Leicestershire County Council

HEALTH AND WELLBEING BOARD: 7th JANUARY 2016

JOINT REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES AND DIRECTOR OF HEALTH AND CARE INTEGRATION

PROGRESS REPORT ON DELAYED TRANFERS OF CARE (DTOC)

Purpose of Report

1. The purpose of this report is to:

   a. Provide the Health and Wellbeing Board with a progress report regarding the local improvements that have been made over the last 12 months on reducing delayed bed days in hospital.

   b. Advise the Board about the new DTOC national guidance and the eight high impact changes recommended to reduce delayed transfers of care.

Link to Better Care Together

Workstream	Relevance	Workstream	Relevance
Maternity, neonates, children and young people	√	Mental health	√
Long term conditions	√	Frail and older people	√
Urgent care	√	Planned care	√
Learning disabilities	√	End of life	√

2. The report applies to all patients who have an acute hospital stay and for whom discharge arrangements may be complex.

3. The majority of complex discharges however apply to frail older people, those with long term conditions, those with complex mental health problems, and those at the end of life.

Policy Framework and Previous Decisions

4. In January 2014 the Leicestershire Health and Wellbeing Board received a comprehensive briefing on the urgent care system in Leicestershire which focused on the impact of delayed transfers of care out of hospital.

5. The paper outlined the multiagency approach to tackling the pressures at that time and the actions being taken, which included specific interventions to improve hospital discharge.

6. In November 2015 the Leicestershire Health and Wellbeing Board received a report on the positive contribution of the housing interventions that have been implemented as part of the action plan to improve hospital discharge.

7. National reporting on the significant pressures during the winter of 2014 across health and social care resulted in additional monies being allocated to Local Authorities during that period to further alleviate the position with respect to delayed transfers of care.

8. The reporting process into government highlighted inconsistencies across the country when applying the DTOC policy and guidance, and in the reporting of data definitions for delayed transfers of care, due to the variability in interpretation of the guidance.

9. There was also insufficient shared learning across the country about the interventions that were having the greatest impact on improving hospital discharge, and these needed to be publicised and shared more rapidly.

10. In response to these issues the national DTOC guidance was revised during 2015 and has since been published along with eight high impact changes which are recommended to improve hospital discharge.

11. A series of nationally planned events (delivered regionally) have recently been held to promote the guidance, take stock of progress and share learning ahead of winter 2015.

Background: Progress on Improving Hospital Discharge during 2015

12. Over the past 12 months, a number of actions/interventions have been implemented across Leicester, Leicestershire and Rutland to change working practices and reduce the number of delays in transferring patients from acute and community hospitals back into the community.

13. These have been funded from the better care fund pooled budgets operating across health and local government, and from winter pressures allocations.

14. In summary these are the actions taken and the impact achieved:

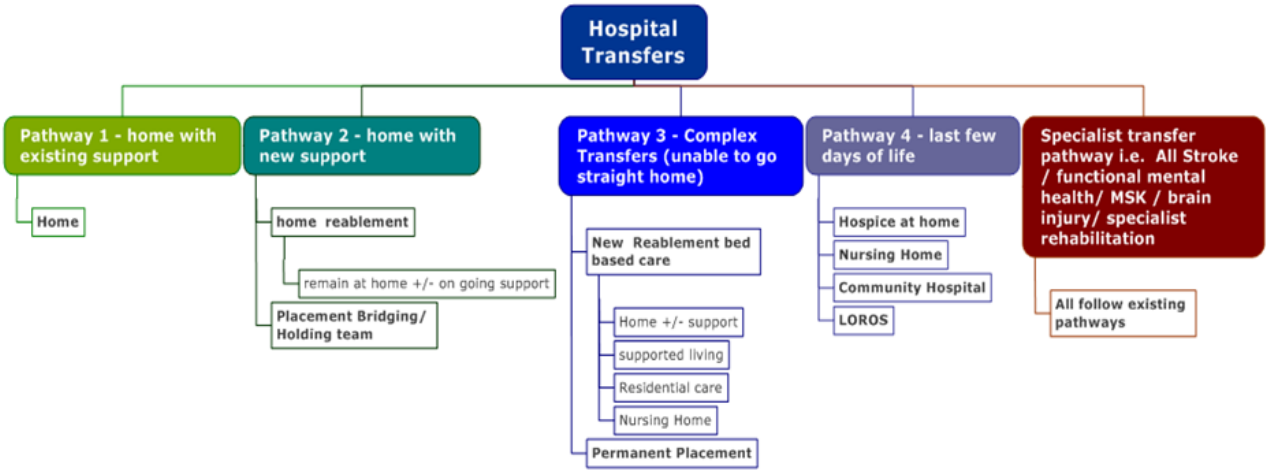
    a. A “home first” philosophy is being applied to all hospital discharges.

