Agenda Item 8

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 14 NOVEMBER 2017

DELAYED TRANSFERS OF CARE

REPORT OF DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of Report

1 The purpose of this report is to provide members of the Committee with information on Delayed Transfers of Care (DTOCs) relating to residents of Leicestershire, including the implications of new national requirements imposed by NHS England, as part of the Better Care Fund (BCF) Policy.

2 The report details the performance targets imposed on the County Council, together with the impact of not meeting the targets, our current performance locally, and the work being undertaken by the Adult and Communities Department in conjunction with NHS partners to reduce delays and meet the required target.

Background

3 The BCF Policy Framework was introduced by the Government in 2014, with the first year of BCF Plan delivery being 2015/16.

4 The requirement to deliver improvements in managing transfers of care is one of the national conditions for the BCF, as set out in the *Integration and Better Care Fund Policy Framework 2017/18 – 2018/19*, which applies to BCF Plans with effect from April 2017 (https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019).

5 In terms of the national conditions targeted to managing transfers of care, each local BCF Plan must provide evidence of how the Local Government Association (LGA)/NHS 'High Impact Change Model – Managing Transfers of Care' for improving hospital discharge are being implemented locally. The High Impact Changes Framework provides a basis for each health and care system to assess their local position and identify where further changes are needed so that all the evidence-based and recommended interventions are made.

6 The LGA/NHS 8 High Impact changes for effective management of transfers of care are:

- Early discharge planning; systems to monitor patient flow;
- Multi-disciplinary /multi agency teams to ensure co-ordination and shared responsibility;
- Home First/Discharge to assess provision that provides reablement and bridges the gap between hospital and home;
- Seven day services to ensure effective flow of patients through the systems;

- Trusted assessors to avoid duplication and speed up assessment times;
- Focus on choice to enable early consideration of options;
- Enhancing health in care homes in order to reduce unnecessary admissions to hospital.

7 In July 2017, after a lengthy national delay, technical guidance was published by NHS England for the preparation and submission of BCF Plans for the period 2017/18–2018/19. This technical guidance included new requirements for improving delayed transfers of care with challenging expectations placed on each Health and Wellbeing Board area in terms of the rate of improvement to be achieved during 2017/18.

8 On 15 September 2017, the Cabinet noted the revised targets for improving performance on DTOCs across Leicester, Leicestershire and Rutland (LLR) by March 2018 and the risk that the poor performing areas which fail to implement such improvements could be subject to Care Quality Commission (CQC) review and potentially face a withdrawal of that national funding.

9 On the 10 October 2017, via a report to Leicestershire County Council's Cabinet and by agreement across the partnership, the Council reluctantly accepted the target imposed by NHS England, due to the significant financial risk to the Council should the target not be accepted, together with the ongoing significant financial risk should the target not be met by November 2017. Leicester City and Rutland Councils responded similarly.

10 While the exact arrangements in relation to financial penalties have not been confirmed, it has been made clear that council areas who do not meet the target by November 2017 could have funds withheld from their BCF pooled budgets in 2018/19. This could affect either the new Improved BCF (iBCF) grant that the Council received in 2017/18 (£9m in Leicestershire) or a larger sum from the core BCF pooled budget (up to £22m in Leicestershire), the element of the fund that Clinical Commissioning Groups (CCGs) contribute in support of adult social care services.

11 The main acute care hospital sites locally are University Hospitals of Leicester [UHL] (based on three sites at Leicester Royal Infirmary, Leicestershire General Hospital and Glenfield Hospital), with Leicestershire Partnership NHS Trust (LPT) providing inpatient mental health, learning disabilities and community services at the Bradgate Unit, Agnes Unit, Evington and Bennion Units, as well as a range of community hospitals sites (for example, Coalville, Hinckley, Loughborough and Market Harborough).

<u>Definition of a Delayed Transfer</u>

12 A delayed transfer of care is defined as follows – it can apply to any patient in any inpatient bed (whether acute or non-acute, including community and mental health care) and occurs when it is agreed professionally that a patient is ready to depart from the inpatient setting, but is still occupying a bed. A patient is defined as ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer;
- a multi-disciplinary team (MDT) decision has been made that the patient is ready for transfer;
- the patient is safe to discharge/transfer.

