MEETING:		**Joint Commissioning Board**		
SUBJECT:		**Delayed Transfers of Care (DTOC) Briefing**		
DATE:		**19 February 2019**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Donna Chapman**	Tel:	023 80296004
	E-mail:	**d.chapman1@nhs.net**		
Director	**Name:**	**Stephanie Ramsey**	Tel:	023 80296941
	E-mail:	**Stephanie.Ramsey@southampton.gov.uk**		

1. Background & Introduction

1.1 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 and 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

1.2 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 A&E Delivery Board and more specifically the Southampton and SW System Integrated Discharge Bureau (IDB) Leaders Group.

1.3 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 Foundation Trust (UHS), Solent NHS Trust and Southern Health 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).

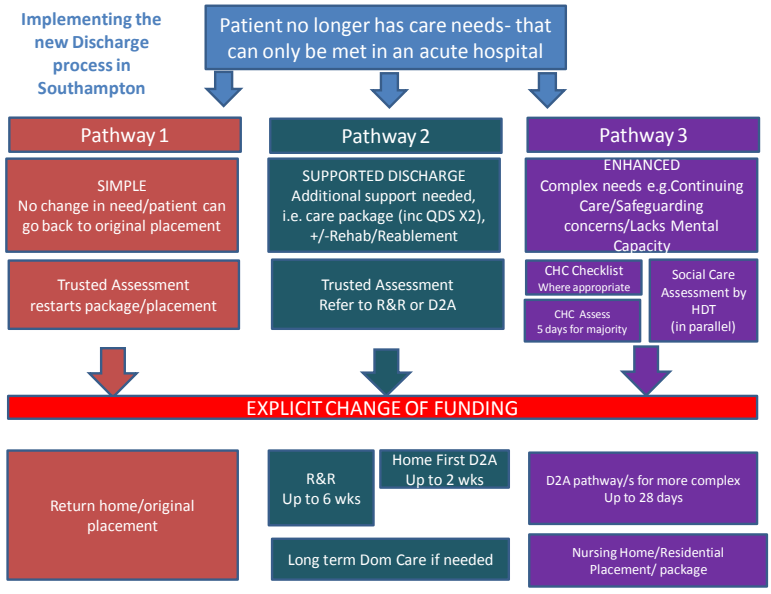
1.4 Three standardised discharge pathways have been adopted across the whole of the Southampton and South West System in order to simplify and streamline discharge processes, as follows:

- 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 (rehab) 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.

Integrated Discharge Model



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

Progress to date

1.5 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 below is a summary of its most recent self-assessment.

High Impact Change	Self Assessed Position	Commentary
Early discharge planning	**Early Progress**	• Use of Expected Date of Discharge (EDD) established and electronically recorded on hospital discharge system (APEX) • Hospital has in place Board Rounds and Red and Green days However there is still more work to be done in ensuring that discharge planning commences at the point of admission, including planning for discharge at the hospital front door and ensuring that patients who are likely be complex are identified early on and case managed through their stay in hospital.
Systems to monitor patient flow	**Early progress**	Whilst systems are in place (SHREWD), challenges still exist in terms of sourcing capacity to meet demand, most specifically related to: • Increasing levels of complexity amongst patients being discharged. • Sourcing complex “double up” care packages. • Sourcing care home placements particularly for patients with dementia • Flow in NHS specialist rehabilitation beds
Multi-disciplinary/multi-agency discharge teams	**Mature**	A system wide Integrated Discharge Bureau (IDB) has been in place for some years with a system wide manager appointed in 2015, jointly accountable to the Acute Trust (University Hospitals Southampton), both CCGs (Southampton and West Hampshire) and both Local Authorities (Southampton and Hampshire). The IDB is made up of teams from UHS, Adult Social Care, Rehab and Reablement and Hospital at Home.
Home first/discharge to assess	**Mature**	Discharge to Assess (D2A) for pathway 2 (people requiring reablement or some level of additional support in their own homes) is now mainstreamed for all people leaving hospital (UHS as well as the community hospitals RSH, Western and Snowdon). There is evidence that discharge to assess and reablement for this group is reducing the need for ongoing care. In addition since November 2017 we have also introduced D2A for the more complex group of people leaving hospital on Discharge Pathway 3. This is now mainstreamed
Seven-day service	**Basic level**	Whilst 7 day processes are in place for rehab and reablement and the hospital discharge team, all partners need to expand their offer to support 7 day working including hospital transport and primary care. Brokerage services only operate Monday-Friday at present and there are challenges with social care providers taking new or receiving back residents over the weekend.