    b. Clear, consistent definition of “medically fit for discharge” and “ready for discharge” between agencies.

    c. Agreed minimum data set being implemented by March 2016 to achieve smooth and safe discharges between acute and community settings.

    d. Discharge pathways have been simplified so that there are now only 5 core pathways for discharge, as shown in Figure 1 below:

Figure 1 – Discharge Pathways Across LLR – 2015



e. Review of domiciliary (home care) packages two weeks post discharge to ensure service users are receiving the right level of support to promote independence. This has released a lot more capacity into the home care market as the review team found that after two weeks approx. 50% of patients could move to a reduced level of support, or no further support as a result of their reablement in their usual place of residence.

f. Daily conference calls involving operational managers from all health and social care services to progress transfer of patients in UHL and Community Hospitals. This ensures a constant focus on progressing discharge on a daily basis and taking shared accountability for coordinating discharge and unblocking any barriers to discharge across agencies.

g. "Transfer Home to Assess" Pilot (County) – health and social care assessors working together in UHL to support patients who previously were transferred to a nursing home for a Continuing Health Care (CHC) Assessment. These patients now go "home first" and then receive their assessment following a short period of recovery. This has demonstrated excellent outcomes for people, and shows there is often a reduced level of health and social care service required once the patient is assessed in their usual surroundings, thus reducing the over prescription of packages of care.

h. Non Weightbearing Pathway – the pathway of care for patients who have no other medical needs, but who cannot stand/bear weight on their limbs during recovery has been changed. Health and social care assessors work together in UHL to support patients to be discharged when medically fit so they can recover with support in their usual place of residence. These patients were previously inpatients for many weeks.

i. Alignment of Community Nursing teams with Adult Social Care teams in Leicestershire's localities. These integrated teams offer case management and care planning to patients/service users in the community including supporting their transfer back into community services after hospital discharge.

j. Adult Social Care dedicated social care team based at the LRI, covering all UHL sites. During winter pressure months, this operational service is provided seven days per week.

k. UHL have direct access to Adult Social Care Reablement (step down discharge service) and Crisis Response Service (step up admission avoidance) seven days per week.

l. Hospital to Home – a voluntary sector provided service to support vulnerable people in transition from hospital to home. This provides practical and emotional support to these people to avoid readmission to hospital (this contract has been extended to March 17).

m. Dedicated housing support and expertise to enable effective discharge planning from acute settings such as the Leicester Royal Infirmary and the Bradgate Unit. (see paragraph 5) - targeted to patients who need rapid support to resolve housing problems.

15. These actions have had a significant impact on our local performance. Appendix 1 demonstrates the improved performance achieved between April and October 2015 when compared with the same period in 2014.

16. This has resulted in Leicestershire achieving the required rate of improvement on delayed bed days per 100,000 population, as measured in our Better Care Fund Plan, and this has been an important contribution in tackling the ongoing pressures affecting the performance of the Urgent Care System as a whole in LLR.

17. We will continue to test the sustained impact of the interventions now in place as we move through the winter of 2015.

18. At the time of writing this report partners are in the process of refreshing commissioning intentions for 2016/17, including refreshing the priorities and investments within the Better Care Fund pooled budget for Leicestershire.

19. Sustaining the improvements in delayed transfers of care, and supporting the overall transformation of the urgent care system will continue to be a high priority in these commissioning intentions, with many of the DTOC improvements that have been tested and implemented this year moving into business as usual.