13 A MDT in this context should be made up of people from different professions, including social workers where appropriate, with the skills and expertise to address the patient's ongoing health and social care needs. If there is any concern that a delay has been caused by the actions or inactions of a local authority, they should be represented in the MDT. The way that the team is organised and functions is fundamental to timely discharge and to the patient's wellbeing.

14 Patients who are unable to leave a hospital setting when they no longer require acute care, specialist care or rehabilitation in a community hospital bed prevent the effective flow through the hospital system and impact on other standards such as the four hour accident and emergency wait times and ambulance performance. Given the demography of LLR and number of both acute, non-acute and out of county hospital sites, the health and social care system across LLR is one of the most challenged and complex systems of any of the 153 English Council areas whose performance along with that of their partner NHS organisations is regularly assessed by NHS England.

15 Information about DTOCs is collected across all inpatient units on the Monthly Delayed Transfers Situation Report (SitRep) return. The focus of the return is to identify patients who are in the wrong care setting for their current level of need and this includes any patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay.

16 The data is captured in three categories: patients who are delayed due to NHS reasons, patients who are delayed due to Local Authority reasons, and patients whose delay is jointly attributable.

17 NHS England DTOC guidance applies to both acute and non-acute patients, including community and mental health patients. This is irrespective of whether the delay is potentially reimbursable and which organisation is responsible for the delay.

18 The Care Act 2014 updates and re-enacts the provisions of the Community Care (Delayed Discharges etc) Act 2003, which set out how the NHS and local authorities should work together to minimise delayed discharges of NHS hospital patients from acute care.

19 The NHS is still required to notify relevant local authorities of a patient's likely need for care and support and (where appropriate) carer's support, where the patient is unlikely to be safely discharged from hospital without arrangements for such support being put in place first (an assessment notice). The NHS also has to give at least 24 hours' notice of when it intends to discharge the patient (a discharge notice).

20 In contrast to the overall recording of delays, the assessment and discharge notifications required under the Care Act only apply to NHS patients receiving acute care.

21 In April 2017, NHS England announced changes to reporting delayed transfers of care in both the Unify collection system and Mental Health services data set. These changes aim to clarify the coding of delays across patient groups and ensure data returns are specific to groups such as mental health service users.

22 It is critical that delays are agreed at the local level between partner agencies and that the correct codes are used when making a return onto the Unify system or the Mental Health services data set.

23 For effective coding and DTOC validation, figures on delayed transfers of care must be agreed with the Directors of Adult Social Services (DASS), in particular those whose residents are regular users of hospital services. NHS bodies will need to have a secure and responsive system with local care and support partners, which will enable these figures to be agreed by an appropriate person acting in the authority of the DASS within the necessary timescale for returning data.

Current position

Implications of national targets

24 The national target set by NHS England is that no more than 3.5% of occupied bed days should be coded as delayed nationally, by November 2017.

25 This target has been apportioned across each Health and Wellbeing Board area and translated into a rate per 100,000 population per day for each local area.

