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Delayed Transfers of Care

Overview for AHSC Scrutiny Committee

August 2015

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Debbie Graham, Head of Service Improvement CCG
Helen Barker, Associate Director Of Community Services & Operations, CHFT

Not just a Calderdale problem

- Statistics for Delayed Transfers of Care (DTOC) are collected and compared nationally
- The Care Act 2014 and The Care and Support (Discharge of Hospital Patients) Regulations 2014 replaced previous legislation
- Performance Targets are set
- National initiatives have been developed to support improvement , such as ECIST Helping people home

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Improving wealth, improving lives

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Everybody's business

- Partners involved with clear governance arrangements
- CCG / CHFT / CMBC / Kirklees MBC / SWYPFT
- Health and Wellbeing Board
- System Resilience Group
- Urgent Care Board
- DTOC governance board
- DTOC improvement group
- Triggers and escalation processes

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Delayed Transfers of Care are a whole system issue

-Symptom of a system that isn't working as well as it should

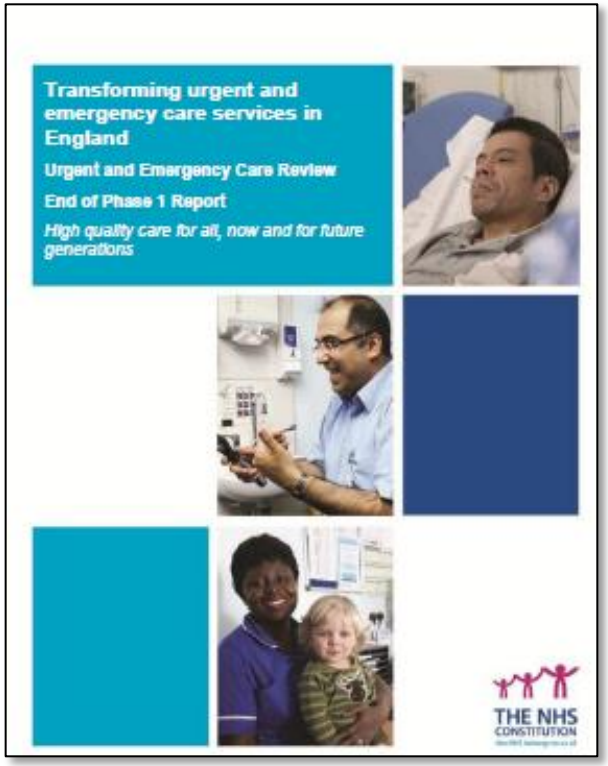
- A reflection of poor "patient flow" within and across all services

-Indication that "right care, right time, right place" not happening for the patients affected

-Poor outcomes and poor experience for individuals and their families

Indication of a capacity and demand mismatch across the system

-Not the best use of our individual and collective resources



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Journey over the past 12 months

- Significant work has been carried out between partners (The focus on targets and numbers can mask the amount of work going on to tackle underlying problems)
- This period includes the business transfer of home care contracts, and these are now embedding
- 'Emergency Care Intensive Support'(ECIST) and 'Helping People Home' Teams came to support our health and social care economy, investigating our position and providing recommendations
- NHSE (NHS England) intervention focused on setting a trajectory for improvement on numbers of delays and % of occupied bed days through delays
- Joint ownership of issues and solutions
- Starting to speak a consistent language

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Joint working to improve DTOC

• Partners agreed a set of principles to guide joint working as part of the ECIST programme

•There is a shared action plan covering:

- **Governance**
- **Policy and protocols**
- **Delay time & volume reduction**
- **Ward ownership/understanding**
- **Pathway redesign**
- **Systems change**

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Data

- Work has been taking place across the partnership to improve the collection and sharing of information, as a result, understanding and ownership of the data is improved.

- Validation by the council of social care reportable delays robustly facilitated. This has been an issue in the past.

- Work in progress on a joint data dashboard, shared across the partnership in an accessible and ready format to ensure that the interpretation of the data is consistent.

