Report to Healthier Communities and Adult Social Care Scrutiny & Policy Development Committee 21st March 2018

Report of: Phil Holmes
Director of Adult Services

Subject: Update on Delayed Transfers of Care

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Summary:
This agenda item provides a summary for scrutiny members of performance on Delayed Transfers of Care in Sheffield. The last time this topic was covered by Scrutiny was in September 2017

A Delayed Transfer of Care is caused by somebody being unable to leave hospital at the point when their treatment is complete. This can have a negative impact on them directly (particularly frail older people who may lose confidence and strength through staying in an unfamiliar environment for too long) and will also have a negative impact on others indirectly (through hospital resources being taken by somebody who does not need to be there).

A Delayed Transfer of Care is caused by two key factors, either singly or in combination. Either planning for the person to leave hospital has not been done in a timely way, or arrangements that they need to support them on discharge have been slow to arrange. Both of these factors can be improved by the NHS and the Council working more closely together.

The report sets out:

- How the NHS and the Council is performing in Sheffield in relation to Delayed Transfers of Care
- What we will be doing over the next year to improve performance.

Type of item: The report author should tick the appropriate box

Reviewing of existing policy	
Informing the development of new policy	
Statutory consultation	
Performance / budget monitoring report	**x**
Cabinet request for scrutiny	
Full Council request for scrutiny	
Community Assembly request for scrutiny	
Call-in of Cabinet decision	
Briefing paper for the Scrutiny Committee	
Other	

The Scrutiny Committee is being asked to:
Scrutiny members are asked to review the information provided in the presentation and appended documents and provide comments on it and identify any priorities for improvement.

Background Papers: Appendix One: Sheffield's Vision for Delayed Transfers of Care
Appendix Two: national guidance on high impact changes

Category of Report: OPEN

Report of the Director of Adult Services
Update on Delayed Transfers of Care

1 Introduction

1.1 This agenda item provides a summary for scrutiny members of Delayed Transfers of Care performance in Sheffield. The last time this topic was covered by Scrutiny was in September 2017

The report sets out:

- How the NHS and the Council is performing in Sheffield in relation to Delayed Transfers of Care
- What we will be doing over the next year to improve performance.

2 Delayed Transfers of Care in Sheffield

2.1 Scrutiny last received a report on Adult Social Care Performance in September 2017.

2.2 The report demonstrated an significant improvement in relationships between the Council, Sheffield Teaching Hospitals and Sheffield Clinical Commissioning Group, with much greater shared understanding of the root causes of people staying too long in hospital, and a “single version of the truth” in terms of shared performance data. This has meant that focus can be on doing the right thing for people delayed, rather than arguing about causes and numbers.

2.3 The improvement in relationships and understanding have been sponsored by the organisations themselves, and also enabled by shared analysis and developmental work. For example three summits were held in 2017, attended by leads from all three organisations and both local and national partners. These looked at new, shared analysis and developed joint plans.

2.4 The analytical work was carried out by Newton Europe, who were initially funded by NHS England to work with Sheffield and two further authorities in the North West of England. Their analysis showed

- **35%** of those impacted by DTOC were waiting for a pathway to be allocated to them.
- **35%** of those impacted by DTOC were on a pathway to either intermediate, nursing and residential care.
- **16%** of those impacted by DTOC were waiting to go home with some extra support.

