CARE, HEALTH AND WELLBEING
OVERVIEW AND SCRUTINY
COMMITTEE
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TITLE OF REPORT: Delayed Transfers of Care/Enablement and ACT Team

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Summary

The purpose of this report is to advise OSC of progress to-date to reduce hospital discharge delays an update on the in house Enablement Service and the new Achieving Change Together team and its remit.

1.0 Background

1.1 Hospital discharge arrangements are an integral part of the care of patients and their overall experience of care. Work to ensure smooth discharge from hospital to community and other settings with minimum delays, requires effective working arrangements across all partners including the voluntary sector. The delayed transfers of care measures (DToC) indicate the impact of hospital services (acute, mental health and non-acute) and community-based care, in facilitating timely and appropriate transfer from all hospitals for all adults. This indicates the ability of the whole system to ensure appropriate transfer from hospital for the entire adult population. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

2.0 What is a Delayed Transfer of Care?

2.1 A delayed transfer of care occurs when a person is ready for discharge from an acute, non-acute and mental health hospital ward bed, and the person is still occupying the bed.

2.2 To achieve a safe discharge there are three criteria which must be applied in order to make the decision that the patient is ready to be discharged. These are not separate or sequential stages; all three should be addressed at the same time whenever possible. They are:

a) A clinical decision has been made that the patient is medically fit for discharge / transfer AND,
b) A Multi-Disciplinary Team (MDT) decision has been made that the patient is ready for discharge/transfer AND,
c) The patient is safe to discharge/transfer.

3.0 Targets

3.1 Three targets were set for the delayed transfers of care for Gateshead by the government, they are:

- An overall transfer target that delays do not exceed an average more than 8.2 per day per 100,000
- NHS transfers do not exceed an average more than 5.6 per day per 100,000
- Social Care transfers do not exceed an average more than 2.6 per day per 100,000

4.0 Current position

4.1 The latest data available is as at November 2017; the data is published monthly but is always two months behind. The latest data shows considerable progress across all three targets, with each target being exceeded. Specifically the latest figures for:

- **All delays are 3.67 well below the target of 8.2.** This has improved significantly on the same point from last year (13.04)
- **NHS delays are 3.93, well below the** t**arget of 5.6.** This has improved on the same period last year (6.29)
- **Social Care delays are 1.24, well below the target of 2.6.** This is a significant improvement on the same period last year (6.42)

4.2 If we look at this data in terms of being a number of people, this is what the rates per 100,000 mentioned above would equate to (rounded to the nearest whole number).

- **For overall delays; approximately 6 people on average delayed per day**. The target requirement was fewer than (approximately) 13 people on average per day.
- **For NHS delays; approximately 4 people on average delayed per day.** The target requirement was fewer than (approximately) 9 people on average per day.
- **For Social Care delays; approximately 2 people on average delayed per day.** The target requirement was fewer than (approximately) 4 people on average per day.

5.0 Key areas that have aided improvement in reducing delays are as follows:

5.1 Social care

5.1.1 We have a long established social work assessment team based at the QE hospital, in the last year we have reviewed the team structure and focus to ensure we are using the resources we have to maximum benefit with the team now only focussing on discharges.

5.2 Emergency Residential/Nursing Care Trusted Assessor

5.2.1 The Council does not have many problems in accessing Residential and Nursing Care homes beds at short notice and can normally get an admission, once assessed, within 48 hours.

5.2.2 At present, before an admission takes place, the registered manager or the responsible officer at the care home must carry out an assessment at the hospital. This is to ensure that the home can manage the persons' needs and have the right levels of staff available. However this can delay admission into the care home.

5.2.3 As part of the winter planning for 2018 it was highlighted that there may be a need at some point in the winter period to transfer people from hospital with a long term care need into a residential / nursing care within a very short timescale.

5.2.4 All thirty care homes were invited to be included in an emergency trusted assessor model, where at a time of crises, homes would accept referrals based on the assessment of the Council Officer and would agree to take the admission as soon as possible; with the aim of two hours if possible. Referrals can be made seven days per week including out of hours if required. A total of eighteen homes agreed to be included if required with these homes having around ninety vacancies that could be used as and when needed.