High Impact Change	Self Assessed Position	Commentary
Trusted assessors	**Basic level**	Trusted assessment is in place for Pathway 1 with hospital staff making decisions regarding return to placement. However we do not have Trusted Assessment in place for care home assessment processes. We are in the process of scoping a Trusted Assessor scheme with care homes. A nurse was appointed in January 2020 to take this work forward, engaging with homes to design the model.
Focus on choice	**Mature**	A choice Policy (referred to locally as complex discharge policy) has been in place for some years and has recently been reviewed and updated.
Enhancing health in care homes	**Substantial progress**	The EHCH Programme is well established within the residential care sector and we are planning on rolling this out to the 9 nursing homes in Southampton over the next few months.

1.6 A significant proportion of the Improved Better Care Fund (BCF)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), Snowdon and Western Community Hospitals (mirroring the scheme that is already in place at UHS) – approx. £122k investment per annum. This commenced November 17 offering 6 discharge slots a week. 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) – approx. £400k per annum. This commenced in November 17 providing an additional 4 discharge slots a week. 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 (approx. £100k per annum). 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 bridging support (approx. £60k per annum).

1.7 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 Rehab and Reablement Service (£800k for period January 2019 – March 2021). Some of this investment has also been used to support training Framework 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.

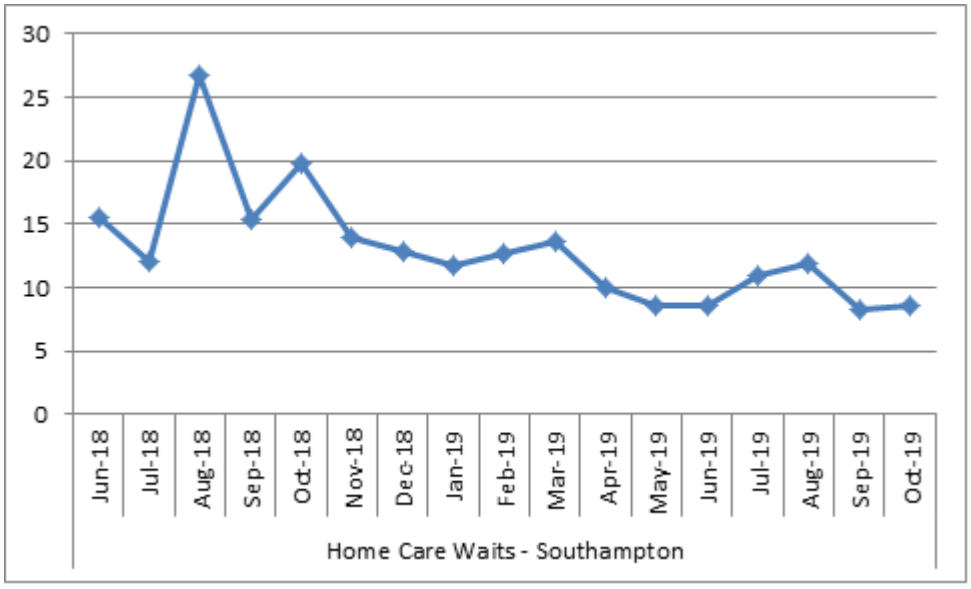
1.8 Overall there has been an increase in home care capacity 2018 to 2019 as follows:

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.

