DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		DELAYED TRANSFERS OF CARE (DTOC)		
DATE OF DECISION:		27 FEBRUARY 2020		
JOINT REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

Reducing Delayed Transfers of Care (DToC) is a key focus of Southampton City's Better Care plan and has always been seen as a joint priority and collective effort between the Council, Southampton City CCG and the city's health and social care providers. The city measures its performance against two targets:

- the NHS England (NHSE) national target of 3.5% for hospital Trusts (i.e. DTOC to be no more than 3.5 % of all available beds)
- the Health and Wellbeing Board (HWBB) target of no more than 26.7 average daily delays in acute and community hospitals (which gives a rate of 13.2 per 100,000 population), which we have broken down locally as follows:
    - University Hospital Southampton (UHS) (acute) – 20 average daily delays
    - Solent NHS Trust (community hospitals) – 2.7 average daily delays
    - Southern Health Foundation Trust (Adult Mental Health and Older Person's Mental health wards) – 4.0 average daily delays.

RECOMMENDATIONS:

(i) To note developments to improve Delayed Transfers of Care

REASONS FOR REPORT RECOMMENDATIONS

1. The Chair of the Health Overview and Scrutiny Panel has requested an update on Delayed Transfers of Care (DToC.)

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED

2. Not applicable.

DETAIL (Including consultation carried out)

3. Clear plans are in place for reducing DToC. Because of the joint focus on University Southampton Hospital NHS Trust (which accounts for approx. 75% of discharges for Southampton), Southampton works very closely with Hampshire County Council and West Hampshire CCG and joint DTOC action plans across the Southampton and South West Hampshire System have been in place for some time, overseen by the Southampton and South West Hampshire System A&E Delivery Board, and, more specifically the Southampton and South West Hampshire System Integrated Discharge Bureau (IDB) Leaders Group.

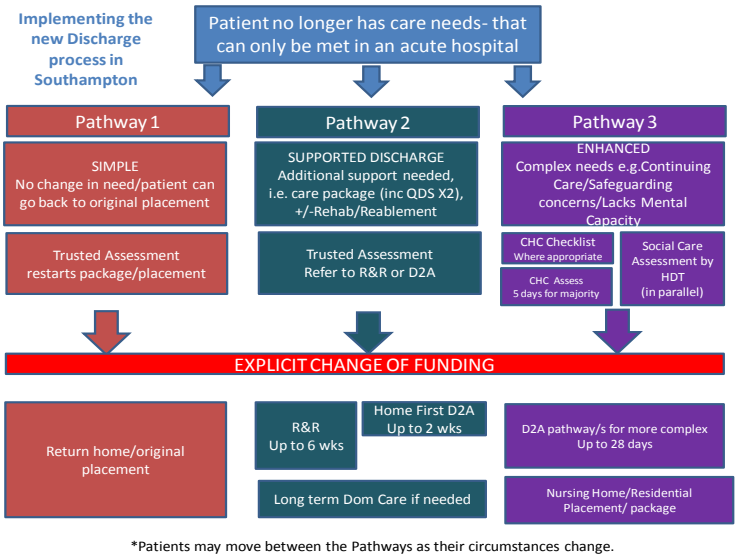
4. The IDB leaders group meets on a monthly basis and includes senior representation from Southampton City CCG, Southampton City Council, West Hampshire CCG, Hampshire County Council, University Hospital Southampton NHS Foundation Trust (UHS), Solent NHS Trust and Southern Health NHS Foundation Trust (SHFT). Together the partners have appointed a single IDB operational manager (in post since 2015) who provides operational oversight across the system on a day to day basis (employed and based in UHS).