Revised National DTOC Guidance and the 8 High Impact Changes

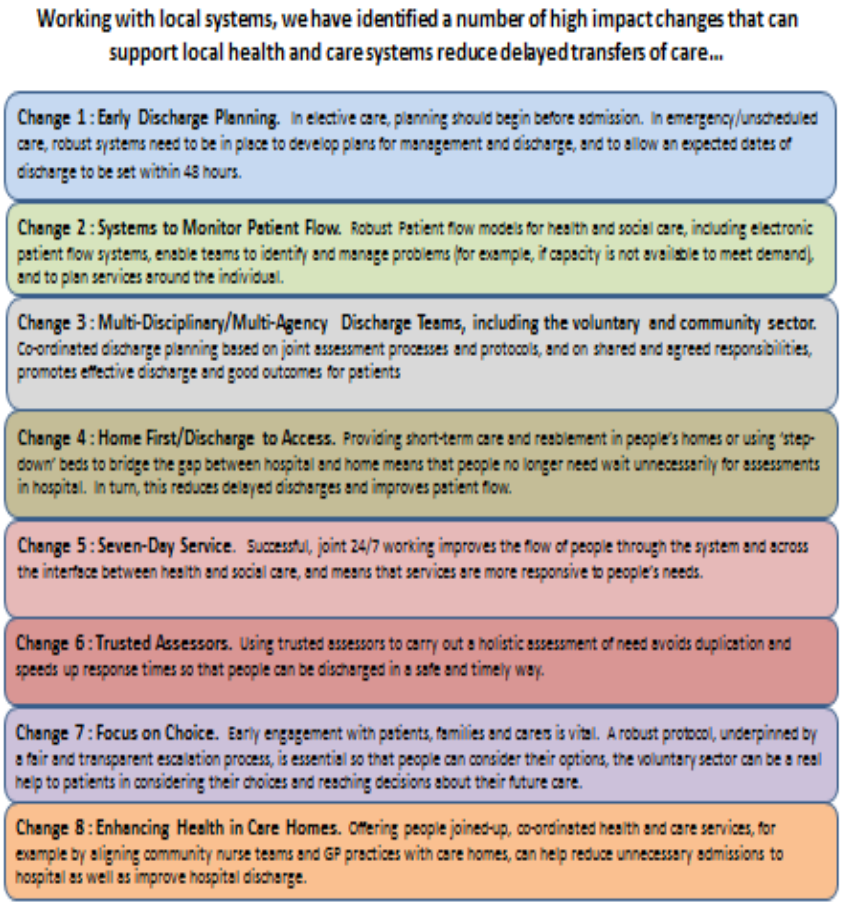
20. Revised national guidance was developed in response to the difficulties experienced in the application of the existing guidance during the winter of 2014, and includes for example clarifying the definitions used in national reporting of DTOC data.

21. A regional event for the Midlands (one of a series taking place nationally) was held on 2 December in Leicester.

22. The event was an opportunity to explore the guidance, raise any concerns or queries, consider the national self-assessment tool for the eight high impact changes for improving DTOC, and to share good practice across health and care economies.

23. The good progress made in LLR on DTOC performance was highlighted at this event

24. The eight high impact changes proposed nationally are given below:



25. A self-assessment tool has also been provided for local systems to use to map their current interventions and performance against the eight high impact changes and identify any gaps and areas of further development.

Proposals

26. Further to the regional DTOC event, a report was made to the Integration Executive on 15 December highlighting the importance of the new guidance, and a number of actions arising locally from the guidance were discussed.

27. The proposed actions from the Integration Executive included the production of this report. Other actions, with suggested timeframes and lead officers were as follows:

I. Completion of the national self-assessment tool against the eight high impact changes by the LLR DTOC group (January 2016), to be coordinated by the Head of Service (Promoting Independence) in the Adults and Communities Department.

II. The outputs of the self-assessment to be brought to the (February 2016) Integration Executive, with recommendations made to the March 2016 meeting of the Health and Wellbeing Board – to be progressed by the Director of Health and Care Integration.

III. To produce guidance for self-funders that can be offered to patients on hospital admission, to help self-funders better understand their options on discharge – to

be progressed by the Director of Adults and Communities – timescale to be agreed in line with departmental workplan.

IV. To consider if there are dashboards/routine analysis that can strengthen urgent care board reporting using the new care and health trak tool - to be progressed by the project lead for care and health trak in conjunction with the Urgent Care Board – this work is in already progress and should be completed by the end of January.