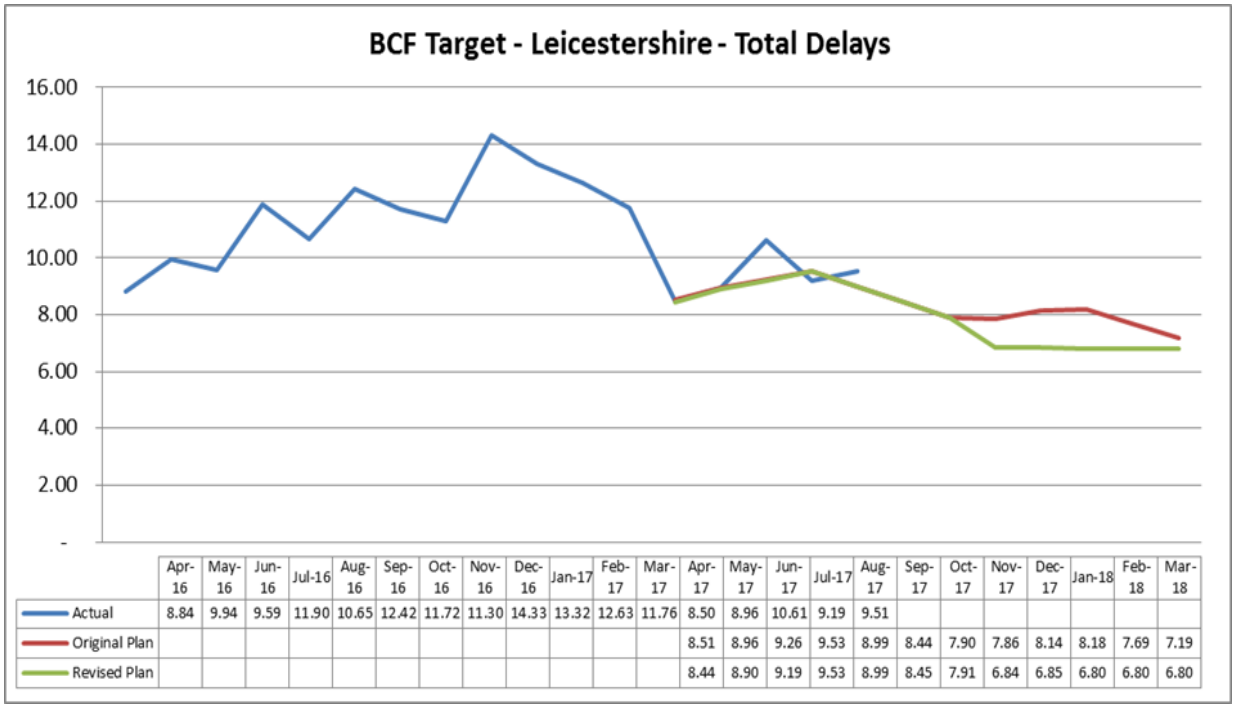
26 Leicestershire is required to achieve a rate of no more than 6.84 beds days delayed per day per 100,000 population by November 2017 in order to meet the national percentage.

27 The Leicestershire rate has been broken down into the three components of the target as shown in the table below:

	NHS Delays	LA Delays	Joint	Total
Performance at August 2017	6.76	1.26	1.49	9.51
Target for November 2017	3.78	1.33	1.73	6.84

28 It should be pointed out that the County Council's Cabinet and other members have expressed serious concern at the risk of financial penalty to the Council arising from delays attributable to NHS bodies and not to social care performance.

29 The locally agreed Leicestershire BCF trajectory was profiled to achieve the national target no later than March 2018, as it was recognised at the time of this target being set that it was highly unlikely to be achieved by November.



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	8.84	9.94	9.59	11.90	10.65	12.42	11.72	11.30	14.33	13.32	12.63	11.76	8.50	8.96	10.61	9.19	9.51							
Original Plan													8.51	8.96	9.26	9.53	8.99	8.44	7.90	7.86	8.14	8.18	7.69	7.19
Revised Plan													8.44	8.90	9.19	9.53	8.99	8.45	7.91	6.84	6.85	6.80	6.80	6.80

30 The majority of delays are now not at UHL but at LPT. A detailed joint action plan is in progress at LPT where a site by site review has been undertaken to ensure each delayed patient in mental health (MH)/Learning Disabilities (LD) and community hospitals has a clear plan. This has included a particular focus on patients within the mental health service for older people.

31 Analysis has been undertaken to profile all LPT delays so we can forecast more easily the resolution date for each person currently delayed and the rate of improvement this will have against the NHS England trajectory over the next eight weeks and beyond.

32 It is still unlikely that the revised target will be reached by November for Leicestershire even though recent improvements on non-acute delays for MH and LD, outlined below, are already having an evident impact.