5. Three standardised discharge pathways have been adopted across the whole of the system in order to simplify and streamline discharge processes, as follows:

    - Pathway 1 Simple discharges - managed by the wards through trusted assessment with support as necessary from the IDB and strong links back to the patient's community care team. Primarily this includes package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients.
    - Pathway 2 Supported discharges - managed by the Rehabilitation and Reablement teams, which in Southampton is an integrated Council/Solent NHS Trust service. The Rehab and Reablement teams will work with ward staff to facilitate discharge through a "community pull" approach. This includes those situations where additional support in the community is required for example a long term care package, rehabilitation, reablement or bed based care. Ward staff are responsible for identifying and directing these patients to the Rehab and Reablement Teams who "in reach" into the hospital.
    - Pathway 3 Complex discharges - managed by the IDB and hospital discharge team. This involves those patients requiring complex assessments, e.g. those who are likely to be Continuing Health Care or where there are Safeguarding concerns. Ward staff are responsible for identifying and directing these patients to the IDB.

6.

Integrated Discharge Model



*Patients may move between the Pathways as their circumstances change.

Progress to date

7. Southampton has modelled its DToC work on the 8 High Impact Change Model published jointly by the Local Government Association (LGA), Department of Health, Monitor, NHS England and ADASS in 2015 and a summary of the most recent self-assessment can be seen in Appendix 1.

8. A significant proportion of the improved Better Care Fund (iBCF) over the period 2017 - 2020 has been allocated directly to schemes that reduce DToC as follows:

- Extending Discharge to Assess (D2A) to the Royal South Hants (RSH), Snowden and Western Community Hospitals (mirroring the scheme that is already in place at UHS). It has been successful both in accelerating discharge and also supporting people to return to independence with 40% of clients going on to have no ongoing care needs.
- Establishing a Discharge to Assess (D2A) Scheme for supported/complex discharge (pathway3) – The scheme is jointly funded (50/50) by the Council and the CCG and the funding also covers additional social work capacity and capacity within the Care Placement Service. Evaluation of the scheme has shown that on average hospital length of stay is reduced by 27 days for each client. The Joint Commissioning Board agreed to mainstream the scheme in January 2020.
- Expanding 7 day social care operation in the hospital discharge team We have used the iBCF funding to recruit permanent staff to this team, rather than relying on locums. This is increasing social care professional input in the Integrated Discharge Bureau.

- Increased capacity in the home care market, in particular to support 7 day working and temporary (bridging) support whilst longer term care is finalised.

Additional investment has also been transferred by the CCG to the Council to fund additional home care hours from both the Domiciliary Care Framework contract (280 hours a week) and also reablement care (120 hours a week) from the integrated Rehabilitation and Reablement Service. Some of this investment has also been used to support training home care providers to meet the needs of patients with specific health needs, e.g. collar care, enteral feeding. Some has also been used to fund additional capacity within the Care Placement Service.

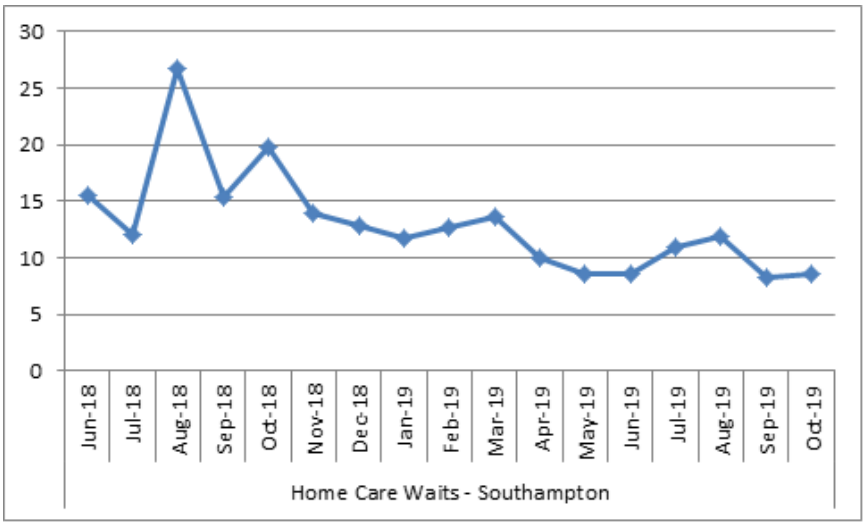
9. Overall there has been an increase in home care capacity from 2018 to 2019 as follows:

Month	Hours a week	Month	Hours a week
Sept 2018	**22,326**	**Sept 2019**	**22,834**
Oct 2018	**22,598**	**Oct 2019**	**23, 094**
Dec 2018	**21,953**	**Dec 2019**	**23,500**

NB. Please note available hours do vary, as a provider leaves the market for example or has difficulties in recruitment, but overall the trend in available hours is demonstrating an increase.

