Agenda Item No: 7

BRIEFING PAPER ON DELAYED TRANSFERS OF CARE FOR THE CAMBRIDGE, HUNTINGDON AND PETERBOROUGH URGENT CARE SYSTEMS

To:	**HEALTH COMMITTEE**
Meeting Date:	**28th May 2015**
From:	**Sarah Shuttlewood, Director of Contracting, Performance and Delivery, NHS Cambridgeshire and Peterborough CCG**
Electoral division(s):	**All**
Forward Plan ref:	**Not applicable**
Purpose:	The purpose of this report is to provide an update to the Cambridgeshire Health Committee on the position regarding Delayed Transfers of Care in Cambridgeshire and Peterborough.
Recommendation:	To note and discuss the current position.

	Officer contact:		***Member contact:***
Name:	Tom Dutton (report co-ordinator)	Name:	Cllr David Jenkins
Post:	Head of Operational Planning	Chairman:	Health Committee
Email:	Tom.Dutton@nhs.net	Email:	ccc@davidjenkins.org.uk
Tel:	01223 725614	Tel:	01223 699170

1. BACKGROUND

1.1 In the following sections of this report, the key causes of delayed transfers of care (DTOC) are described for each urgent care system and the remedial actions that are being taken and/or are planned for implementation. The report combines perspectives from Health and from Social Care, in order to provide a balanced picture.

1.2 A Delayed Transfer of Care [1] 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 patient is ready for transfer **AND**
b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c. The patient is safe to discharge/transfer.

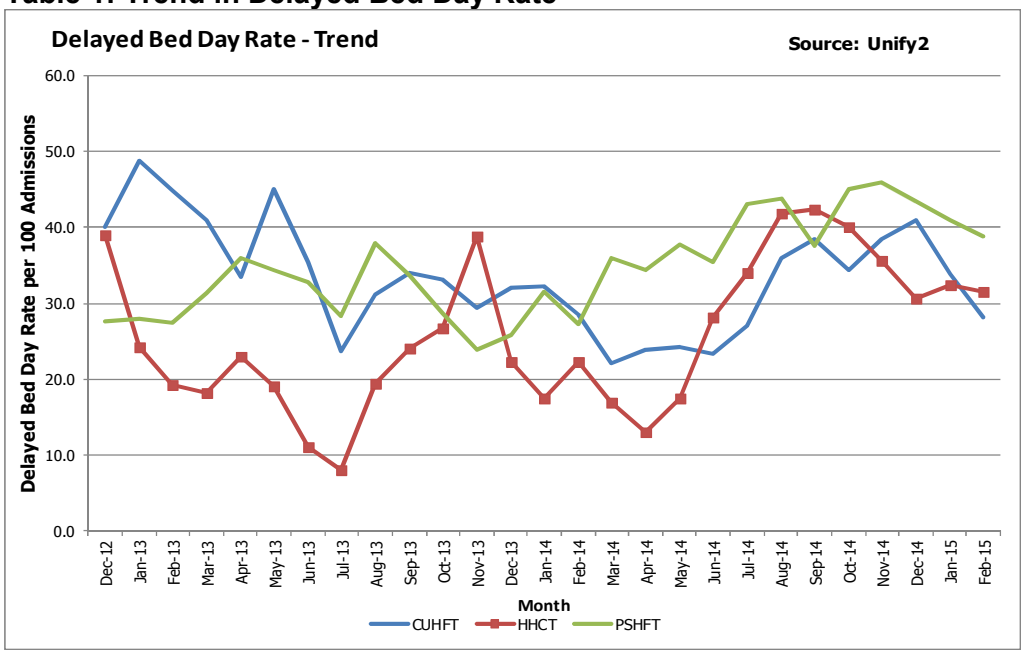
A multi-disciplinary team in this context includes nursing and other health and care and support professionals, caring for that patient. This national definition aids activity measurement and comparative benchmarking across local authority areas.

1.3 Operational oversight of DTOC levels in the County is provided by three multi-agency System Resilience Groups comprising:

- Borderline and Peterborough System Resilience Group
- Cambridge and Isle of Ely System Resilience Group
- Huntingdonshire System Resilience Group

1.4 NHS Cambridgeshire and Peterborough CCG (the CCG) works with all providers across the urgent care pathway to ensure that services are responsive and that they support patients to flow through the system. As an overview, **Table 1** below presents the trend in delayed bed day rate using the most recent national information available. A trend line has been included for each of the major acute hospitals in the County.