1.9 This time last year we supported on average 147 people a month to source home care, with this year the figure being 173. Of these, last year 16 people per month were acute hospital discharges, with this year the figure being 20.

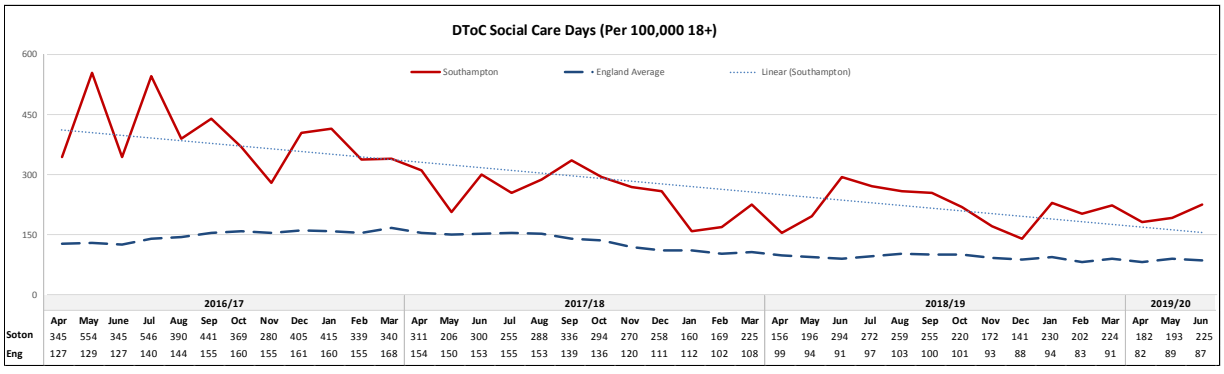
1.10 There has also been an improvement in the waiting times for Home care as shown in the chart below which shows the time in days between referral and package starting:



NB. It should be noted that the chart includes all clients who require support from Home Care and will mask the fact that responses to the acute hospital are significantly faster than that of other sites/referral sources.

2. Impact

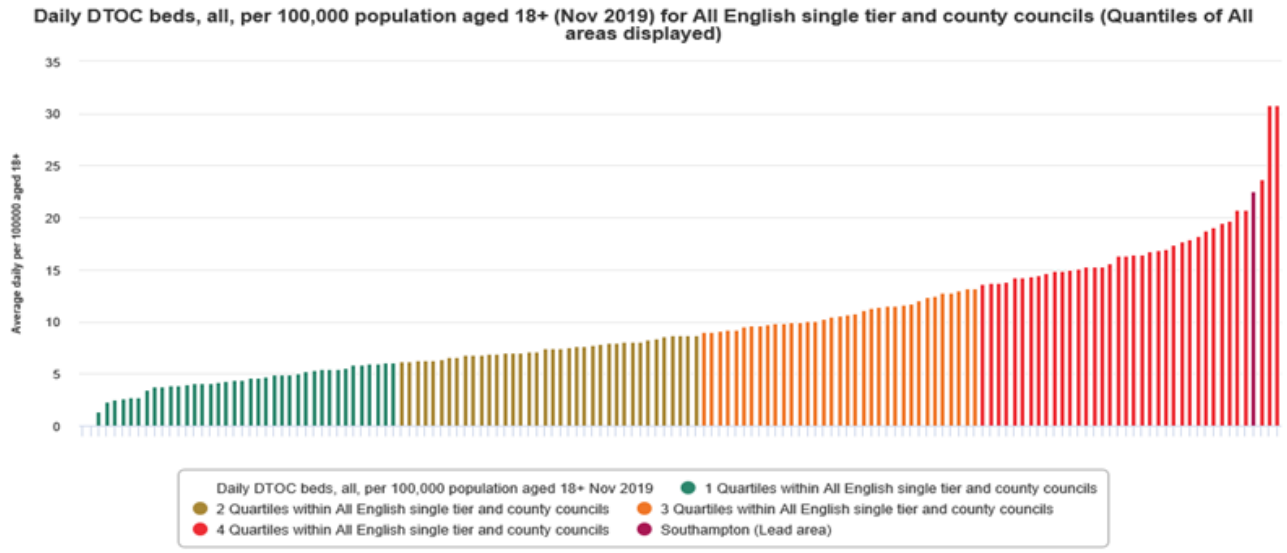
2.1 The improvement work undertaken to date has resulted in a significant reduction in DToC since 2016/17 as can be seen in the chart below.



