Bury Health and Wellbeing Board

Title of the Report	State of Delayed Transfer of Care in Bury
Date	30.01.19
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HWB Lead in this area	Julie Gonda Interim Executive Director, Communities and Wellbeing

1. Executive Summary

Is this report for?	Information ☐	Discussion ☐	Decision ☐
Why is this report being brought to the Board?	Report requested for up-date		
Please detail which, if any, of the Joint Health and Wellbeing Strategy priorities the report relates to. (See attached Strategy) www.theburydirectory.co.uk/healthandwellbeingboard	Priority Areas 3 & 4 Living Well with a long-term condition or as a Carer & Ageing Well		
Please detail which, if any, of the Joint Strategic Needs Assessment priorities the report relates to. (See attached JSNA) http://jsna.theburydirectory.co.uk/kb5/bury/jsna/home.page	N/A		
Key Actions for the Health and Wellbeing Board / proposed recommendations for action.	To monitor progress in the reduction of DToCs across the Bury Health and Social Care System		
What requirement is there for internal or external communication around this area?	None		
Assurance and tracking process – Has the report been considered at any other committee meeting of the Council/meeting of the CCG Board/other stakeholders….please provide details.	No		

2. Introduction / Background

2.1 A 'delayed transfer of care' occurs when a patient is ready to leave an acute or non-acute hospital but is still occupying a bed. Delays can occur when patients are being diIDTscharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital or hospice.

2.2 Delayed transfers – also referred to as 'DTOCs' or sometimes, often in the media, described as 'Bed-blocking' – can cause considerable distress and unnecessarily long stays in hospital for patients. They also affect waiting times for NHS care, as delayed transfers reduce the number of beds available for other patients.

2.3 Delayed Transfers of Care are a national Key Performance Indicator (KPI) for both the NHS and Adult Social Care (ASC). Figures are reported daily to NHS England by the local NHS following a set process that allows a multi-disciplinary team (MDT) time for plans to put in place for a timely discharge to an appropriate, safe place for patients with complex needs.

2.4 Reasons for the delays are coded according to the area of responsibility and are very specific, eg,

- waiting for "further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)" is attributable to the NHS whilst
- waiting for a package of home-care is usually attributable to social care (although there are circumstances where it is attributable to the NHS or Both).

2.5 The detailed Statutory Guidance, which is complex and often open to different interpretations, can be found at,
https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

2.6 NHS England, the body responsible for monitoring delayed transfers of care nationally, defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer, and
- a multidisciplinary team has decided that the patient is ready for transfer, and
- the patient is safe to discharge/transfer.

2.7 As soon as a patient meets these three conditions the patient is classified as MOAT (Medically Optimised, Awaiting Transfer) and the 'clock' starts until they are classified as 'a delayed transfer'. The process is explained in 2.8 below.

2.8 An Assessment Notice (known as an N2 for historic reasons) is issued to the Integrated Discharge Team (see para 3.2.1) by the Ward that gives an estimated discharge date which cannot be less than 2 days away unless the notice is received after 2.00pm. In this case the timing slips over into the next day, ie if the notice is received at 12.00noon on Monday, services must be in place before 11am on Wednesday but if it's received at 2.30pm the team have until 11 am on Thursday to complete their arrangements. The IDT can then begin its assessment process to determine the most suitable onward destination. Once the discharge date is confirmed and the 3 conditions overleaf are met, the ward will issue a Discharge Notice (N5) and the clock then begins to tick down for 48 hrs (depending on time of referral as explained above) to the person becoming classified as a DToC.

2.9 Each month NHS England publishes two measures of delayed transfers –

- the total number of bed days taken up by all delayed patients across the whole calendar month and
- the average daily number of delayed transfers across the month. These reports are produced two months in arrears.

2.10 The latest detailed report available from ADASS in respect of November's performance across the region can be found at:

file:///C:/Users/d.colam/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/ST0JZUT3/NW%20ADASS%20DToC%20Dashboard%20January%202019.pdf

3. key issues for the Board to Consider

3.1 Mental Health DToCs

3.1.1 In May last year Bury had a significantly higher number of DToCs than either the national, regional or GM-wide and was seen as an outlier in this KPI. On undertaking a 'deep dive' into the reasons for this it was found that patients in the Irwell Unit (Mental Health) at Fairfield General Hospital (FGH) had been responsible for a large proportion of DToCs since October 2017, when their method of reporting changed. Previously a patient was consider a DToC once an onward placement had been found and the patient was ready to transfer. PCFT changed this to reflect the requirements of the Statutory Guidance and reported patients as DToCs once the time-scale after receipt of the N5 had ended.