Table 1: Trend in Delayed Bed Day Rate



[1] Monthly Delayed Transfer of Care SitReps; Definition and Guidance V1.08 dated April 2015; NHS England Analytical Service

Key:
CUHFT: Cambridge University Hospitals NHS Foundation Trust
HHCT: Hinchingbrooke Health Care NHS Trust
PSHFT: Peterborough & Stamford Hospitals NHS Foundation Trust

1.5 The reasons for DTOC are multi-factorial and need to be addressed by the whole system. Whilst it is not unusual to have delayed transfers of care, the numbers of DTOC across the CCG are higher than the system can manage. A concerted effort continues to be made by all providers in partnership with Commissioning and Local Authority leads to reduce the impact of DTOC.

2. MAIN ISSUES

2.1 Adult Social Care: Cambridgeshire County Council

Cambridgeshire County Council (the Council) has made delayed transfers of care a very high priority, and has worked closely with NHS partners at both strategic and operational levels in all of the hospital systems that support Cambridgeshire residents. While there is still more work to be done, considerable progress has been made and sustained. We have seen bed days lost which were attributable to Adult Social Care reduce from a monthly average of 932 in the financial year 2013/14 to 468 in 2014 /15. Delayed Transfers of care reduced from a monthly average of 41 to 30 (monthly snapshot figure). The details are set out in the **Table 2** below which shows performance in relation to lost bed days.

Table 2: Average bed days lost per month as a result of Delayed Transfer of Care

Attributor	2013 / 2014	2014 / 2015 (1st April to 31st March)	% Change
NHS	1294	1728	33%
Adult Social Care	932	468	-49%*
Both	61	38	-38%* (low number impacts on proportion.)
Total	2287	2234	-2.3%*

** a minus figure in the Change column represents improvement*

Figures produced by the Department of Health suggest that, at the end of March 2015, the Council was responsible for 21% of the total number of bed days lost in acute hospitals. A further 2% were attributable to both NHS and Adult Social Care and the remaining 76% were attributable to the NHS. The Cambridgeshire social care position is slightly better than the current national average distribution of 26% of delays being attributed to Adult Social Care.

Specific actions that have been taken to achieve this improvement include the introduction of 7 day working for hospital discharge planning teams and a zero tolerance approach to assessment delays. Additionally, the Council has invested heavily in reablement services. This service enables service users to be assessed in their own homes when clinically fit without requiring a formal social work assessment. It also focuses on maximising independence, enabling 55% of service users to not require on-going care at the end of their reablement episode. However, in relation to other services there continue to be capacity challenges in particular care homes and domiciliary care. The Council has engaged with independent providers to identify short

term solutions such as interim bed provision and interim domiciliary care services (i.e. mobile rounds) and has also developed the Cambridgeshire Brokerage which enables much quicker take-up of vacancies in care homes, as well as providing more market intelligence.

In addition to the above, the Council was allocated £520k by the Department of Health in February 2015 which was required to be used by the end of April 2015, in order to help reduce Social Care delays. A further £120K was allocated at the beginning of April 2015. The Council has used the money to support 7 day working to enhance its "discharge to assess" services and to relieve the pressure on Home Care. An example is the establishment of 7 reablement flats in the Ditchburn Place Extra Care Sheltered Housing scheme. This was a partnership arrangement with Cambridge City Council. This service is also supported by an Occupational Therapist, employed by Cambridgeshire and Peterborough Foundation Trust, to help maximise independence.

Much of the Council's focus has been on the widely-reported, immediate pressures within the hospitals, including the Accident and Emergency four hour wait target. However, whilst operational pressures have received much attention, there has also been a longer term planning approach in place. This has included the establishment of the multi-agency Cambridgeshire Executive Partnership Board whose remit is to oversee the implementation of the Better Care Fund. The strategic aim is to transform the overall approach to supporting older people with complex needs. The emerging model includes a commitment to greater co-ordination through the development of community multi-disciplinary teams, and early intervention involving the voluntary and community sector.

2.2 Borderline and Peterborough System Resilience Group

DTOC continue to contribute to significant number of lost bed days at Peterborough and Stamford Hospitals NHS Foundation Trust (PSHFT). During this year, the total has been 4,700 bed days for Cambridgeshire Local Authority (LA) patients (12,300 across Cambridgeshire and Peterborough).

The system DTOC averages at 8.2% of bed base for March 2015. The target is no higher than 3.5% (equivalent to 20 DTOCS on any one day, with a stretch target of 2.5% (equivalent to 13 DTOCS) in 2015/16. Throughout the Winter, the system has had a concerted effort on reducing the number of DTOCS.

