REPORT TO: OSC

DATE: 8th November 2017

REPORT TITLE: Delayed Transfers of Care

REPORT AUTHOR/S:
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PURPOSE OF REPORT:

- Information on the current figures for delayed transfers of care
- Data identifying the recorded reasons for delays
- Set out how the Better Care Fund is being used to reduce Delayed Transfers of Care
- Summary of the implementation of the High Impact Change Model and the success these changes have had in mitigating delayed transfer of care

SUMMARY:
NHS England has set the HWB trajectory for areas in relation to metrics for Delayed Transfers of Care, in which the Enfield Health and Wellbeing Area (which is larger than the Enfield CCG area as it includes a small portion relating North Middlesex Hospital) has been set a target of no more than 20.6 DToC per day from July 2017 and for this to be maintained until March 2018.

This report sets a summary of the current performance and the reason for delays, alongside a summary of the schemes that form part of the Integrated and Better Care Fund being used to reduce delays in hospitals.

1. BACKGROUND

A delayed transfer of care (DToC) 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 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 the patient is ready for transfer and
c) The patient is safe to discharge / transfer.

Delayed transfers of care are a significant concern for the health and social care system; frontline staff want to treat patients with greater needs once a patient is well enough to leave hospital and there are potential effects on the patients associated with longer stay in hospital. The National Audit of Intermediate Care Summary Report 2014 state ‘Undue waiting in hospital is highly damaging for older people. A wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a

10% decline in muscle strength'. In addition, there are financial consequences, with an impact on waiting times.

2. PRIMARY REASONS FOR DELAYS

Appendix A sets out the reasons for delays as set out in NHS England guidance, alongside Enfield performance on delays transfer of care from April 2015 to August 2017. Information below provides a narrative to these figures.

In July 2017 NHS England set out Enfield Health and Wellbeing Board area trajectory for reducing delayed transfer of care. Locally, partners agreed how the trajectory would be met by health attributable delays, social care attributable delays, and delays which are joint between health and social care. As of August 2017, Enfield target of 1277.9 delayed days per 100,000 population has been exceed and stands at 1352. This was within target for social care attributable but above target for both health attributed delays and those which are joint.

The most reported type of delay attributed to Health are:

- awaiting further non-acute NHS care
- patient and family choice
- completion of assessment

For those delays attributable to social care the reasons for delay are

- public funding
- awaiting placements in residential or nursing home
- care packages in own home

Collectively partners have agreed processes in place to monitor those patients who are both becoming medically optimised (focusing on those who will be able to leave hospital shortly to ensure next steps proactively identified) and those who are delayed transfer of care; the latter is to ensure there is open communication on reasons for delays and finding solutions often to complex barriers preventing a person from leaving hospital to the most suitable location and with the right support.

3. BETTER CARE FUND CONTRIBUTION TO DTOC REDUCTION

The Integration and Better Care Fund (BCF) Planning Requirement 2017-2019 set out an expectation under national condition four that requires health and social care partners to work together to implement the High Impact Change Model (HICM) for managing transfers of care.

From April 2017, there were additional funds provided through the Improved Better Care Fund (iBCF), which is a grant paid to a local authority for the purposes only of meeting adult social care needs, reducing pressure on the NHS, including supporting people more people to be discharged from hospital

when they are ready, and ensuring that the local social care provider market is supported. The Improved Better Care Fund (iBCF) grant requires local authorities to work with their CCG to implement the High Impact Change model; this does not mean the iBCF grant can be spent only on the HICM, but that it is up to local areas to decide how best to spend the iBCF and how to implement the model.

The Better Care Fund currently supports several schemes specifically for the purposes of reducing delayed transfer of care; these should be considered in the wider context of numerous activities taking place to move health care closer to home and preventing individuals from going into hospital in the first place.