	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

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

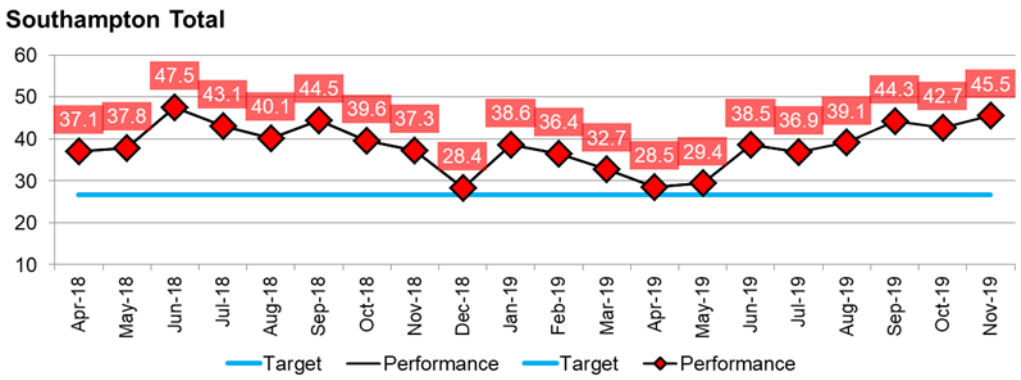
2.3 However, Southampton remains a long distance from its national targets and benchmarks poorly against other Local Authorities as shown in the chart below.