3.1.2 At this time 15 patients had been delayed for over 1,800 days with 7 of them having individually been delayed over 100 days.

3.1.3 The problem was compounded by the way the Community Mental Health Team (CMHT) worked to strict 'Zoning' criteria based on risk and as these patients were in a safe place they were considered low risk, so they were not prioritised. There was also no escalation process in place to alert senior managers to the situation. Once the issue was understood and CMHT management and workers engaged, the problem significantly reduced.

3.1.4 A link manager was put in place to liaise between the CMHT and the Irwell Unit and discharge planning began in earnest. This eventually reduced the list of those waiting discharge along with the number of bed-days they'd been delayed.

3.1.5 However, a significant issue in these figures is the lack of mental health beds available across the country for onward discharge for those suffering mental ill-health and the lack of social housing within the area. This remains a concern both nationally as well as across GM and the GM Commissioning Unit is looking at ways to stimulate the market to provide more of these types of beds across the authority.

3.1.6 The DToC situation is much improved although the full effect has only gradually been felt due to the NHSE method of calculation. There are currently 2 people waiting to be discharged accounting for 24 days (as at 31.01.19) and one additional patient who is on leave to a placement and not occupying a bed but technically classed as a DToC for 119 days. In addition there is one person from Rochdale who is

3.1.7 In addition to the Irwell Unit, which caters for those in an acute episode of mental illness who are sectioned under the Mental Health Act, the Ramsbottom Unit caters for those older people with mental health issues such as dementia which is often complicated by psychosis. DToCs here are common because of a lack of EMI Nursing Homes across the region that can cater for complex behaviour which challenges.

3.2 Acute hospitals

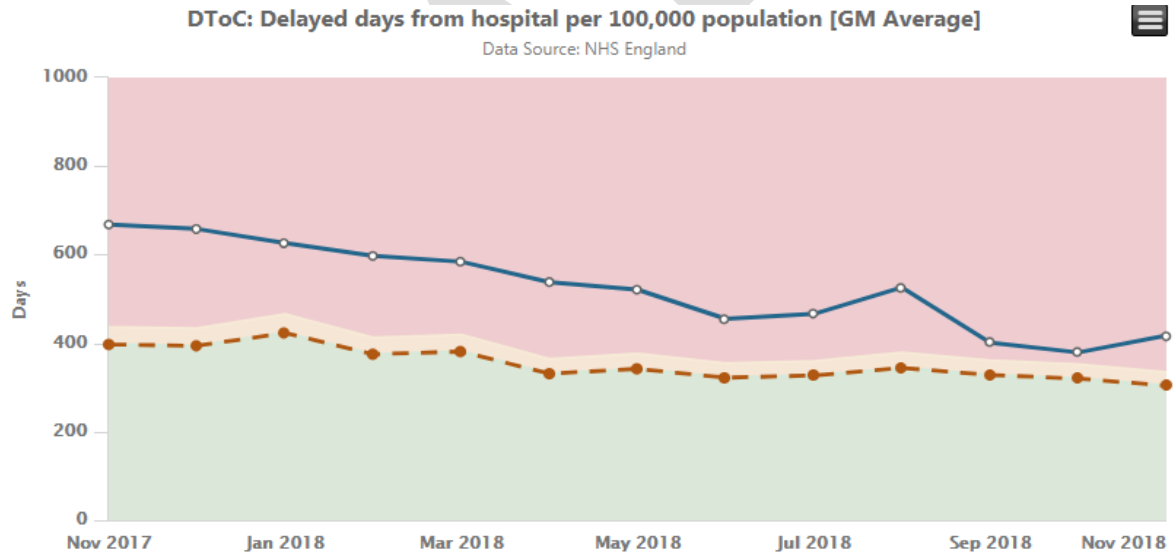
3.2.1 Bury's performance has also improved across both acute hospitals which serve its population, FGH and North Manchester General Hospital (NMGH). The Integrated Discharge Teams comprise of Social Workers and Discharge Liaison Nurses/Transfer of Care Nurses who liaise with ward staff and therapists to discharge plan as patients become MOAT.