The **Care Home Assessment Team** (CHAT) assist with enhancing health in care homes, offering people joined up and coordinated health and care service to help reduce unnecessary admissions to hospital, as well as improved hospital discharge. The CHAT work closely with other services, such as GPs, Integrated Locality Teams and Rapid Response, to improve management of long term conditions. This expected outcome is to reduce the number of non-elective admissions from care homes, including excess bed days. For 2016/2017 there was a 15% reduction in A&E attendances and a 7% reduction in non-elective admissions from care homes, as well as a 17% reduction in number of falls and a 5% reduction in the number of falls which resulted in hospitalisation. The CHAT Team are now increasing their scope to act as Trusted Assessors, completing holistic assessments of needs to speed up discharges out of hospital. The Enfield CHAT have used this approach in partnership with Haringey and have found this model is working to improve transfer of care; the model is being extended into Enfield care homes.

Investment has been made by the BCF in **seven day working**, to shift barriers to discharging patients home safely on the weekend. Social care practitioner capacity has been increased and we are improving equity of discharging across the week. This approach is contributing to improved patient flow in the system.

The BCF also funds **Discharge to Assess**, a key component in the High Impact Change Model. There are step down beds which continued from a 2016/17 pilot, enabling individuals with intermediate care needs to be in a more appropriate setting to improve their independence prior to returning to home.

The new iBCF funds from April 2017 have supported three specific schemes to reduce delayed transfer of care:

- **discharge to assess –** additional resources for pathway 1, which moved individuals out of hospital once ready into their own homes, where a holistic assessment of the needs takes place with appropriate health and social care professionals.
- **Mental health Navigators –** enabling adults with mental health needs to have the appropriate support and guidance to move out of acute setting into the community

- **intermediate care at home –** supporting those awaiting Continuing Healthcare Assessment to be safely supported at home with the right package of care until a funding decision is made, as opposed to waiting in hospital for the assessment to be undertaken.

5. HIGH IMPACT CHANGE MODEL (HICM)

This High Impact Change Model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help to reduce delayed transfers. They key successes from the implementation of this model in Enfield are as follows:

- early discharge planning by locating hospital social work teams with discharge co-ordinators in the acute trusts, leading to swift identification of blockages in system
- Daily monitoring of patient flow, to monitor those who are clinically fit for discharge and although they may need to continue their recovery, that does not need to be in an acute setting
- Integrated Locality Team model is moving from virtual to planned co-location in 2017/2018, with plans for combining this work with the Care Closer to Home Integrated Networks (CHINs) model so that health and social care professionals are working as a cohesive team around individuals.
- Joint Commissioning Board between the Council and CCG since 2016
- Rapid response and GP services seven days per week, to help with discharging on weekends and evenings
- Using Trusted Assessors to complete assessments on behalf of organisations

All the HICM activities taking place are expected to result in a reduction in DToC days in Enfield. It is important to note that in addition to the activities set out under these eight changes, the wider preventative and community based model of care in the BCF ultimately aims to keep people outside of hospital in the first place and receiving appropriate support in the community. For example, a new proposed scheme under the BCF aims to locate mental health link workers with primary care (and co-located in practices where possible) to manage and maintain working age adults with emotional or mental health needs in the community. This will also seek to minimise and reduce inappropriate referrals to specialist secondary services.

6. MENTAL HEALTH DTOC

The Barnet, Enfield and Haringey Health and Care System are prioritising reducing DTOC in mental health services for 2017/18 and 18/19. This applies equally to working age adult and older people Mental Health services and is part of an agenda focused on the Parity of Esteem (tackling mental health issues with the same energy and priority as we have tackled physical illness).

The Top three causes for delay in mental health are described as:

- Access to housing
- Access to accommodation based services
- People with No Recourse to Public Funding

Additionally, Barnet, Enfield and Haringey Mental Health Trust placed 410 patients Out-of-Area last year. There is a direct correlation between levels of DTOC and numbers of patients placed in Out-of-Area Treatment. The CCG, BEH MHT and the Council are working in partnership to ensure that we are operating together to reduce DTOC to 2.5%, which will ensure access to local services for people who are in mental health crisis.