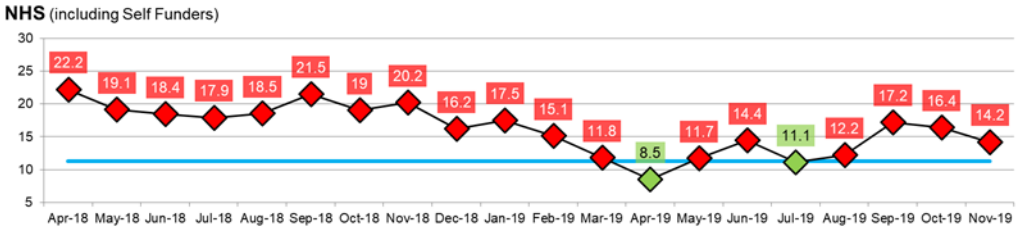


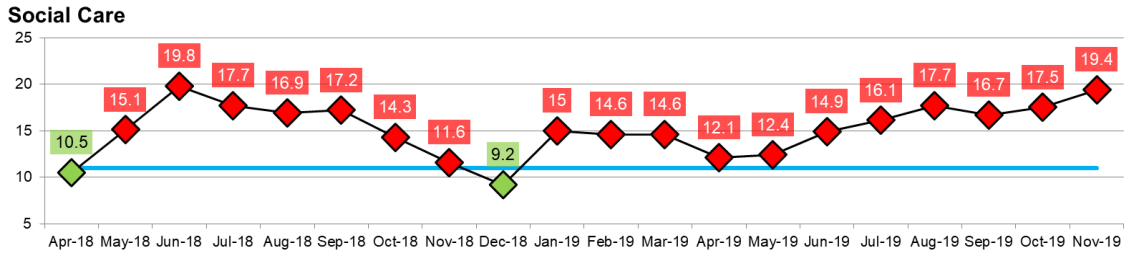
3. Current Position

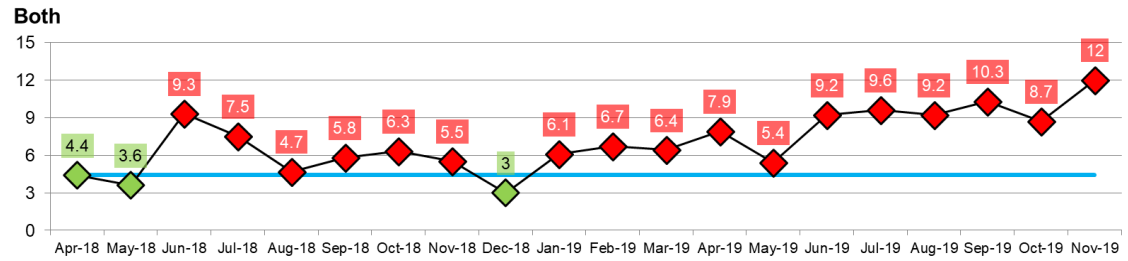
3.1 As at November 2019 (latest available data at time of writing), Southampton's percentage DTOC across all hospitals was 6.6% against the NHSE target of 3.5% with a year to date average of 5.6%. The average daily number of delays for November 2019 was 45.5 against the national target for Southampton of 26.7, with a year to date average of 38.1. The charts below 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".

<u>Southampton Average daily delays (across all hospitals)</u>



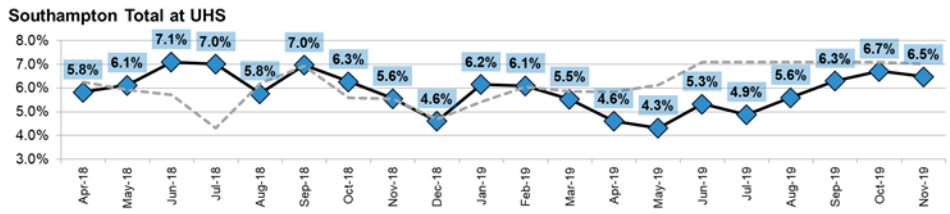


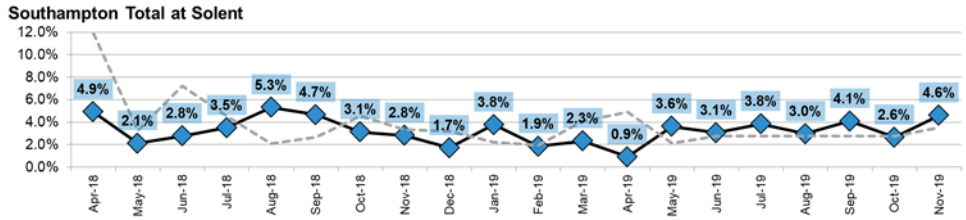


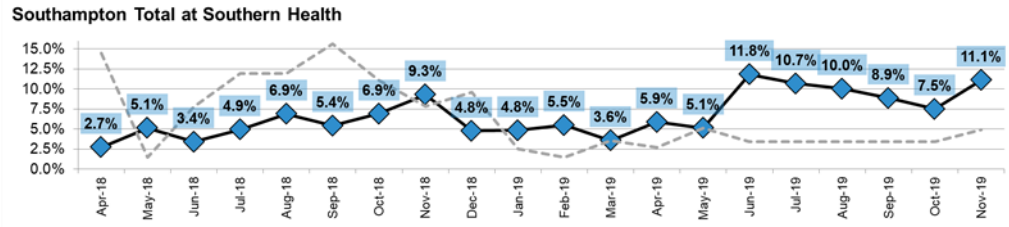


3.2 In terms of overall hospital discharges for Southampton residents, UHS accounts for around 75%, Solent for 10% and Southern Health for 15%. Trust level data on DTOC is shown in the charts below against the 3.5% NHSE target and shows the greatest areas of challenge to be at UHS and Southern Health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

The dotted line shows the trend for the previous year.







