Agenda Item 12

Leicestershire County Council

ADULTS AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE 5 JUNE 2018

DELAYED TRANSFERS OF CARE: YEAR END REPORT

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of Report

1 The purpose of this report is to provide the Committee with the end of year performance up to March 2018 in relation to Delayed Transfers of Care (DTOCs).

2 The report also sets out in detail the specific improvement actions that have been undertaken and their impact on the patient journey, including the implications of new national requirements imposed by NHS England, as part of the Better Care Fund (BCF) Policy.

Policy Framework and Previous Decisions

3 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.

Background

4 The BCF Policy Framework was introduced by the Government in 2014, with the first year of BCF Plan delivery being 2015/16. 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 is being implemented locally. The High Impact Changes Framework provides a basis for each health and care system to assess its local position and identify where further changes are needed so that all the evidence-based and recommended interventions are made.

6 The LGA/NHS eight 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 DTOCs 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 10 October 2017, via a report to the Cabinet and by agreement across Leicester, Leicestershire and Rutland Health partners, the County 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.

Definition of a Delayed Transfer

9 A DTOC 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.

10 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.

11 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.

12 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.

13 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).

14 For effective coding and DTOC validation, figures on DTOCs must be agreed with the Directors of Adult Social Services (DASSs), 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.

Improvements made in 2017/18

15 Across LLR, DTOC's have improved significantly during the 2017/18 financial year, despite not meeting the BCF target. Data below shows that overall there has been a 21% reduction in delayed bed days when compared to the 2016/17 financial year. Monthly delayed days per 100,000 population has fallen from 11.53 on average in 2016/17 to 9.04 in 2017/18.

16 For adult social care the reduction is greater still. There was a 24% reduction in delays attributable to adult social care over 2017/18 compared to 2016/17. Average monthly delayed days reduced to 1.13 delays per 100,000 from 1.50 in 2016/17.

17 When analysing the hospital provider data, it shows the greatest reductions in delays are attributable to the Leicestershire Partnership NHS Trust (LPT), community hospitals and non-acute hospital wards. Comparable data for 2016/17 is not available, however when comparing the first half of the 2017/18 financial year with the second half there was a 44% reduction in the overall average monthly delays in the last six months of the year. For the LPT delays attributable to adult social care, there was a large reduction in the latter half of the 2017/18 financial year of 98% when compared to the first half of the year.

18 Conversely, the overall delays at University Hospitals of Leicester (UHL) have risen in the second half of the year by 24%. Adult social care delays have also risen in this period but remain low from eight in the first half of the year to 14 in the latter half of the year. So the decline in adult social care performance is relatively slight when considered in context.

19 A series of charts showing the trend lines over time, from 2016/17 through 2017/18 are attached as Appendix A to this report.

20 Many actions from across LLR contributed to the reduction in DTOCs from October 2017. Below shows the activity that took place during this period:

- LPT restructuring staffing to focus on complex patients with a long length of stay;
- focusing matrons on wards to look at Census data directly and reviewing all end to end processes to improve patient flow;
- development of the Integrated Discharge Team (IDT) in UHL;
- utilising the Red2Green process, which looks at patient delays on a daily basis in UHL and community hospitals;

- Multi Agency Discharge Events (MADE) in January 2018, concentrated efforts across partners to focus on DTOC actions and specific patients including those with long length of stay to maximise impact on delays;
- Improvements were made to the discharge to assess process including accessing short stay beds at Peaker Park (pilot of 14 beds) – to impact the number of permanent admissions to care homes;
- Improvements in social care practice, rigorous management oversight and development of robust sign off agreement processes;
- Help to Live at Home, domiciliary care service, designed to help service users achieve maximum possible independence at home by focusing on reablement and maximising independence.

Actions in progress

21 In line with the LGA/NHS Eight High Impact actions, the Adults and Communities Department is working with Health partners to improve performance taking a system wide approach. Outlined below are the various initiatives that have been undertaken over the previous year to ensure continued improvement in DTOC reported rates.

22 The LLR wide DTOC action plan is being enacted by all partners and this continues to be a top priority for all, including Leicestershire's adult social care team.

23 Key strategic aims of the new action plan include:

- Expansion of the Integrated Discharge Team;
- Embedding LLR system and process around delivery of a Home First methodology,
- Supporting self-funders to make more informed, speedier choices around care;
- Create systems across LLR partners to ensure flow through all settings is timely and appropriate;
- System-wide leadership and commitment to reviewing and supporting changes and consolidation of the Discharge 2 Assess (D2A) pathways across LLR.

24 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.

Learning Disability

25 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 looking at lessons to be learned.

26 As at 8 March 2018, there were no Leicestershire DTOCs in respect of Non-acute ward based patients with a learning disability to report. This is a significant development achieved for the first time in two years. Work will now focus on admission avoidance and reducing the length of stay for detained patients in order to improve outcomes and the patient journey.

Mental Health - Younger Adults

27 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 provides temporary housing for inpatients based at LPT's Bradgate Unit who are fit for discharge, but waiting for permanent housing. To date there has been 80% to 100% occupation levels and there is evidence that this initiative has successfully contributed to the continued reduction in DTOC levels within this cohort of mental health patients.

Mental Health – Older Adults

28 A revised flow and discharge pathway has been developed at the Evington Centre; two wards for patients over 65 years of age. This pathway seeks to achieve safe discharge, developed on strong partnership working between health and social care staff that is clinically led and informed and regular system wide reviews.