<u>Actions in progress</u>

33 In line with the LGA/NHS 8 High Impact actions, the Adults and Communities Department are working with our Health sector partners to improve performance taking a system wide approach. Outlined below are the various initiatives that are being undertaken.

34 The LLR wide DTOC action plan is being enacted by all partners and this continues to be a top priority for all partners, including Leicestershire's adult social care team. There is a good joint understanding of the position across the partnership. For the last two years the Accident and Emergency Delivery Board (AEDB) has strategically prioritised DTOC improvements aimed at supporting a reduction in acute delays in UHL; as a consequence the impact of delayed bed days is now primarily on non-acute sites and out of county acute sites.

Learning Disability

35 Work is in train to establish reasons for admission to the specialist learning disability unit (Agnes) at LPT. This will include detailed patient journey and case analysis, to ascertain how a patient has been admitted, supported, and discharged into the community. Lessons as to how partners might do things differently will be collected and shared. A “no blame”, but challenging approach is taken with partners looking at lessons to be learned.

Mental Health

36 In relation to Adult Mental Health, an 18 month pilot commenced on 6 November 2017, focusing on the ‘move on accommodation’. This five unit accommodation will provide temporary housing for inpatients based at LPT’s Bradgate Unit who are fit for discharge, but waiting for permanent housing. It is anticipated that this development will also contribute to the reduction in DTOC levels within this cohort of mental health patients.

Community Hospitals

37 A Community Hospital Integrated Services Workshop is scheduled for 16 November 2017, to look at how community hospital link workers and community hospital discharge ward manager/discharge nurses are working together and to plan improvements to ensure ‘one team approach to dealing with discharges within the community hospital setting’.

Senior Escalation meetings

38 LLR health and social care partner agencies are currently trialling a twice weekly senior escalation teleconference to discuss rapid resolution of common themes, individual cases with a significant delay and system issues for patients delayed within LPT’s community services. The initial focus will be on community hospitals and MH older people.

Improving data quality and reporting

39 Various initiatives have been undertaken across LLR to ensure that recording of data is accurate and timely. These initiatives are all cross agency. A key driver has been to ensure collective understanding and ownership of the challenge to meet revised national targets.

40 The Director of Adults and Communities has formally written to all out of county hospitals where there is an identified mis-coding of DTOCs to request compliance with more rigorous expectations and accountability for coding prior to submission to the Unify collection system.

Formal local systems

41 Locally across LLR there are several formal Boards where the DTOC position is regularly reported to senior managers from key stakeholder agencies. AEDB,

chaired by John Adler, UHL Chief Executive Officer, covers urgent care across the entire LLR wide systems and includes adult social care and clinical commissioning.

42 The LLR Discharge Working Group has been reconvened, with a refreshed purpose and senior level direction in order to oversee delivery and ensure one set of LLR data is available and analysed, giving a consistent view of system wide performance weekly and monthly. This group takes a more operational focus on managing changes. There is strong collaboration and partnership working at both the strategic and operational levels.

43 All existing actions remain in place to support UHL discharges. A positive position is being maintained at the acute site where adult social care coded delays for Leicestershire remain very low.

Escalation Process if the DTOC Targets are not met

44 The Council's corporate risk register has been upgraded to a red risk level on the achievement of this target and financial risks this may entail**. Elected members, however, continue to register concern that the County Council may be financially penalised due to local NHS performance.**

45 It remains highly unlikely the target will be reached by November, and it is not yet possible to accurately forecast when this might be reached, although the analysis mentioned in paragraph 31 will provide more assurance on when the target could be reached.

46 Monthly DTOC performance data is not usually available and nationally validated until six weeks after the end of the month (for example, November's data would be available in mid-January). It should therefore be known by mid-January which local areas have not reached the November target and will face escalation via NHS England.

47 The process will include escalation meetings for key officers, which could also involve the Chair of the Health and Wellbeing Board, the withholding of funds from councils in 2018/19, and/or further conditions being placed on how funds should be prioritised via the BCF plan and pooled budget.

