appropriate by the *Care Act 2014.*

16. The aim of this law and subsequent guidance / definitions, has been to improve people's experience by better "flow" through the whole system, supporting people to:

- avoid hospital admission where an equally effective alternative can be provided;
- be re-directed from hospital where an equally effective alternative can be provided
- if admitted, experience effective discharge from hospital where each partner agency exercises their responsibility to ensure the best onward provision of care and support from hospital.

Specific issues relating to delayed transfers of care

17. Ensuring a good experience for the person requiring a transfer of care can be a complex process involving the resources and actions of, amongst others:

    - the person who is in hospital, their family, informal carers,
    - public sector agencies such as
        - Dudley Council Adult Social Care Services,
        - Dudley Group NHS Foundation Trust,
        - Dudley Clinical Commissioning Group
        - Dudley Walsall Mental HealthTrust
        - Care or Nursing Homes, and
    - other specialist providers dependant on individual circumstances

18. Monitoring transfers of care is one way of measuring how effectively organisations are working together to facilitate the timely transfer of patients from hospital and so improve a person's experience. The issue of transfers of care is also complex because of the definitions and information requirements needed. For instance, delayed transfers of care are commonly defined as follows:

    A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

    A patient is ready for transfer when:
    (a) a clinical decision has been made that the patient is ready for transfer
    AND
    (b) a multi-disciplinary team decision has been made that the patient is ready for transfer*
    AND
    (c) the patient is safe to discharge/transfer.

    (*A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.)

19. There is an expectation that delays to transfers of care will be minimised through the following steps:-

    - discharge planning begins on admission to hospital or in the early stages of recovery;
    - there are no built-in delays in the process of deciding that a person will no longer benefit from acute care and is safe to be transferred to a non-acute (including community and mental health) setting;
    - that the NHS and social care will jointly review policies and protocols around discharge, including handling of choice of accommodation; and have systems and processes for assessment, safe transfer and placement, as part of their capacity planning

- these steps should be guided by good professional practice and safe, person-centred transfers. Although an acute ward is not appropriate once an acute episode is over, joint planning is needed to ensure that appropriate care is available in other settings.

Reasons for delays in transfers of care

20. Relevant guidance takes account of the fact that the reasons for delays in transfer of care may be various. Categories for reasons for delay have been established by the Department of Health as shown in the Table below. Using the categories shown in this Table, both the number of patients whose transfer of care is delayed (a) and the number of days delayed within the month (b) are subdivided by the reasons for delay: A patient should only be counted in ONE category of delay ad this category should be the one most appropriately describing their reason for delay and total numbers allocated to reasons for delay should equal the number of patients delayed.

	Attributable to NHS	Attributable to Social Care	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	×	×
D i). Awaiting residential home placement or availability	✓	✓	×
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	×
H. Disputes	✓	✓	×
I. Housing – patients not covered by NHS and Community Care Act	✓	×	×

Monitoring delays

21. Using a national monthly Situation Report (SITREP) collected through a system known as UNIFY, data is collected on:
    - the number of patients delayed on the last Thursday of each month and
    - the total delayed days during the month for all patients delayed throughout the month.

22. Data is :
- shown at provider organisation level, (NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups)
- shown by Local Authority that is responsible for each patient delayed.
- split by the agency responsible for delay (NHS, social care or both), type of care that the patient receives (acute or non-acute) and reason for delay.

23. The Table above also shows which reasons can be attributed to NHS, social care and both. On the other hand, the delayed days for a given patient can be split across the reasons for the delay. For example, if the total length of delay is 10 days, the first two days were due to waiting for the assessment to be completed and the following eight days were due to waiting for a nursing home placement, then the delayed days will be split across reason A and Dii.

The Situation in Dudley

24. At the time of writing this report, the SITREP data submitted to UNIFY covered September2014. This gives the following figures for Dudley Council of the number of patients whose transfer of care has been delayed (figures for Birmingham, Walsall and Wolverhampton are also included for comparative purposes:)

Local Authority	NHS	Social Care	Both	Total number of patients
Dudley	9	18	2	29
Birmingham	103	88	0	191
Walsall	7	5	5	17
Wolverhampton	12	8	3	23

25. These figures reflect the patients falling within the strictly defined SITREP categories. However, it is recognised across the health and social care economy that SITREP figures alone do not reflect the full scale of the challenge we face in Dudley, because there may be significantly higher numbers of patients in hospital who are medically fit for discharge but not included in these figures. In this context, it is important to note that people's health may vary in terms of medical fitness for discharge. As an example, the council does not deem patients 'safe' for discharge until a social care assessment has been completed because the public are entitled by law to an assessment by the Council. While the number of patients in this category varies on a daily basis, there can be occasions when 20-30 patients are considered safe for discharge in the view of their clinicians but unable to leave hospital until a social care assessment has been carried out.