10. The number of people being supported to source home care is increasing year on year. For example December 2018 we supported on average 147 people but in December 2019 the figure was 173. Of these, last year 16 people per month were acute hospital discharges, with this year the figure being 20.

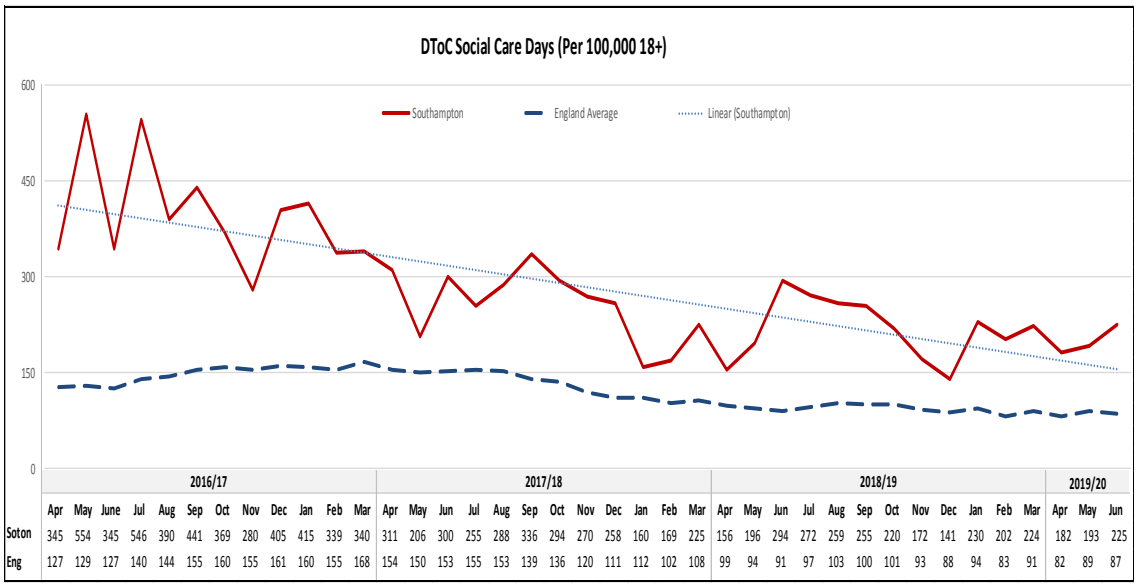
11. There has also been an improvement in the waiting times for home care as shown in the chart below which shows the waits for home care from referral point:–



NB. It should be noted that the chart includes all clients who require support from Home Care and does not show that responses to the acute hospital are significantly faster than that of other sites/referral sources.