48 Whilst several other councils are in the same position as Leicestershire, a small number of councils have refused to accept the imposition of the target. Their BCF plans have been deemed to be non-compliant at the time of submitting the plans in September 2017 and they have already been escalated via NHS England. Outcomes are unknown.

49 The escalation process may also include a CQC system area review being imposed on local authority areas.

50 There are also 12 local areas that have been selected for the first wave of CQC system reviews.

51 The next group of areas who will form phase two of these reviews will be selected in late January/February, when the November DTOC data has been analysed nationally.

Resource Implications

52 The BCF Plan has a pooled budget totalling £52m for 2017/18 and £56m for 2018/19. This includes the additional non-recurrent adult social care grant funding allocated by the Government in the March budget (£16m over 2017/18-2018/19). This funding has specific grant conditions, one of which concerns improving DTOC from hospital.

53 There is also a requirement that a proportion of the new adult social care allocation will be spent on reducing DTOC. In Leicestershire, the total amount of funding being spent on this priority across the entire BCF plan during 2017/18 is £16.4 million. This includes both a proportion of funding from the adult social care allocation and a proportion of funding from the core BCF pooled budget.

54 £11.4million of the funding to improve DTOC is recurrent from the core BCF budget and funds existing services such as seven day hospital discharge support from the adult social care department, including link workers for supporting discharge at community hospital and mental health sites, core reablement services across health and social care.

55 The Director of Corporate Resources has been consulted on the content of this report.

Background Papers

High Impact Change Model – Managing Transfer of Care
https://www.local.gov.uk/sites/default/files/documents/Impact%20change%20model%20managing%20transfers%20of%20care%20(1).pdf

Report to Cabinet: 15 September 2017 – Delayed Transfers of Care
http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4863

Report to Cabinet: 10 October 2017 – Delayed Transfer of Care and Assurance of the Leicestershire Better Care Fund Plan
http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4864 (item 46

House of Commons Briefing paper Delayed Transfers of Care in the NHS June 2017
http://researchbriefings.files.parliament.uk/documents/CBP-7415/CBP-7415.pdf

Circulation under the Local Issues Alert Procedure

None.

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Appendix

Appendix A – Case examples of patient/service user experiences and improved outcomes evidencing effective discharge processes to avoid and reduce DTOC

Relevant Impact Assessments

Equality and Human Rights Implications

57 The Adults and Communities Department takes a personalised approach towards assessment, review and delivery of service as part of their statutory duties and obligations in relation to all equalities and human rights issues.

Partnership Working and Associated Issues

58 Effective partnership working is key to the delivery of this business critical area of work for all agencies within LLR.

APPENDIX A

Case examples of patient/service user experiences and improved outcomes

Effective discharge processes to avoid and reduce Delayed Transfers of Care

Case example 1

A 45 year old service user/patient with Autism Spectrum Disorder and a history of placement breakdown and multiple admissions (both supportive living and residential care). The last placement on discharge lasted only days before further admission under S3 of the Mental Health Act.

A care provider was identified prior to accommodation being made available; assessments confirmed that 2:1 support was required. It was agreed that suitable accommodation and specialist provider were required. The care manager commenced their assessments by observing the patient on the Assessment Treatment Unit and how staff interacted with the patient. Care staff supported on the unit for two weeks in the lead up to discharge. The unit ensured that anxieties were managed with a countdown calendar. It was agreed trial visits would not be beneficial and there was a crisis plan created. Positive behaviour support plans were created and shared by outreach.

The multi-disciplinary team met regularly and in the lead up to discharge were meeting almost weekly.

A specialist provider was commissioned and a bespoke property was purchased.

Case example 2

A 30 year old with Autistic Spectrum Disorder. Rapid deterioration in mental health results in a hospital admission under S3 Mental Health Act. Admitted to an out of area Assessment Treatment Unit to provide accommodation until a local bed is available. Section 17 leave identifies that being out in the community is beneficial. Local specialist provider is identified to support patient by travelling to the unit and taking patient out for activities, increasing in time and varying activities. Building confidence and support mechanisms with a personalised support programme. Clinical Commissioning Group agreed to fund this due to safeguarding concerns raised on ward. A short break respite plan is devised and patient is transferred from the out of area unit to the short breaks facility in preparation for the move home.