3.2.2 Ideally the discharge planning process would start on admission but this is not possible at the present time for a variety of factors, not least of which is related to staffing. However, the IDTs work in a truly integrated way and over the past year this has proved invaluable in reducing the DToCs in the area.

3.2.3 In addition, the Provider Relationship Team have worked with care home providers to create Discharge to Assess (D2A) beds where patients can be safely discharged for full assessment once they have had a period of recuperation and reablement, rather than at a point of crisis in their health or social care needs.

3.2.4 At the end of last year we were able to negotiate the provision of all these beds at Heathlands and this has proved a much improved situation. The whole service was able to be provided on one site so therapy staff were not having to travel across the borough to work with patients at the three previous, different sites.

3.2.5 The graph below, for November, demonstrates the overall progress that is being made in the reduction of DToCs in Bury (despite the increase in the summer, which was unprecedented, with related high acuity of patients), along with tables which show the overall downward trend for Bury compared to last year. There is still some way to go to achieve our target of 3.8% of delayed days but delays attributable to Social Care have shown the most progress and are now approaching the national benchmark.



Responsible Organisation	Social Care		NHS		Both		Trend compared to last month SC		Trend compared to 6 months ago SC	
National %	30%		62%		8%		N/A		N/A	
Bury figures	241	39.6%	272	44.7%	95	15.6%	↓	30.8%	↓	46%

Average delayed days per 100,000	Bury	NW Average	GM Average	Trend compared to last month	Trend compared to 12 months ago
	417	366	304	↑ 379	↓ 668

3.2.6 It was agreed last autumn that part of the System Resilience Grant (SRG) could be used to enhance the staffing levels in FGH's IDT for both nurses and social workers but it has proved impossible to recruit staff on such short-term contracts. Further efforts are being made to increase staffing levels in the team moving forward in the New Year and negotiations are taking place with the CCG in order to secure the SRG funding on a 3 years basis.

3.2.7 In addition to the D2A beds, the provision of Intermediate Care (IMC) beds for both nursing (at Bealeys) and Choices for Living Well at Killelea has been invaluable in the reduction in delays. Choices has flexed its admission criteria wherever possible to accommodate requests for patient transfer, particularly at times of crisis in the hospitals. A request to enable Choices to provide nursing, as well as residential care, has recently been made to CQC to enable greater flexibility within the system.

Non-Acute Hospital DToCs

3.2.8 This includes community & private hospitals and, whilst there are occasional DToCs from Bealeys waiting for Choice's Community Reablement service, the main cause of DToCs in this sector is again mental health provision and Out-of Area patients who are awaiting assessment for onward placement.

Winter Pressures Grant

3.2.9 In December the Local Authority received £817k from the Government to assist in the flow of patients out of hospital. It was decided to use a large part of the money to create extra capacity within the D2A bed-base; to contract the GP Federation to provide medical cover for the additional beds at Heathlands; to purchase specialist equipment which may be delaying a discharge; to employ additional therapists in the reablement service to enable earlier discharge from Choices, therefore improving flow; and to have a contingency fund for any emergency which may arise. A detailed account of spend against this is being maintained and reports are provided to the Department of Health on a regular basis on how it is being spent.

3.2.10 Staff in our IDTs have worked hard and have proved their dedication to the patients in their hospitals by working extended hours, coming in on days off and focussing on the reduction of DToCs based on the safety of patients and an appropriate onward destination.

3.2.11 The numbers of DToCs in Bury have reduced significantly since close monitoring of these, although there was a recent increase over the December period, linked to high attendances at A&E, high admissions rates and associated high patient acuity. Patients, when moved, were often really poorly and required longer periods in D2A or IMC beds, which in turn reduced flow across the system. However the situation has improved once more with DToCs showing a marked reduction (as reported from the hospitals in January), especially in those that are attributable to Adult Social Care.

4. Recommendations for action

4.1 The Board are asked to not the contents of the report and support the actions being taken to reduce DToCs across Bury.

5. Financial and legal implications (if any)

If necessary please seek advice from the Council Monitoring Officer Jayne Hammond (J.M.Hammond@bury.gov.uk) or Section 151 Officer Steve Kenyon (S.Kenyon@bury.gov.uk).

6. Equality/Diversity Implications. Please attach the completed Equality and Analysis Form if required.

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