Impact

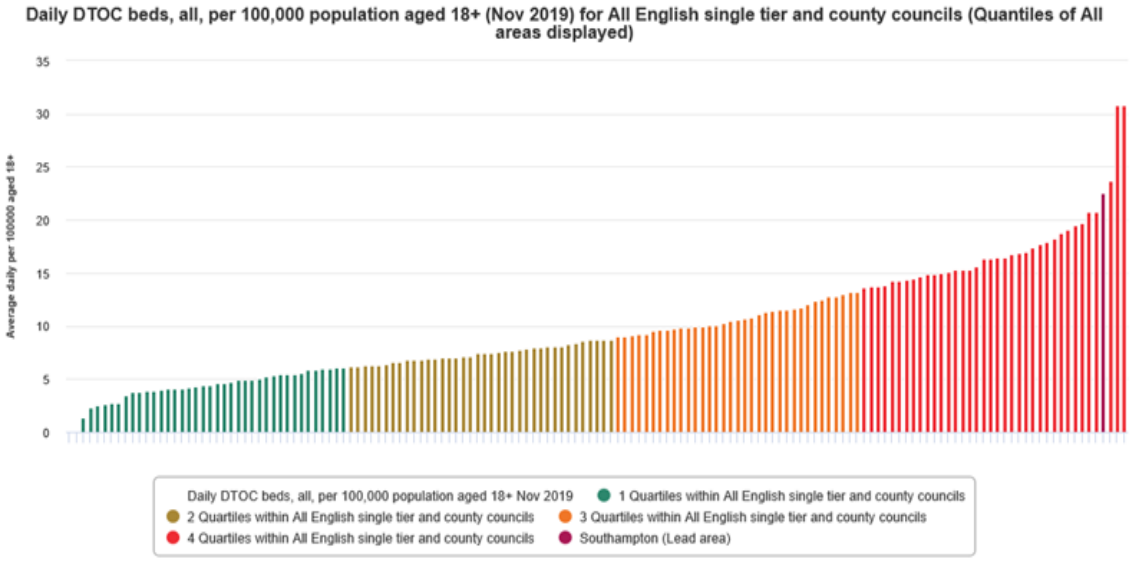
12. The improvement work undertaken to date has resulted in a significant reduction in DToC since 2016/17 as can be seen in the chart below.



	2016/17												2017/18												2018/19												2019/20		
	Apr	May	June	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Soton	345	554	345	546	390	441	369	280	405	415	339	340	311	206	300	255	288	336	294	270	258	160	169	225	156	196	294	272	259	255	220	172	141	230	202	224	182	193	225
Eng	127	129	127	140	144	155	160	155	161	160	155	168	154	150	153	155	153	139	136	120	111	112	102	108	99	94	91	97	103	100	101	93	88	94	83	91	82	89	87

13. Data comparing December 2019 with December 2018 shows that we are discharging more patients than ever (96 patients discharged in December 2019 compared to 74 in December 2018) and the overall length of stay is reducing.

14. However, Southampton remains a long distance from its national targets and benchmarks poorly against other Local Authorities as shown in the chart below.



Current Position

15. As at November 2019 Southampton's percentage DToC across all hospitals was 6.6% against the NHS England target of 3.5% with a year to date average of 5.6%. The average daily number of delays for November 2019 was 45.5 against the national target for Southampton of 26.7, with a year to date average of 38.1. The charts in Appendix 2 show how this breaks down by delays attributed to the NHS, Social care and both agencies, illustrating that the increase has been more marked in social care delays. The increase in delays recorded as "both" is

primarily linked to a change in recording whereby reablement delays, previously recorded as social care delays, are now recorded as “both”.

16. In terms of overall hospital discharges for Southampton residents, UHS accounts for around 75%, Solent for 10% and Southern Health for 15%. Trust level data on DToC is shown in the charts in Appendix 3 below against the 3.5% NHS England target and shows the greatest areas of challenge to be at UHS and Southern Health (mental health and older person’s mental health).

17. Further analysis of the Southern Health delays shows that the high proportion of DToC relates almost exclusively to the adult mental health wards.

18.