- Greater definition of patients Medically fit for discharge vs Delayed Transfer of Care

- Real time validation to support escalation being implemented

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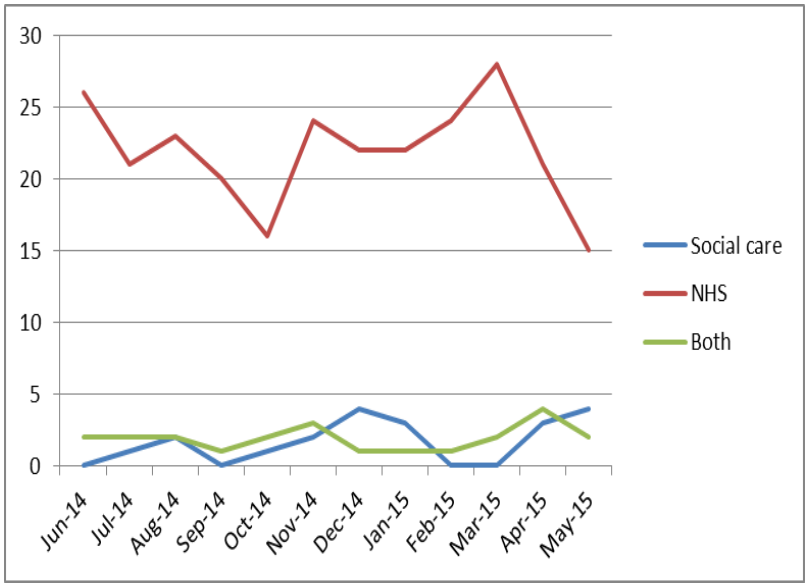
Recent trends – All Trusts
Calderdale snapshot data



All Calderdale residents - data submitted via multiple trusts.

People reported as delayed (monthly **snapshot** on the last Thursday of the month)

Month	Total	Social care	NHS	Both
Jun-14	28	0	26	2
Jul-14	24	1	21	2
Aug-14	27	2	23	2
Sep-14	21	0	20	1
Oct-14	19	1	16	2
Nov-14	29	2	24	3
Dec-14	27	4	22	1
Jan-15	26	3	22	1
Feb-15	25	0	24	1
Mar-15	30	0	28	2
Apr-15	28	3	21	4
May-15	21	4	15	2
Annual Total	305	20	262	23
		6.6%	85.9%	7.5%

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Recent trends

- Calderdale was the subject of national attention at the start of 2015.
- This was based on data submitted showing the monthly figures for ‘days delayed’ – but not validated by the council before submission.
- Significant activity took place to minimise the risk of delays over the winter period.
- Nationally it is recognised that 25% of delays are due to social care. Calderdale Council’s figures fluctuate but remain consistently below 25%.

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DTOC Dashboard June 2015 – CHFT all councils

5. Snapshot delays by category and responsibility

Category of delay	Responsibility							
	Bradford	Calderdale			Kirklees			Total
	Health	Health	Joint	Social	Health	Joint	Social	
Awaiting care package in own home (e)		2	1	2	2		5	12
Awaiting community equipment or adaptations (f)				1				1
awaiting completion of assessment (a)		9	2		3		3	17
Awaiting further non-acute NHS care (c)	1	8			7		1	17
Awaiting nursing home placement or availability (d2)		1	1		2	1		5
Awaiting public funding (b)								0
Awaiting residential home placement or availability (d1)		3					1	4
Disputes (h)		1				1		2
Patient or family choice (g)		4			2			6
Grand Total	1	28	4	3	16	2	10	64
Compared to May 2015	↗	↗	↘	↘	↘	↗	↘	↗