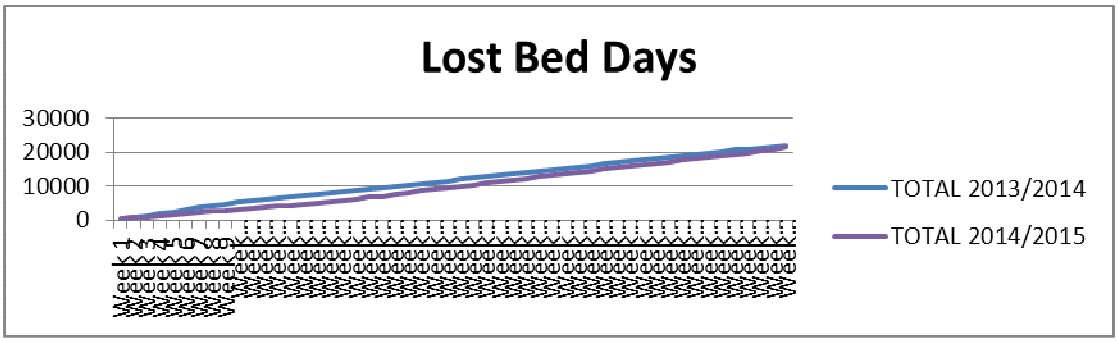
Overall, the position is improved with the number of DTOCS now ranging between 20-25, with 30 being the exception rather than the norm. Previously, DTOC numbers could be in the 30-50 range. However, whilst the DTOC numbers are improved there is a need to have continued daily review of DTOCS to prevent numbers escalating. The system is positive in wanting to meet the stretch target and is putting in plans for 2015/16.

The main issues within the Borderline and Peterborough Health system are as follows:

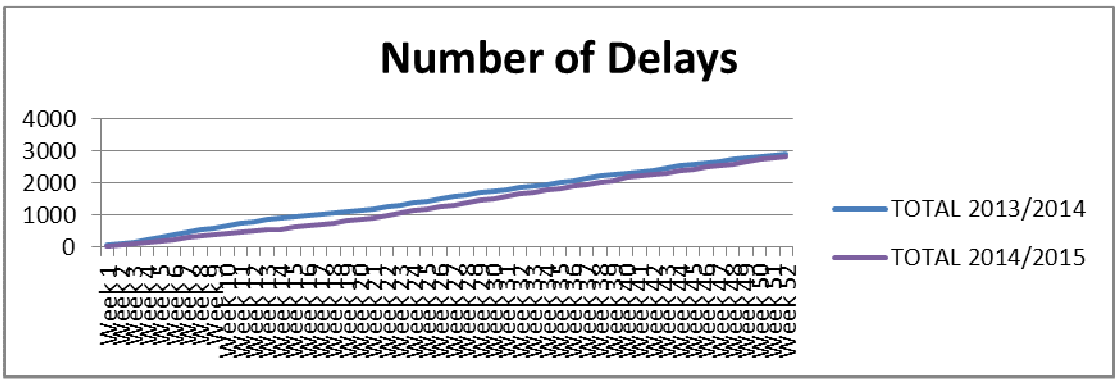
Issue	Actions	Lead partner
Delays in Care Homes coming into assess patients. Homes not accepting patients at weekends.	Working with Local Authorities to move the Care Home Sector to 7 day working. The need to develop an approach to Trusted Assessor.	LA, CCG
Hospital discharges taking place too late in the day, and too few discharges at the weekend thus restricting the availability of beds for patients requiring admission at peak times.	PSHFT has increased the numbers of consultant ward rounds/Multi-Disciplinary Teams that commence earlier in the day. New departure lounge to open in July 2015. There are three different discharge teams working in the Trust and these are being pulled together into one integrated team with a manager to oversee the work processes and flows.	PSHFT
Expected Date of Discharge not being universally used as a driver for discharge.	Increased numbers of consultant ward rounds/patient reviews. More discharge coordinators on wards – now on all wards.	PSHFT
Reduced care home capacity due to safeguarding issues.	Working with Peterborough City Council to ensure that all homes are appropriately supported. Care Home Educator has been in post since September 2014. New care home opened and additional 13 beds commissioned.	All agencies/CCG
Delays attributed to patients waiting for assessment.	Discharge to Assess was introduced for Cambridgeshire and Peterborough CCG patients in January 2015. 12 beds were purchased in a care home purely for discharge to asses patients. This has reduced the number of patients delayed due to assessment considerably.	CCG

2.3 Cambridge and Isle of Ely System Resilience Group

DTOC continues to contribute to a significant number of lost bed days at Cambridge University Hospitals NHS Foundation Trust (CUHFT). During 2014/15, the total bed lost days was 21,381 compared to 21,945 during 2013/14 as illustrated in the diagram below. This is a 3% reduction which is a bed equivalent of 1.55 per day.