DTOC levels have been steadily reducing and this is due to a range of Interventions introduced to work in partnership to manage DTOCs effectively:

- A weekly Partnership call that includes CCG Commissioners, Local Authority representatives and BEHMHT operational teams
- BEHMHT hold daily bed management escalation calls internally where DTOC is prioritised
- Tracking of DTOC performance at monthly Contract meetings
- Held a Mental Health DTOC workshop with executive membership in September with another planned for November 2017 to review position and performance

We are proposing to set up a system resilience structure for mental health that has parity of esteem with physical health e.g. requires engagement at a senior executive level across partnerships and is part of the current wider system resilience processes. We have developed a new post called the Mental Health System resilience programme Manager that is funded by the iBCF from contributions in Barnet, Enfield and Haringey areas, and will be responsible for:

In November 2017, ADASS and NHSE will be launching the Mental Health DTOC Management Guidance. The CCG, BEHMHT and Local Authority will work in partnership to review the Guidance and develop an action plan that is taken forward as a collaborative.

7. ISSUES AND CHALLENGES

The NHS England Mandate for 2017-2018 sets a target for reducing delayed transfers of care nationally to 3.5% of occupied bed days by September 2017. The health and social care system should work together to achieve reductions in DToC and that the agreed trajectory for doing so should reflect ambitious targets for reducing delays attributed to both NHS organisations and social care. Government will consider a review, in November, of 2018-2019 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.

8. RECOMMENDATIONS

This report is for information and noting only.

9. NEXT STEPS

As part of the national metric for the Integration and Better Care Fund, DToC will continue to be monitored through the Better Care Fund (BCF) governance systems in place, and reported up to the Enfield Health and Wellbeing Board.

APPENDIX A: ENFIELD DELAYED TRANSFERS OF CARE - PERFORMANCE

Reasons for delays are set out in guidance from NHS England and in brief are defined below:

A. Awaiting completion of assessment - patients awaiting assessment of their future care needs and an identification of an appropriate care setting
B. Delay awaiting public funding – assessment is complete but awaiting funding from LA, NHS, jointly funded or disputes over Continuing Healthcare
C. Delay awaiting further NHS care, including intermediate care – transfer is delayed due to awaiting any further NHS care, i.e. non0acute care, including intermediate care
D. Delay awaiting residential / nursing home placement or availability – lack of availability of a suitable place to meet their assessed care needs
E. Delay due to awaiting care package in own home – where transfer delayed due to care package in home not being available
F. Delays due to awaiting community equipment and adaptations – where assessment is complete but transfer delayed due to awaiting the supply of items of community equipment
G. Delay due to patient or family exercising choice – where reasonable offer or services but patient have refused the offer. It would also include delays incurred by patients who are self funders e.g. through insisting on placement in a home with no foreseeable vacancies
H. Disputes – used to record disputes between statutory agencies either concerning responsibility for the patients onward care or concerning an aspect of the discharge decision
I. Housing (patients not covered by the Care Act) – relates to housing delays where individual is not eligible for care and support.

*2017-18 data in tables below only provided until August 2017

Delayed Transfers of Care – April 2015 to August 2017

Days Delayed	Social Care Delays			Health Delays			Joint Delays			Total Delays		
Reason For Delay	2015-16	2016-17	2017-18	2015-16	2016-17	2017-18	2015-16	2016-17	2017-18	2015-16	2016-17	2017-18
A) Completion of assessment	383	370	37	629	674	173	402	135	156	1,414	1,179	366
B) Public Funding	202	206	244	17	48	37	0	297	6	219	551	287
C) Further non-acute NHS care (incl intermediate care, rehab etc)	0	0	0	1,101	1,727	700	0	0	0	1,101	1,727	700
Di) Awaiting Residential Care Home Placement	625	710	120	26	296	31	0	0	0	651	1,006	151
Dii) Awaiting Nursing Home Placement	39	273	129	554	309	119	0	0	13	593	582	261
E) Care package in own home	69	463	86	5	1	19	0	0	0	74	464	105
F) Community Equipment/adaptions	60	18	19	282	355	169	0	0	0	342	373	188
G) Patient or family choice	38	30	0	914	1,410	581	0	0	0	952	1,440	581
H) Disputes	172	69	12	117	226	13	0	0	0	289	295	25
I) Housing - patients not covered by NHS & Community Care Act	0	0	0	184	156	236	0	0	0	184	156	236
Financial Year Totals	**1,588**	**2,139**	**647**	**3,829**	**5,202**	**2,078**	**402**	**432**	**175**	**5,819**	**7,773**	**2,900**