26. Flow through the system is also dependent upon the availability of community based beds for people stepped down from acute services. These are also subject to delayed transfers of care. At the time of preparing this report, 45 community bed delays are attributable to social care. 35 are awaiting an assessment by a social worker.

27. In addition delayed transfers of care impact on the ability of the hospital to deal with patients in the Emergency Department (ED) and in turn this is reflected in performance in relation to the 4 hour ED wait target. This requires 95% of patients to be either discharged, transferred or admitted within 4 hours of their arrival. Year to date performance is illustrated in Appendix 1.

28. There are occasions, however, when partners dispute the figures used as referred to earlier in this report. The current SITREP definition of a dispute is as follows;

"*This should be used only to record disputes between statutory agencies, either concerning responsibility for the patient's onward care, or concerning an aspect of the discharge decision, e.g. readiness for discharge or appropriateness of the care package.*

*Disputes may **not** be recorded as the responsibility of both agencies. NHS bodies and councils are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort*."

29. Evidence shows that the reason for the vast majority of Dudley delays on the SITREP, for the period April to August 2014 is "dispute." This recognition has spurred partners to clarify the practice and management information processes through a project to review and agreed a defined way forward which avoids this occurring. The Council has also agreed to work with the Department of Health as part of a regional Sector Led Improvement approach to improve the current situation.

External Review

30. To help all partners update their understanding and plans of the challenges they face across the whole system, the Department of Health's Emergency Care Intensive Support Team have carried out a review of the operation of the Dudley urgent care system. Their work has been presented to the multi-agency System Resilience Group. It covers a range of factors about the way in which the whole emergency care system works which are the responsibility of all agencies, the Dudley Group, Dudley CCG and the Council's adult social care function.

31. The System Resilience Group has now agreed an Action Plan designed to address all issues of flows through the system. The allocation of additional resources from NHS England to the Dudley Health and Social Care Economy to manage winter pressures will be dependent upon completing a number of required actions.

32. The Emergency Care Improvement Support Team returned to Dudley in early September in order to carry out further work in relation to primary care, nursing homes, mental health and the West Midlands Ambulance Service, with a view to identifying any other system blockages. Any required actions will be built into the existing agreed action plan.

33. Relevant actions designed to reduce delays are attached as Appendix 2. Some significant actions, including the removal of weekly funding panels, remain outstanding.