OPMH Delayed Transfers of Care Number of delayed days versus occupied bed days

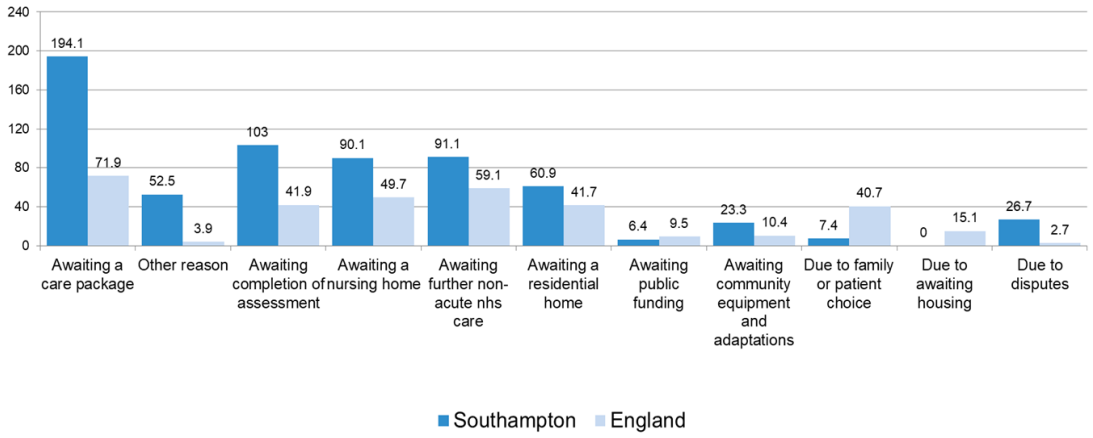
	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	576	598	597	623	457	554	639	629	625
DToC Days	32	58	46	2	0	0	0	0	0
Rate %	5.6%	9.7%	7.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%

AMH Delayed Transfers of Care Number of delayed days versus occupied bed days

Value	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	1813	1748	1718	1591	1580	1483	1615	1698	1897
DToC Days	91	65	188	217	237	194	152	219	202
Rate %	5.0%	3.7%	10.9%	13.6%	15.0%	13.1%	9.4%	12.9%	10.6%

19. The rise in DToC on the Adult MH wards from June 2019 is due to more robust identification, standardisation and governance of DToC that was put in place around this time. Southern Health has identified suitable supported housing as a significant discharge barrier in a number of cases. There are some particular challenges with a number of long stay patients on the male acute ward, which is a top priority for Southern Health and correlates to use of out of area beds.

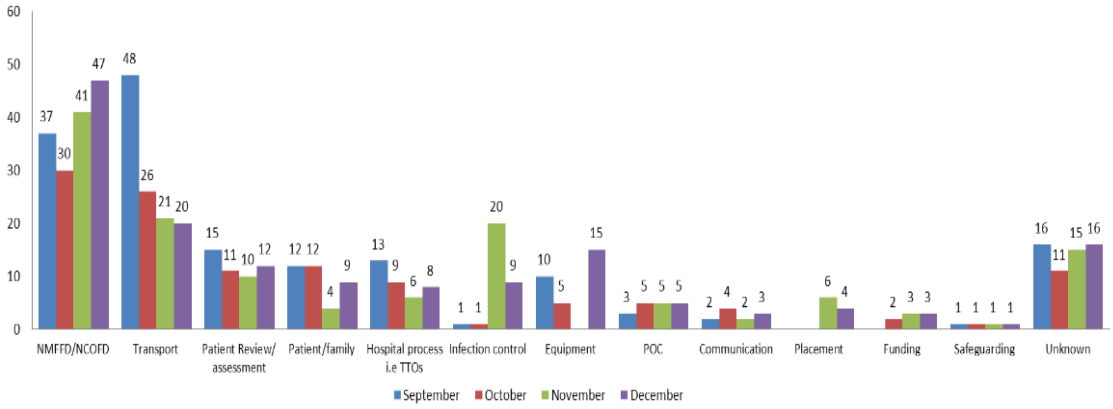
20. When reviewing the main reasons for delay across the board, home care placement is the most prominent, followed by awaiting assessment (which relates almost exclusively to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care.



21. Further analysis of the factors underpinning these delays shows that the main reasons are associated with increasing levels of complexity requiring more visits with two carers (“double up” care) or harder to source nursing home placements.

22. The delays in further non acute NHS care also seem to be related to increasing complexity and demand for specialist rehab beds e.g. Spinal or neurological rehabilitation, the main provisions being Salisbury Hospital (spinal rehab) and Snowdon (Solent) for neurological rehab.

23. Additionally it is recognised that internal hospital process issues are still contributing to a number of the delays. For example, hospital transport.