During the year 2014/15, there were a total of 2,841 delays compared to 2,987 in 2013/14 which is a decrease of 2%.



The causes have been attributed to both health and social care and, as a consequence, an improvement plan has been developed. The main issues within the Cambridge and Isle of Ely Health system are as follows:

Issue	Actions	Lead provider
Discharge dates not clear and well-understood or used. Discharge planning starts from the moment of admission as all patients are given a Clinically fit date (CFD) which forms the focus of their care plan. This should be changed only by the Multi-disciplinary Team as should a patient stay in hospital beyond this agreed date they become classed as Delayed. Both the patient and	"Clinically Fit Date" (CFD) is set within 24 hours of the patient being admitted to a ward and recorded accordingly on EPIC (new electronic patient record system). If it is not possible to determine the CFD, the Consultant will decide during Discharge Facilitation meetings which are held daily on the ward, during Multi-disciplinary Team meetings and also reinforced during patient listing for those patients who require discharge planning input. The CFD is the date that all professionals who are involved in the patient's discharge planning work towards including the patient and their family. With the introduction of the new electronic patient record system (EPIC), there has been intense training to ensure the use of the CFD. Reports can now be run daily	CUHFT

their family are informed of the date and the expectation that it will become the agreed date of discharge.	on CFDs to enable escalation of delays i.e. simple and complex. Work is currently on going to have discharge pathways on EPIC which will improve discharge planning further.	
Oversight and high level management of the problem.	Daily teleconferences continue system wide. The system operational teleconference call that was originally scheduled for 1300hrs has now been moved to 0900hrs so that there is enough time to facilitate discharges and escalate any problems identified during the teleconference. The 1100hr escalation calls have continued and top 10 DTOC patients discussed and escalated accordingly. A Discharge Transformation Manager is now in full time post from March 2015 and manages the DTOC by escalation to relevant organisation including Out of County. A Chief Executive Officer DTOC meeting will commence on 4th of June 2015 and the Discharge Transformation Manager will attend to provide system-wide performance data and system wide action plan to reduce DTOC.	CCG
High number of patients delayed for assessment reasons.	There has been successful recruitment of 2 DPSNs into the vacancies within the current DPSN establishment. There are currently two vacancies and these continue to be advertised. A business case to increase the establishment of the team is being looked into. CUHFT have commissioned Medihome to assist with Continuing Health Care assessments and nurses are currently undergoing training. The Continuing Health Care (CHC) Team have worked with the Discharge planning team at CUHFT to review CHC processes and supported to clear some of the back log.	CUHFT
Delays attributed to patients who are funding their own care.	Cambridgeshire County Council has a Care Manager who has been working with the patients who fund their care.	CUHFT

	The choice policy has now been implemented and the policy is now being embedded system-wide.	
Lack of community capacity. The numbers of sick patients, especially over the age of 85 years, has steadily risen and many of these patients require care on discharge. This may be in the form of step down medical/nursing care, or rehabilitation.	L Byron B has 16 fully functional beds from 9th February 2015. Due to the increase in patients requiring rehabilitation, the beds have been used more for rehabilitation purposes. The ward has been staffed mainly by agency nurses and has sometimes not made it possible to utilise it fully. The System Resilience Group has agreed funding for the beds and plans to recruit into the posts are underway. There are currently on-going talks with Cambridgeshire and Peterborough Foundation Trust to increase community beds (10 dementia beds).	CPFT/CCG

2.4 Huntingdonshire System Resilience Group

DTOC continue to be a significant problem in the Huntingdonshire system. The recorded year to date average for DTOC is 6.9% of bed base, which compares to 4% for 2014/15. In some months, DTOC numbers have been as high as 8.5% of bed base.

Hinchingbrooke Health Care NHS Trust continues to lose a considerable number of bed days to DTOC against a target of 3.5%, which is being stretched to 2.5% as one of the eight High Impact changes introduced recently by NHS England [2]. Please refer to **Appendix 1** for details, specifically, High Impact Intervention 8.

The System Resilience Group conducts regular escalation calls across the system aimed at managing the factors which are causing the delays. In March 2015, Hinchingbrooke Health Care NHS Trust (HHCT) conducted an initiative entitled 'Breaking the Cycle' which was successful in creating bed capacity and in identifying a large number of patients who could be discharged.

Notwithstanding this, the causes of DTOCs remain the same and the System Resilience Group is working currently with Emergency Care Intensive Support Team to identify and implement solutions which form the basis of the Huntingdonshire Operational Resilience Plan.