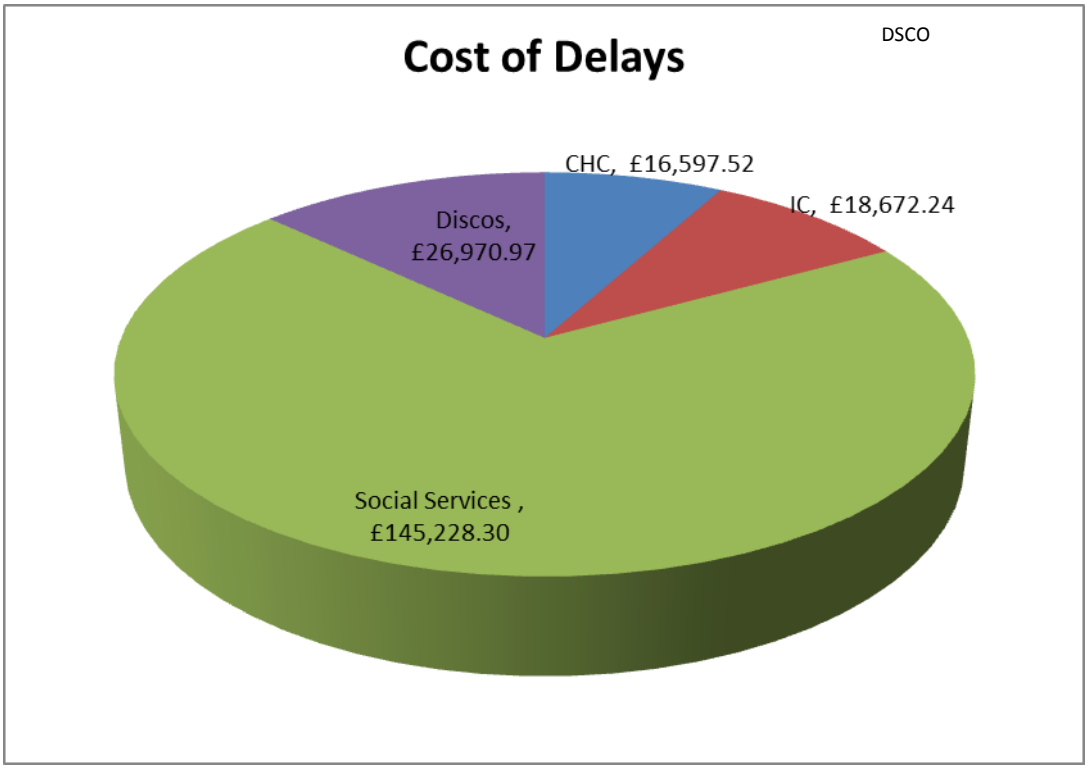
Finance

34. Work is being done to ensure that the information systems used by all agencies are more reliable for all partners to have confidence in analyses made and actions planned based on those analyses. This will support improved efficiency of the system and improved experience by people. All agencies have views about the costs of delays or the processes to their agencies and they are working to ensure that the information sources are more consistent so that view can be reconciled and appropriate actions taken.

35. The CCG has carried out a retrospective analysis of the delays taking place in May 2014, both in terms of the cause of the delay and the associated cost to the CCG. At the time the review was undertaken, the reason for the delay was agreed and none were in dispute.

36. The pie charts below indicate that the majority of delays (70%) were attributable to social care, based on current CCG analysis, at a total cost to the CCG for the month of £145,228, an annual equivalent of £1,742,736.

This data and outcome is currently being challenged and scutinised by the Local Authority so that we can achieve a shared agreement



CHC = NHS Continuing Healthcare
IC = Intermediate Care
DISCO = Dudley Group NHS FT discharge co-ordinators

Law

37. The legal and government guidance framework to manage issues connected to delayed discharges is set through:

- The *Community Care (Delayed Discharges etc.) Act 2003* which was enacted in 2004
- Delayed Discharges (England) Regulations 2003
- Health Service Circular 2003/009
- Delayed Discharges (Continuing Care) Directions 2013
- Monthly Delayed Transfer of Care Satraps: Definitions and Guidance Version 1.07 (last updated 8 April 2013)
- *Care Act 2014*

Equality Impact

38. Transfers of care will need to be made equally for all people. People's needs will vary according to their health and assessments should take account of all relevant factors at the point of transfer from hospital.

Recommendation

39. That the Committee note and comment on
    - issues connected to quality transfers of care between hospital and other settings,
    - work being done in the health and social care economy to continually improve our services and people's experience of transfer of care between hospital and other settings
    - specific issues relating to delayed transfers of care

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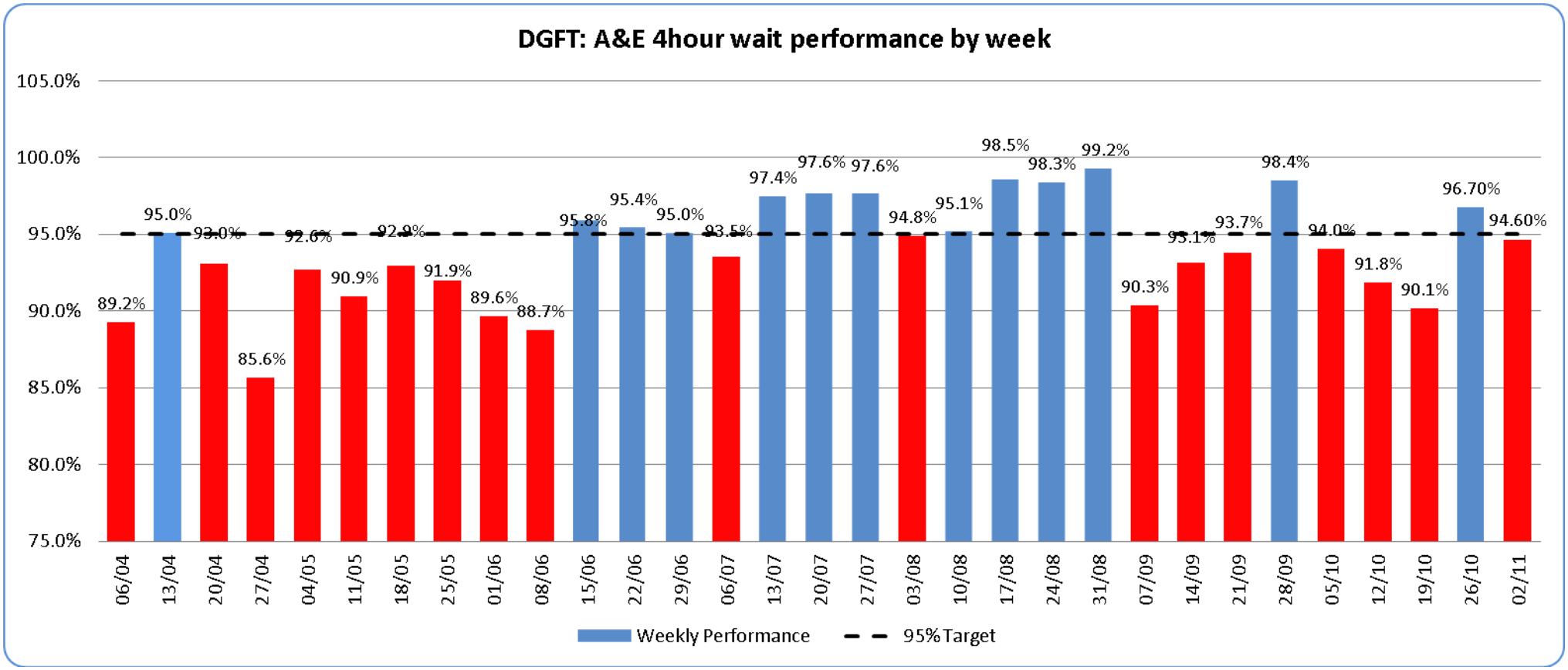
Background Papers