Consultation/Patient and Public Involvement

28. Officers continue to engage with Leicestershire Healthwatch who provided valuable insights into the experience of service users during hospital discharge. These insights were reported to the Health and Wellbeing Board in January 2014 and have been used in designing the improvement plan we implemented in 2015.

Resource Implications

29. Through the Better Care Fund plan Leicestershire has committed a total of £3.8m on the new interventions described in paragraph 14 and a table is provided below of the main areas of expenditure.

Table 1 –BCF Investments in support of Improving Hospital Discharge

Description of Service/Intervention	**Investment made via BCF Plan 2015/16 £'000**
Acute Hospital Discharge Support	2,811
Community Hospital Discharge Support (Bridging)	325
Care Packages Review Team	277
Hospital to Home (RVS)	72
Residential Reablement (Oak Court/Catherine Dalley House)	294
Housing Offer for Discharge Support	19
TOTAL	3,798

Conclusions/Recommendations

30. It is recommended that the Health and Wellbeing Board:

a. Support the follow up actions for the new DTOC guidance as proposed by the Integration Executive and set out in paragraph 27 of this report;
b. Receive the outputs of the local self-assessment against the eight high impact changes for DTOC in March 2016

c. Seek assurance that good performance in DTOC will be sustained in 2016/17 and that any remaining gaps arising from the self-assessment are prioritised in support of this
d. Review refreshed joint commissioning plans for 2016/17, including the refreshed Better Care Fund Plan, to seek assurance that:
    i. DTOC interventions and investments can be sustained in 2016/17
    ii. Discharge support is in place to maximise performance on a 7 day basis, per the national conditions within the Better Care Fund

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Background papers

Improving the Urgent Care System in LLR: Focus on Hospital Discharge: Report to the Health and Wellbeing Board on 22 January 2015
http://politics.leics.gov.uk/Published/C00001038/M00004289/AI00040255/$ImprovingtheUrgentCareSysteminLLRFocusonHospitalDischarge.docA.ps.pdf

Housing Interventions to Support Reductions in Delayed Hospital Discharge: Report to the Health and Wellbeing Board on 19 November 2015
http://politics.leics.gov.uk/Published/C00001038/M00004294/AI00045558/$HousingHospitalDischargeSchemes.docxA.ps.pdf

Simple Guide to Care Act and DTOC http://londonadass.org.uk/wp-content/uploads/2015/11/DToC-Simple-Guide-Final.pdf

Circulation under the Local Issues Alert Procedure

None.

List of Appendices

- Appendix 1 – Analysis: Leicestershire's DTOC performance April 2014 – October 2015
- Appendix 2 - DTOC Guidance

Relevant Impact Assessments

Equality and Human Rights Implications

31. Discharge planning is a person centred approach which considers the specific needs and preferences of the patient/service user, and involves working closely with their advocates, carers, or family members. Due regard is paid to protected characteristics in assessing an individual's needs and preferences and health and care staff receive specific equality duty training. As part of discharge planning person centred information is transferred securely between agencies within the health and care system which is essential to ensure continuity in care between hospital and community settings.

Partnership Working and associated issues

32. The delivery of sustained improvements in DTOC remain and high priority for all partners in LLR and a joint approach is taken to delivering system improvements, reporting our position and sharing accountability for our performance as a system.

33. The local position is reported operationally daily between partners, and on a 2 weekly basis into the LLR Urgent Care Board.

34. There is also a system of routine national reporting for DTOC (monthly), the intervals for this can be weekly during winter pressure periods.

35. There is also quarterly joint reporting specifically for DTOC via NHS England linked to the delivery of the national conditions and metrics within the Better Care Fund.

Risk Assessment

36. The impact of DTOC poor performance presents risks to patient/service user experience, quality of care, and the delivery of the entire system of urgent care.

37. It is essential that smooth, timely and effective discharge processes are in place and that these are sustainable, so that care takes place in the right setting and patients can move effectively between settings of care with the appropriate level of support and coordination.

38. Poor discharge processes affect all organisations within the system and can lead to the breakdown of care plans for patients leaving hospital. This can in turn cause a deterioration in the service users reablement, health and wellbeing and can ultimately lead to readmission to hospital.