The main issues within the Huntingdonshire Health system are as follows:

Issue	Actions	Lead partner
There is insufficient community home care capacity to ensure that	Cambridgeshire County Council (CCC) is working closely with the domiciliary care market to look at	CCC

[2] Letter to CCG Clinical Leaders and CCG Accountable Officers dated 24 April 2015 issued by NHS England (Publications Gateway Reference: 03376)

patients are moved out of hospital. Currently 135 reablement packages are in place, 22 of which are currently awaiting domiciliary home care.	ways to increase capacity. CCC recognise that this sector needs to change significantly if it is to cope with the demand now and as a result of the ageing population. A Home Care summit was conducted to start development of the strategic direction for Home Care provision.	
Availability (capacity) of local community nursing and dementia nursing placements for Continuing Healthcare (CHC) patients at benchmark price. This accounts for 2 to 3 patients a week.	Actively looking at out-of-area/alternative placements. CCC have implemented a county-wide brokerage scheme which will help to source placements and to prevent prices from over-inflating.	CCG
Hospital discharges taking place too late in the day, which impacts adversely on the availability of beds for patients requiring admission at peak times.	HHCT has increased the numbers of consultant ward rounds/Multi-Disciplinary Teams (MDTs) which commence earlier in the day to achieve 12 discharges by 12 noon. This is being monitored daily. Community teams are discharging patients before noon wherever possible.	HHCT
Delays in assessing mental health patients in HHCT. This accounts for 1-2 delays a week.	An escalation protocol has been agreed with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) and HHCT.	CPFT
Estimated Discharge Dates are not used universally as a driver for discharge.	The number of consultant ward rounds/patient reviews has been increased. More discharge coordinators are available in wards.	HHCT
The number of patients with a long length of stay, i.e. greater than 30 days, is too high. For example, during week commencing 20 April 2015, there were 36 such patient. 102 patients have a length of stay of more than 10 days with a high proportion being higher acuity patients.	Review all patients whose length of stay exceeds 28 days by means of active case management. HHCT has recently started to do this and has found that approximately 60% of patients are being managed for supported discharge. HHCT will focus on the inpatients by actively reviewing long stay patients.	HHCT

3. SIGNIFICANT IMPLICATIONS

3.1 Resource Implications

There are no significant implications within this category. This work is conducted within the annual financial allocation.

3.2 Statutory, Risk and Legal Implications

There are no significant implications within this category.

3.3 Equality and Diversity Implications

There are no significant implications within this category.

3.4 Engagement and Consultation Implications

There are no significant implications within this category. The report describes the operational work of the System Resilience Groups.

3.5 Localism and Local Member Involvement

There are no significant implications within this category.

3.6 Public Health Implications

There are no significant implications within this category.

Source Documents	Location
Monthly Delayed Transfer of Care SitReps; Definition and Guidance V1.08 dated April 2015; NHS England Analytical Service	http://www.england.nhs.uk/?s=searcwww.england.nhs.uk%2F...%2FMonthly-Sitreps-Definitions-DTOC-v1.07.doc+h+the+site
Letter to CCG Clinical Leaders and CCG Accountable Officers dated 24 April 2015 issued by NHS England (Publications Gateway Reference: 03376)	http://www.england.nhs.uk

Appendix 1

High Impact Changes

- No patient should have to attend A&E as a walk in because they have been unable to secure an urgent appointment with a GP. This means having robust services from GP surgeries in hours, in conjunction with comprehensive out of hours services.
- Calls categorised as Green calls to the ambulance 999 service and NHS 111 should have the opportunity to undergo clinical triage before an ambulance or A&E disposition is made. A common clinical advice hub between NHS 111, ambulance services and out-of-hours GPs should be considered.
- The local Directory of Services supporting NHS 111 and ambulance services should be complete, accurate and continuously updated so that a wider range of agreed dispositions can be made.
- SRGs should ensure the use of See and Treat in local ambulance services is maximised. This will require better access to clinical decision support and responsive community services.
- Around 20-30% of ambulance calls are due to falls in the elderly, many of which occur in care homes. Each care home should have arrangements with primary care, pharmacy and falls services for prevention and response training, to support management falls without conveyance to hospital where appropriate.
- Rapid Assessment and Treatment should be in place, to support patients in A&E and Acute Medical Units to receive safer and more appropriate care as they are reviewed by senior doctors early on.
- Daily review of in-patients through morning ward or board rounds, led by a consultant/senior doctor, should take place seven days a week so that hospital discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.
- Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the DTOC rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.