Summary of additional work underway to improve the position

24. Building on the output from the April 2019 DToC Peer Review facilitated by the Local Government Association on 30 April 2019, senior oversight and leadership has been strengthened by ensuring that there is a regular focus on DToC performance at the monthly Better Care Steering Board meetings; reporting processes and accountability have also been strengthened so that on any one day performance can be tracked against each of the 3 discharge pathways.

25. On top of this the Southampton and South West Hampshire system is taking the following additional actions:

<u>In recognition of Home Care capacity being the main cause for delay:</u>

- Use of Southampton and South West Hampshire System Winter Pressures Fund to increase home care, bridging and Discharge to assess capacity:
    - 300 additional hours
    - An additional reablement bed in the residential care sector from September 2019
    - 2 additional Discharge to assess Pathway 3 beds (on top of existing 5 beds) from 31 December 2019
- Employment of an Occupational Therapist locum to review double up home care packages in view of making them single handled care.

26. In recognition of waits for Care Home assessment and placements being a key cause for delay:

- Piloting a trusted assessor scheme for care homes in order to improve responsiveness and reduce the number of repeat assessments for patients by different homes.
- Care Home Hotline introduced by UHS in December 2019 for post discharge medical advice and support within the first 48 hours of post discharge – in response to care home concerns around being able to contact someone should a resident's condition deteriorate

27. In recognition of NHS non acute onward care being a key cause for delay:

- Advanced Practitioner Therapist post in the Community Independence team to undertake Comprehensive Geriatric Assessment with a view to reducing hospital length of stay.
- Additional therapy capacity over weekends at the Royal South Hants Hospital to improve flow.
- Enhanced Community 'In-reach' to UHS over the weekends to facilitate weekend discharges.

28. In addition the following actions are being taken to improve flow:

- A system wide marketing campaign to promote key messages to the public and staff about the benefits of "home first" and out of hospital provision, linked to other work we are doing on "ageing well". This was launched 20 January 2020.
- Delegation of small budget to "unblock" common causes of delay such as patient transport to enable someone to go home on time.
- British Red Cross have specifically been commissioned to provide additional transport capacity.

29. Work is underway with UHS ward staff (as part of the "Always Improving Inpatient Care" programme being led by PWC for UHS) to improve the interface between the Integrated Discharge Bureau (IDB) and the ward. In addition, the IDB leaders group is planning to undertake a series of Rapid Improvement Workshops during March and April to process map each of the discharge pathways and identify key areas for improvement. Pathway 3 will be the initial priority.

30. In addition the following specific actions there are numerous actions being taken to address discharge delays at Southern Health.

Better Care Support Visit

31. Southampton has been offered 15 days of peer-facilitated support by the national Better Care Programme as part of its national support offer – to be used before April 2020. The Better Care Support programme has commissioned the Local Government Association (LGA) to undertake this programme of work.

32. This support will be tailored to meet the needs of our system and officers will be actively involved in selecting the best-fit peers to meet our needs, and in agreeing the scope and key lines of enquiry of this work. It will align with the PWC work outlined above.

33. As a city we have proposed that this support is used to undertake a deep dive into each of the Discharge pathways to test and challenge current practice, identifying bottle necks in the process and thereby informing an improvement plan. Also to focus on:

- data, projections and reporting
- market development.
- Impact of admissions avoidance work
- System processes and leadership
- Mental health delays

The scope is still being refined.

RESOURCE IMPLICATIONS

Capital/Revenue

34. No implications.

Property/Other

35. No implications.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

36. Not applicable.

Other Legal Implications:

37. Not applicable.

RISK MANAGEMENT IMPLICATIONS

38. The approach to improve Delayed Transfers of Care in Southampton will help to mitigate legal, financial and reputational risks.

POLICY FRAMEWORK IMPLICATIONS

39. This supports the council's objective of supporting people to live safe, healthy, independent lives and the council's priority to improve wellbeing as part of its 2025 investment programme.

KEY DECISION?	**~~Yes~~/No**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	High Impact Changes
2.	Average delays
3.	Community Health Provider Data

Documents In Members' Rooms

1.	None.
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	**~~Yes~~/No**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	**~~Yes~~/No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	