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

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

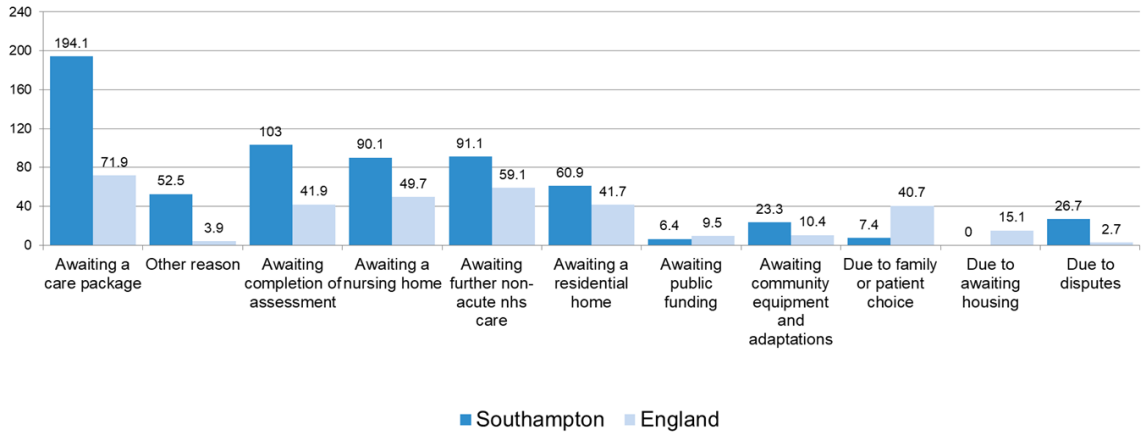
	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19
OBD	576	598	597	623	457	554	639	629	625
DToC Days	32	58	46	2	0	0	0	0	0
Rate %	5.6%	9.7%	7.7%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%

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%

3.4 The increase in DTOC on the Adult MH wards which is visible from June 2019 is understood to be reflective of 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. Other issues that have specifically been identified impacting on Adult MH delays relate to timescales for completion of Care Act Assessments (although a new process has in the last week been put in place), training hospital staff on processes and timescales for social care funding decisions. Action being taken specifically to address these issues is discussed in the next Section.

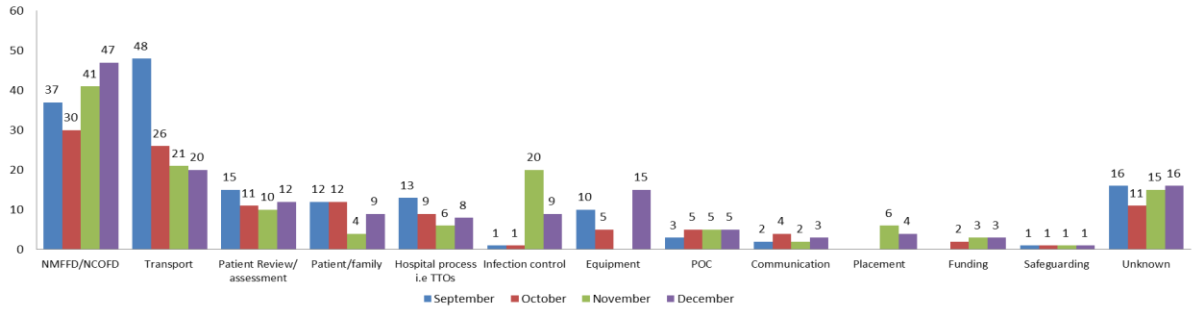
3.5 When reviewing the main reasons for delay across the board, home care placement is the most prominent, followed by awaiting assessment (which relates almost exclusively to social care providers coming into hospital to assess), nursing home placement and then awaiting further non acute NHS care. This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



3.6 Further analysis of the factors underpinning these delays shows that the main reasons are associated with increasing levels of complexity requiring more “double up” care or harder to source nursing home placements. This is borne out in further data which shows that for 2018 the percentage discharges for each of the pathways were: 8% for Pathway 1 (simple discharges), 39% for Pathway 2 (supported discharges) and 53% for Pathway 3 (complex discharges) compared to 8%, 27% and 65% respectively for 2019.