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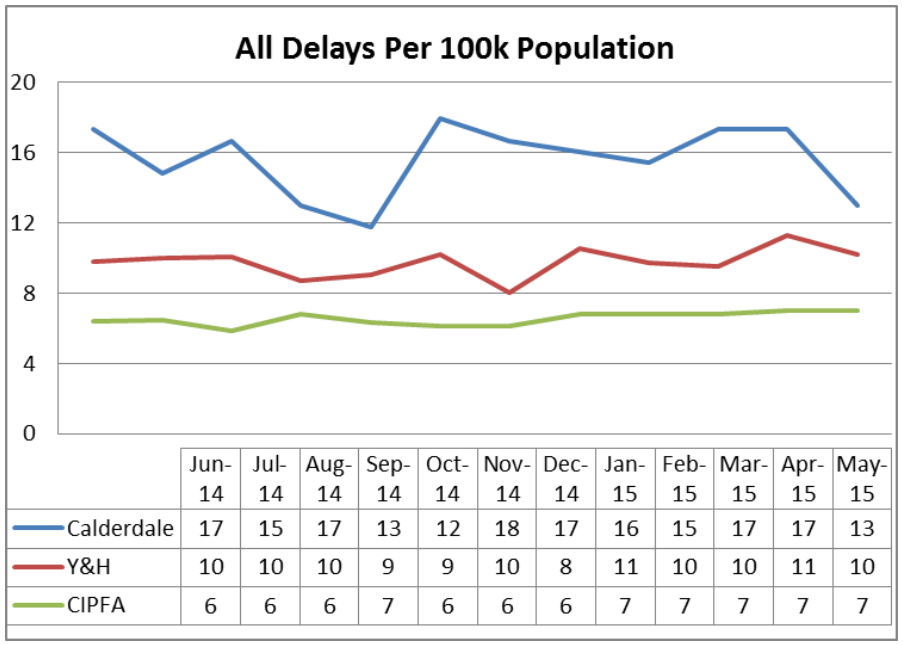
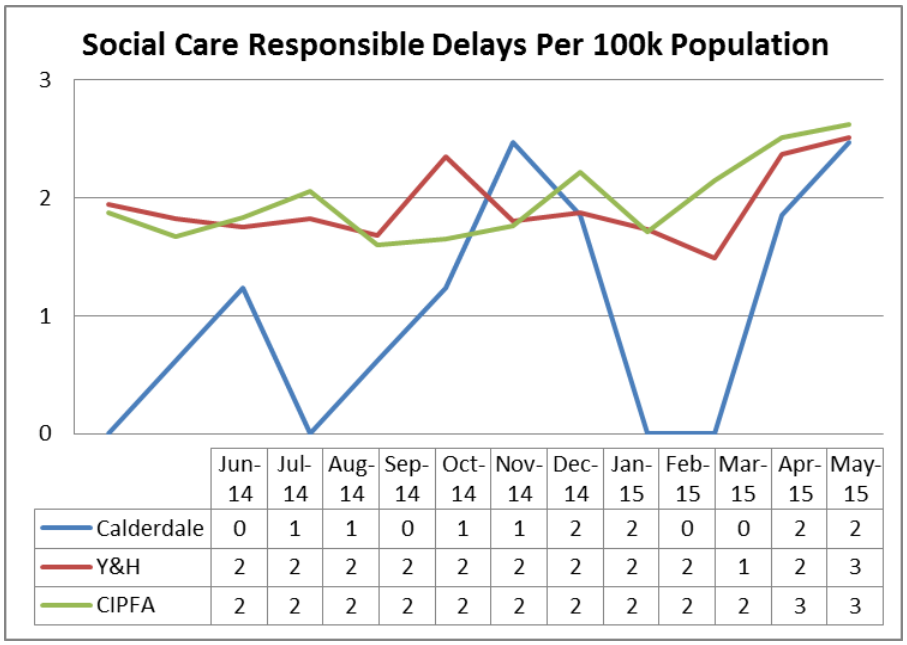
DTOC – Calderdale ASCOF (Adult Social Care Outcomes Framework) comparator



	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Calderdale	17	15	17	13	12	18	17	16	15	17	17	13
Y&H	10	10	10	9	9	10	8	11	10	10	11	10
CIPFA	6	6	6	7	6	6	6	7	7	7	7	7



	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15
Calderdale	0	1	1	0	1	1	2	2	0	0	2	2
Y&H	2	2	2	2	2	2	2	2	2	1	2	3
CIPFA	2	2	2	2	2	2	2	2	2	2	3	3