More detailed definitions, guidance and the most up to date national statistics are available from the NHS England website at http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

APPENDIX 1


DGFT: A&E 4hour wait performance by week
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02/11
Weekly Performance
95% Target

APPENDIX 2

Delayed Transfers of Care

Extract from Emergency Care Intensive Support Team Action Plan

Area No	Area	Scheme Description	Lead	ECIST suggested key performance indicators	Start Date	Current status of scheme eg: date implemented, key milestones, date for full implementation	RAG Red= not yet started Amber partially implemented % Green fully implemented	Mitigation actions to progress/ comments
1	**Improve the discharge process**	Reduce variation in medical models across inpatient ward areas. Provide a consistent model for provision of ward and board rounds. Implement clinical criteria for discharge with expected discharge dates. Review existing internal professional standards in relation to DTOC. Set internal professional standards with associated escalation for diagnostic tests.	Jon Scott	Number of Discharges taking place each day. Meeting the 4 hour standard.	Oct-14	Some work underway internally.	**Partially Complete**	Mark as complete when D2A live and weekly panel meetings are increased.
2	**Reduce the level of DTOC**	There is a need to reduce delays for community services and partner organisations. Internal length of stay review is completed for all patients in beds over 7 days for both acute and community	Brendan Clifford / Jon Scott / Paul Maubach	Number of Discharges taking place each day. Meeting the 4 hour standard.	Oct-14	Planning and roll-out of D2A model will significantly reduce DTOC issues. Discharge to Assessment workshop agreed for 18th September. LA to review its Panel decision making process. 08.10.14 S Lackenby confirmed that twice weekly panel meetings will commence immediately.	**Partially Complete**	Mark as complete when D2A live and weekly panel meetings are increased. 08.10.14 D Fitton to at UCWG on 22.10.14 re DTOC/EMS Levels - Trigger 14.
3	**Discharge Lounge**	Recommend that the discharge lounge is ring fenced and not used as a contingency for inpatients.	Jon Scott	Discharge lounge used for its primary function and no longer compromised due to inappropriate use.	Aug-14	Ring fence policy issued.	**Complete**	N/a
4	**Weekly panel decisions**	Improvement access to continuing Healthcare panel.	Brendan Clifford	Remove reliance on weekly continuing care assessment panels. Increase frequency of sign-off and agreement of funding decisions. **ECIST Recommendation**: replace weekly panels with 'real time' decision making system.	Oct-14	Currently weekly panel still in place although some decisions are made outside of this meeting. Review of Panel (LA) is to take place early September with the aim of allowing decisions making for placements available across the working week.	**Partially Complete**	Need confirmation of revision of this practice. Proposal ready within the next few weeks. 24.09.14 B Clifford & J Scott to meet on 29.09.14 to discuss this issue. A pope-Smith to write to DGFT with full update. 08.10.14 S Lackenby confirmed twice weekly panel meetings will commence immediately.
5	**Discharge to Assess Model**	Launch Discharge to Assess model.		Pay attention to: medical model for complex medical patients who are clinically stable. Consider using a memorandum of agreement to help clarify governance arrangements across the system. Ensure that optimum use is made of home based assessment pathways. Importance of therapy input in this model - flexibility between acute and community teams required.			**Partially Complete**	