3.7 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 neuro rehab, the main provisions being Salisbury Hospital (spinal rehab) and Snowdon (Solent) for neuro rehab.

3.8 Additionally it is recognised that process issues are still contributing to a number of the delays. For example, on any given day there are approx. 6 failed discharges across UHS (which will be a mix of both Southampton and Hampshire patients) owing to hospital processes as shown in the chart below, hospital transport making up 20% of these (the improvement from October onwards relating to introduction of a dedicated transport team in the IDB which has been funded from the South West System Winter Pressures Fund).



4. Summary of additional work underway to improve the position

4.1 Building on the output from the April 2019 Peer Review facilitated by the LGA 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.

4.2 On top of this the system is taking the following additional actions:

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

- Use of South West System Winter Pressures Fund to increase home care, bridging and Discharge to assess capacity:

- 300 additional hours a week from Enthuse for bridging from 16 December 2019 (approx. 20 additional packages) and an additional 260 hours a week from early January 2020 (approx. 17 additional packages)
- An additional reablement bed in the residential care sector from September 2019
- 2 additional D2A Pathway 3 beds (on top of existing 5 beds) from 31 December 2019

- Employment of an OT locum (using iBCF) to review double up home care packages with a view to identifying any packages that can be reduced and freeing up capacity. It is believed that there could be a reduction of up to 40% in double up care packages through training, risk management and using equipment out of the approx. 200 Southampton City Council cases that have a double up package due to mobility and hoisting.

<u>In recognition of waits for Care Home assessment and placements being a key cause for delay:</u>

- 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. Southampton is already engaged in a Hampshire wide project aimed at engaging care homes in the trusted assessment approach. Recognising the importance of building trust and relationships, the pilot which commenced in January 2020 will focus on engaging with local care homes to design and implement a trusted assessor scheme.
- 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

<u>In recognition of NHS non acute onward care being a key cause for delay:</u>

- Joint review with West Hampshire CCG of Specialist Rehab provision to gain a greater understanding of the level of demand and associated processes in order to better manage flow going forward. This is due to conclude in March 2020.
- Use of South West System Winter Pressures Fund to increase capacity in the integrated rehab and reablement service to improve flow:
  - 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

    (NB. Along with the additional home care and D2A capacity referenced above, this equates to an additional £196k investment from the SW System Winter pressure fund)

<u>In addition the following actions are being taken to improve flow:</u>

- 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 an enabling budget directly to the IDB manager to be used 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 to the IDB. (NB. This has been funded through the SW System Winter Pressures Fund)
- Work 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 IDB and the wards – workshop planned for February 2020 followed by training programme for ward staff.
- Commissioning the voluntary sector to work alongside the Care Placement Service and provide support to families in making timely choices around onward care. This is currently being scoped and is due to commence March 2020.

4.3 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.

4.4 In addition the following specific actions are being taken to address discharge delays at Southern Health (adult mental health wards):

- Daily/weekly escalation calls
- Mental health and housing action plan in place to improve accommodation pathways
- Established Rehab Outreach team to support discharge to the community for people who may need a period of enhanced support
- Council/CCG flexibility to offer out of panel funding decisions to support discharge if applicable/supported by appropriate application information to avoid DToC status; same arrangement being explored for housing gateway panel
- Exploring possibility to pilot Housing Officer In Reach support to Antelope House/Forest Lodge
- ICU undertaking a housing needs assessment and market position statement to address demand/availability of housing/ supported accommodation
- Winter pressure funding secured to focus on improving flow; increased social worker capacity on inpatient wards and additional funding to complement the existing bed management team; new Social Care process being trailed from 3 February 2020.

5. Offer from Better Care support

5.1 Southampton City 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. This will link with the UHS PWC work as well.

5.2 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.

5.3 It is 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.