5.2.5 To date, there has not been a need to use this approach but it is available should it be required.

5.3 Bridging service

5.3.1 One of the main reasons for delayed discharges was people waiting for a long term package of home care to start in the community. Due to the workforce issues the home care market is facing, not only in Gateshead but the rest of the country, providers don't always have the resources to enable packages to start as soon as someone is ready to leave hospital.

5.3.2 To enable people to leave hospital as soon as they were ready for discharge, the Council need a service that is responsive and has staff available to start within two hours. It was agreed to pilot over a three month periods a new approach with the independent sector providers. They agreed to have a small team of salaried staff who will deliver support to enable people with a long term care needs to be discharged and receive support for a short period of time whilst waiting a long term package of care.

5.3.3 The Pilot was evaluated and overall proved very successful. It enabled over fifty people to return home on the day they were fit to leave hospital. The overall satisfaction from service users and their families was really high with the vast majority rating the service good to excellent.

5.3.4 The Council agreed that the service was required all year round and have commissioned the service with three providers (Clece Care, Comfort Call and Dale Care) from September 2017 to March 2019. Over 100 people have been supported within the first three months since the service has been reintroduced

with the majority moving to a long term package within two weeks of receiving the bridging service.

5.4 Enablement

5.4.1 The Enablement service has been in place for some time, and we have supported many service users to remain independent. As part of Enablement the below services are also being provided:

- Overnight Service has proven to be instrumental in maintaining people at home, minimising residential care admissions. Staffing resources are being doubled in this area.
- Training in Systematic Instruction (**TSI**) interventions in Promoting Independence Centres and People Regaining Independence by Means of Enablement (**PRIME**) provision is effective in maintaining people in their own homes
- Promoting Independence Centre (**PIC**) Intermediate Care home discharge levels have been at an effective level (71%), facilitating opportunities for people to remain at home.
- PRIME and Rapid Response services actively used (particularly North East Ambulance Service use of Rapid Response service) to prevent admissions into residential care and acute hospital admissions
- OT introduction into PRIME is paying dividends in determining effective lifestyle and environmental interventions for people, enabling them to remain in their own homes
- Rapid Response service is providing immediate support (average response time of 27 minutes) to people in a crisis in their own homes; serving to stabilise individuals and (if need be) providing Enablement support. Service has won the 'Putting People First Personalisation award at the 2017 North East Care Awards in November 2017 for its instant person centred, crisis support.
- Step-down trusted assessor routes into PRIME and PIC's are now firmly established, facilitating seamless discharges.

5.5 The Achieving Change Together (ACT) team

5.5.1 The Achieving Change Together team is a new team which has been developed to review service users who have complex needs, primarily people with a Learning Disability, with the aim of working with these people to promote independence which in turn will result in less dependency on long-term statutory services.

5.5.2 The development of the team has the support of senior managers within Care Wellbeing and Learning. The team consists of staff from assessment, in house provider (enablement) and commissioning. There have been two development days which were very positive. The team go live on the 22nd January 2018.

6.0 Joint work between CCG/Trust/Council in the following areas has also assisted in reducing the reported delays:

6.1 Regular meetings at first line, middle line management and senior management from the Trust and Council regarding analysis of discharge arrangements and performance:

- *Weekly Surge Meeting* – A problem solving meeting to discuss specific cases where there are possible issues re discharge.
- *Winter Planning Meeting* – Looking at any issues from the winter beds (Ward 6)
- *Daily Surge Meeting Gold command* – This meeting is ad hoc and can be called on at very short notice when the trust is in a particularly difficult position.
- The LA also receives a daily list of people who may be ready for discharge who are able to have an early discharge.

6.2 The above meetings are over and above the daily "board rounds" which take place every day on the wards with a multidisciplinary team.

6.3 There are presently 97 extra beds open at the QE.

6.4 Considerable work has been carried out redeveloping DToC monitoring procedures and systems. By working closely with partners at the Foundation Trusts and NTW we have established a more robust process to challenge and report DToC. This work has included enhancing existing monitoring templates, reinforcing reporting procedures from Sit-Rep meetings, dedicated monthly meetings with colleagues at NTW to discuss delays and the monthly presentation of DToC through Adult Social Care Performance Clinics.

7.0 Recommendations

7.1 The views of the OSC are sought on the report and, in particular:

- Whether it is satisfied with progress so far and the future plans in place to continue to work towards reducing Delayed Transfers of Care
- Continued work of Enablement including the new services being provided
- Development of the Achieving Change Together team

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