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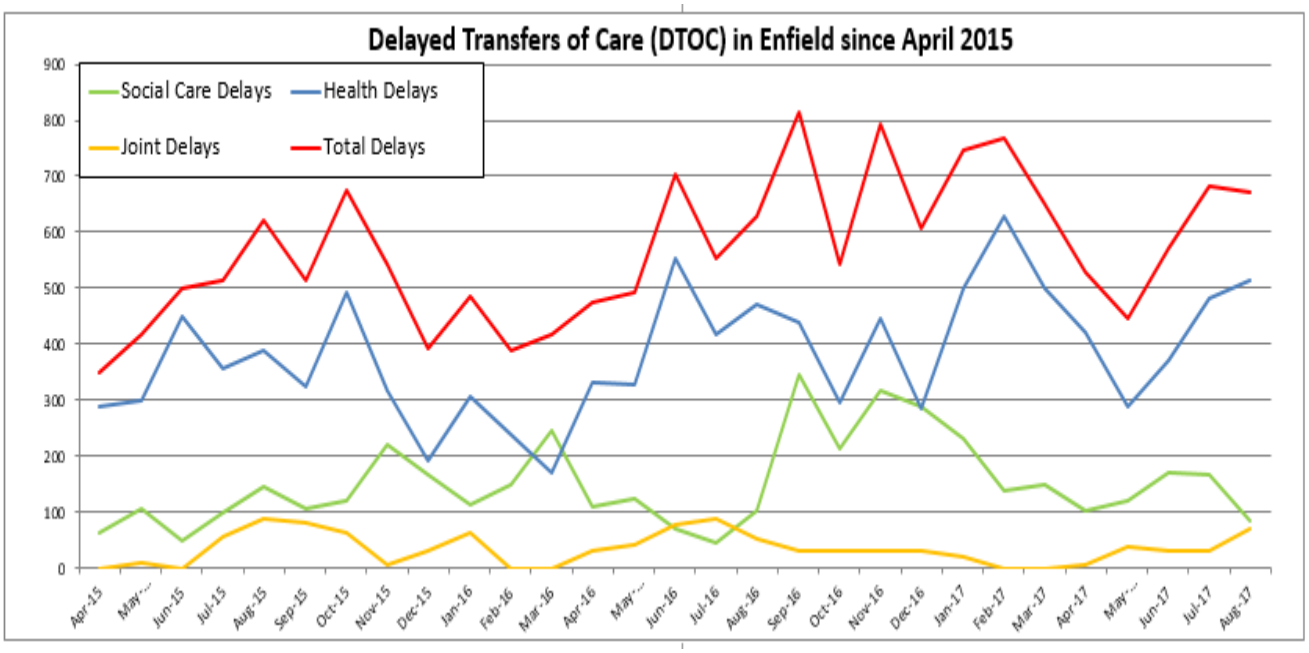

Quarterly Performance against Target (Broken down by month)

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NHS attributed delayed days	420	708	1080	483	998							
Target	439.4	893.4	1332.8	454.1	908.1	1347.5	454.1	893.4	1347.5	454.1	864.2	1318.2
Social Care attributed delayed days	102	224	395	167	252							
Target	148.9	302.8	451.8	153.9	307.8	456.7	153.9	302.8	456.7	153.9	292.9	446.8
Jointly attributed delayed days	6	43	73	32	102							
Target	30.0	61.0	91.0	31.0	62.0	92.0	31.0	61.0	92.0	31.0	59.0	90.0
Total Delayed Days	528	975	1548	682	1352							
	618.3	**1257.2**	**1875.5**	**638.9**	**1277.9**	**1896.2**	**638.9**	**1257.2**	**1896.2**	**638.9**	**1216.1**	**1855.0**

*Above data is quarterly cumulative