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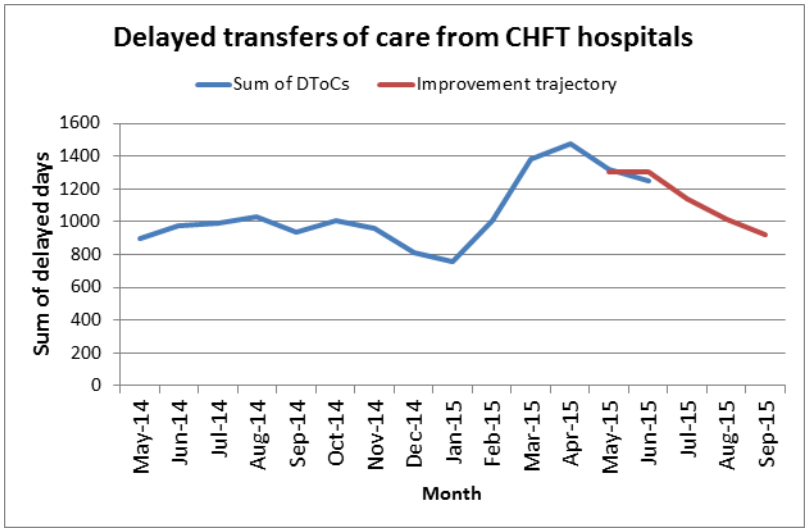
Current position

- New Governance arrangements embedded
- System working greatly improved with regular dialogue
- Revised action plan in place, very patient focussed
- Joint discharge policy agreed (including Equality impact Assessment)
- ‘Moving on’ process agreed
- Developing a more integrated approach to discharge planning
- Implementing real time validation and accurate ‘clock starts’
- Clear triggers and escalation

Moved from weekly to Monthly reporting

CHFT – performance target



- NHSE has set a trajectory for the reduction in the proportion of occupied bed days
- In June CHFT performance was 6.2% against a contractual target of 5%
- Improvement trajectory being agreed to move to 3.5% in 16/17 with ultimate aim to move towards 2.5%

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Challenges

- Winter – an all year problem
- Workforce availability
- Reablement Pathway
- Nursing Home Capacity
- Aging population and increasing complexity
- Patient (& Family) expectations
- Need to do more with less – doing it differently

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Reablement performance: update

- ASCOF Measures – Calderdale performance

ASCOF Indicator	2010/11	2011/12	2012/13	13/14	14/15
2B(1) - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	84%	79%	70%	72%	80%
2D Effectivness of reablement -% Fully independent	New Indicator in 14/15				59%

The way in which the new effectiveness of reablement indicator is calculated is significantly different to the similar local measure which has been used since 2011. The local indicator outturn in 2014/15 was 40%.

Performance has been improving, but has further to go.

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Reablement pathway: update

- We have continued to work in partnership to improve the pathway and target the reablement resource more effectively, now by involving social work assessment and review throughout the journey to help move people on and focus on independence.

- There are some ongoing problems arranging a care package for some individuals which affects the timeliness of moving people on from reablement.

- Recent (March, April, May 2015) analysis has looked closely at the reablement hours delivered. Just under half were delivered to people who were awaiting an ongoing package of care or who were assessed as not having reablement potential. The pathway work will support improvement here.

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Strategic development & services

- Care Closer to Home and Vanguard
- Hospital avoidance team and psychiatric liaison team
- Ambulatory care expansion
- Staying Well in your neighbourhood
- Market development and resilience
- Capacity and demand work – system resilience
- Reablement, Rapid Response Home Care
- Occupational Therapy Assessment and Equipment
- Intermediate Care and Transitional Care
- Heatherstones
- Rehabilitation Strategy
- Establishment of a Community Division – Board developed in Co-production with system partners

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Shared next steps

- Continue to keep the patient at the heart of everything we do
- Implementation of the joint action plan
- Planning for winter (and summer, autumn and spring)
- Reablement pathway redesign to support effectiveness
- System wide approach to building resilience in nursing care market and home care sector
- Continued work with CQC on impact of regulatory actions
- Regular meetings between senior teams

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