29 There is also a dedicated and increased adult social care staff presence working on the wards; each worker carries a case load and works directly with ward clinicians to develop effective care and discharge planning.

30 There are also regular meetings with the Mental Health Services for Older People (MHSOP) clinical lead and senior NHS management where issues and areas for improvement are discussed and changes to process promptly made.

Community Hospitals

31 There are 12 wards at eight community hospital sites across Leicestershire. Some are specialist stroke hospitals such as Coalville and St Luke's in Market Harborough. Others provide more generic nursing provision.

32 A Community Hospital Integrated Services Workshop was held on 16 November 2017, to look at how community hospital link workers and community hospital discharge ward manager/discharge nurses work together and to plan improvements to ensure 'one team approach to dealing with discharges within the community hospital setting'. There are further planned events to look at various issues such as Continuing Health Care, Mental Capacity Act requirements and access to Help to live at Home domiciliary care provision.

33 As part of the Adults and Communities Department's social care offer, link workers dedicated to work on patient discharge at each community hospital site are provided. County departmental link workers are active members of the MDT at these hospitals and continue to make a positive contribution to reducing delays due to DTOCs at these sites.

34 In April 2018, partners from LLR wide health and social care started on an NHS Elect programme, alongside system leaders from Nottinghamshire, Worcestershire and Essex. This work will bring together LLR system leaders who are working on non-acute DTOC. The aim is to collectively look at the complex systems and share good practice, network and learn collaboratively to produce solutions. Each system in this learning cohort is of a sufficiently complex scale to ensure that collective learning will be a real benefit to all participants. Partners will look at challenges but also best

practice. In Leicestershire the learning and best practice around recent improvements in non-acute learning disability NHS settings will be shared.

Senior Escalation meetings

35 LLR health and social care partner agencies currently have a weekly senior escalation teleconference to discuss rapid resolution of current delays and tackling common themes, individual patients who are significantly delayed and system issues for patients delayed within LPT's community services.

Improving data quality and reporting

36 Since April 2017, various cross agency initiatives have been undertaken across LLR to ensure that recording of data is accurate and timely. A key driver has been to ensure collective understanding and ownership of the challenge to meet revised national targets.

37 In October 2017, the Director of Adults and Communities formally wrote 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. Out of county hospital delays have historically accounted for around a third of all adult social care attributable delays but these data returns were not an accurate reflection of activity. A more robust sign off process was needed to be developed and since making contact with this cohort of out of county hospitals rigorous reporting and sign off processes have been developed.

38 During the first half of 2017/18, out of county delays totalled 433 days. As a result of improved management oversight the number of delayed days in the second half of the year was 275. This equated to a reduction of 36%. Improvement is even more noticeable when compared to 2016/17. During that year out of county hospitals averaged 555 days for a half-year period.

Targets for 2018/19

39 On 15 May 2018, new BCF provisional targets were announced. The new target will use performance as at quarter 3 of 2017/18 as the baseline. Overall, Leicestershire's target will change from 6.84 to 7.88 using the current methodology (as shown in the table overleaf). This is mainly due to the positive work that has been undertaken by the Department to reduce the number of delayed days during Q3. Therefore this good performance needs to be maintained. The NHS target has changed from 3.78 to 5.50 and this is because the Q3 performance was 6.98 so the target is reduced to 5.50.

Average Days Delayed per Day per 100,000 population (Target)

	Average Days Delayed per Day per 100,000 population – Target/Threshold			
	NHS	**Adult Social Care**	**Joint**	**Total**
2017/18 (November 2017 Target)	3.78	1.33	1.73	6.84
2018/19 (Provisional, September 2018 Target)	5.50 (Adjusted to 5.50)	1.25 (Maintain)	1.13 (Maintain)	7.88
Variance	**1.72 (Increased)**	**-0.08 (Decreased)**	**-0.60 (Decreased)**	**-1.04 (Decreased)**

Resource Implications

40 It is difficult to estimate the entirety of the Council resource commitment to managing Delayed Transfers of care. However it is estimated that £16m of the total BCF funding in 2017/18 and £21m in 2018/19 is attributed to DTOCs. Around 18% of Adult Social care contacts and referrals are associated with people being discharged from hospital and therefore the resources committed by the Council on provision of services for people post hospital treatment are extensive.

41 During 2017/18 the Council made the decision to invest an additional £170,000 to support extra capacity in the hospital social work team. The Council is also not currently progressing planned reductions in funding to the HART reablement services in order to ensure timely discharge from hospital for residents of the county.

Timetable for Decisions

42 The action plan for 2018/19 is being implemented and overseen by the Discharge Working Group, an operational group reporting to the AEDB. In terms of the new DTOC target, there will be a follow up approach to take this plan with provisional targets to the Integration Executive on 5 June 2018 for formal sign-off, (with a caveat of the targets being provisional targets if formal guidance has not been issued by then).

Conclusion

43 Adult social care DTOC performance has continued to improve and has met the required target for 2017/18. This report outlines the significant progress that has been made.

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)

Report to Adults and Communities Overview and Scrutiny Committee: 14 November 2017 – Delayed Transfers of Care - https://bit.ly/2IGD18i

Circulation under the Local Issues Alert Procedure

44 None.

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List of Appendices

Appendix A – Summary of DTOC April 2017 to March 2018

Relevant Impact Assessments

Equality and Human Rights Implications

45 There are no equality or human rights implications arising in this report.