The multi-disciplinary team works closely with hospital and family. Short breaks used to assess more locally how the reintroduction to Community Life Choices and family home would impact on mental health.

A positive set of outcomes are achieved for this patient, demonstrating effective professional discharge working, based on partnership working with the multi-disciplinary team.

Case example 3

External out of County hospital discharge from an out of County acute hospital, where a patient was going to be discharged to a care home. As our workers had local knowledge of this service user we knew that it was her preference to remain in her own home.

Family wanted their parent in a care home and the ward would have discharged her there against her wishes.

We arranged for a Social Worker to go and complete a capacity assessment with regards to discharge destination. The service user did return home with an increase in care. Had we not intervened this service user would have been placed in a care home against her wishes. The ward had no idea about the legalities and possible implications of their actions had we not have stepped in.

This case example demonstrates that our role is not just about supporting hospital discharges; it is also about the education to ward staff that we provide.

Case example 4

A service user had been in hospital for four months and had not mobilised for this period, had progressed from a hoist to rotunda in hospital, however had been diagnosed with a form of cancer which affects their health and abilities and also had other long term health conditions. Referral made to specialist bed based reablement facility to practice their transfers with a rotunda and the assistance of two carers. It was envisaged that they would require four calls daily with two carers on discharge.

The service user participated well with the therapist at the reablement facility and was motivated to complete all exercises to improve stamina and muscle tone, eventually progressing from a rotunda to being able to mobilise with a frame and became independent with transfers.

A daily morning and evening call was commissioned for discharge home with one carer and this was shortly reduced to a daily morning call. As part of the assessment process, Attendance Allowance claim forms were given along with a Carers assessment and a referral was made via First Contact Plus for smoke alarms. The therapist also ensured that the service user had all equipment in situ at home for discharge.

We received a card after discharge with the following:

“To all of you looking after my father,

I would like to thank you from both of us for helping my father ‘find their legs again’ I cannot tell you what it meant to me to see them walk again from his bed to his frame with no help. I know we have a long way to go but father does seem very positive about everything and I will make sure that he continues to do everything they have been told to do when at home.’

Case example 5

Service user was living at home prior to admission and although family had privately arranged support previously, the service user would cancel leaving their daughter

extremely stressed with supporting as the main carer. Service user was admitted to hospital after having a fall resulting in a fractured humerus which was in a cast.

Service user also has an undiagnosed dementia with short term memory impairment and was referred to a reablement facility to increase their confidence, mobility and transfers. Daughter advised that trying to find homecare to support at home had been very difficult due to their mother's reluctance to have support and was aware that their mother was self-neglecting their personal care, medication and nutrition.

Service user engaged well with the therapy team at the reablement facility and was able to mobilise very well with a walking stick and complete all transfers independently. Therapy assessments were completed which indicated that they required support with prompting with personal care and meal preparations due to their sequencing of tasks.

An assessment was completed and a multi-disciplinary team meeting was held with the therapist, service user and their daughter which resulted in a daily morning and tea call being commissioned for discharge to assist with personal care and meal preparation which service user was accepting of.

Attendance Allowance claim forms were given to the daughter to complete and a Carers Assessment was also completed with a one-off budget being commissioned to help to pay towards a gardener and cleaner to relieve some carers strain. A referral to assistive technology was made for Lifeline and to First Contact Plus for smoke alarms and a carbon monoxide monitor. A follow up phone call was made post discharge and was advised by service user's daughter of everything going well and service user accepting of the care.

A card was received on the unit:

'To All staff,

I would like to say a very big thank you to everyone who has helped my Mum to recover over the past four weeks.

This is a wonderful place and the care and support you offer both those recovering and their families amazing. Mum would not have made such a good recovery if she had stayed in hospital and would not have coped at all if they had been straight home.

Signed a very grateful daughter'