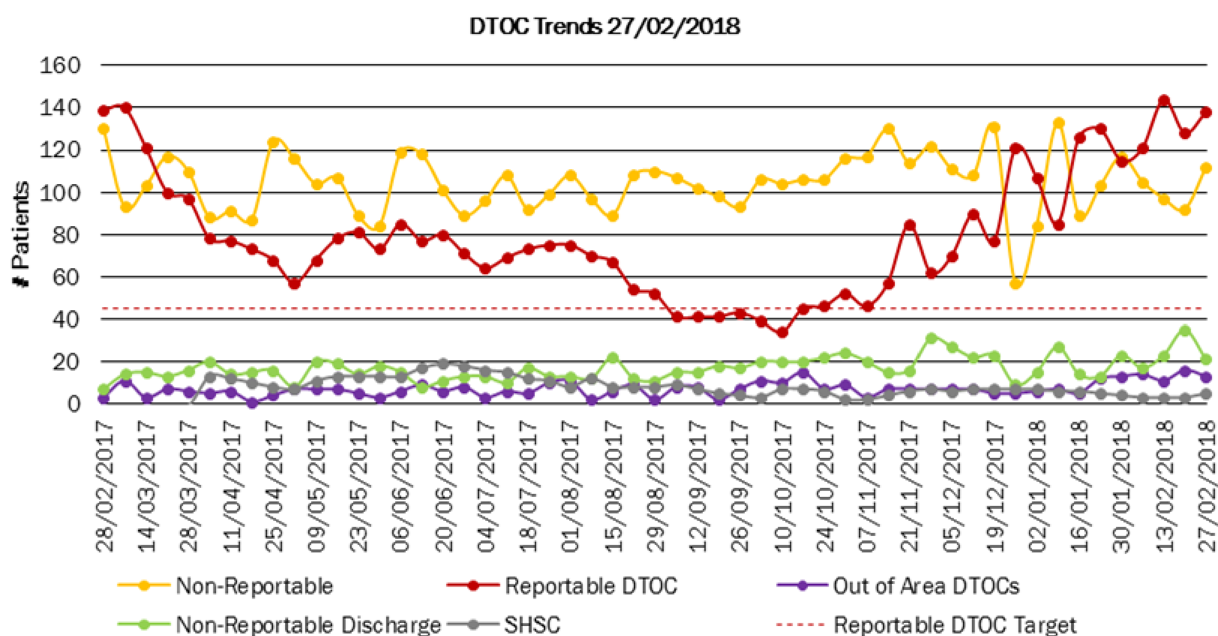
2.5 Therefore a programme of work was set up to tackle these core issues. This comprised an “in-hospital” workstream and an “out-of-hospital” workstream with the Council sponsoring the former and the NHS the latter. This allowed senior managers to gain insight into the hard work being undertaken in other organisations.

3. Updates on performance since last report

3.1 There had been significant improvements in Delayed Transfers of Care when Scrutiny last received a report in September 2017. However, performance deteriorated again over the winter, starting at the end of October and continuing to the present point in time.

3.2 The graph below sets out the position on Delayed Transfers of Care over the past year. Each data point reflects a weekly snapshot taken at the same point each week.

- The red line sets out “reportable” delays which are reported to NHS England alongside all other Local Authority areas.
- The red dotted line shows the NHS England target for Sheffield, which represents the number of delays not exceeding 3.5% of the available beds.
- The yellow line sets out “non-reportable” delays that show people who are waiting to leave hospital but have not reached a point where they need to be reported to NHS England.

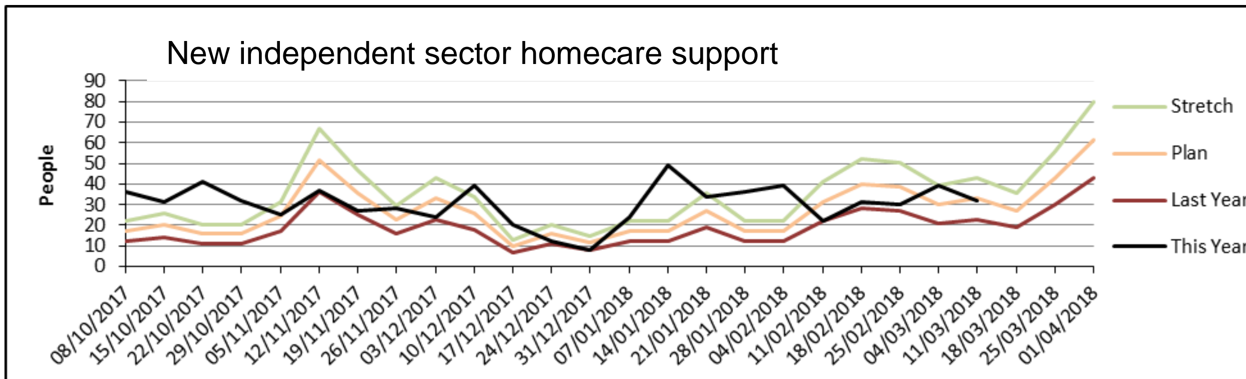


3.3 Sheffield achieved the NHS England target in late August and maintained until late October. This is in the context of extremely challenging performance throughout 2016 and the beginning of 2017 and some very focused action to recover.

3.4 By the end of October, performance had started to slip again. Some of this reflected some long-standing issues that had not yet been sustainably addressed:

- The above graph shows significant fluctuations in “non-reportable” delays from late October onwards, and particularly over the Christmas period. By contrast, in the period when reportable delays (the red line) had reached the NHS England target, the level of fluctuation in non-reportable delays was very small. Significant fluctuations in non-reportable delays occur in the lead-up to holiday periods when hospital staff catch up on actions to expedite discharges. This creates a surge of demand for community services which is hard to fulfil.

- At the same time, as indicated by the chart below, there can be a slow-down of independent sector homecare capacity in holiday periods. The black line shows this year's performance.
- The combination of temporary surges of demand from the hospital and temporary loss of supply in the community creates a situation where queues build up and significant pressure develops.



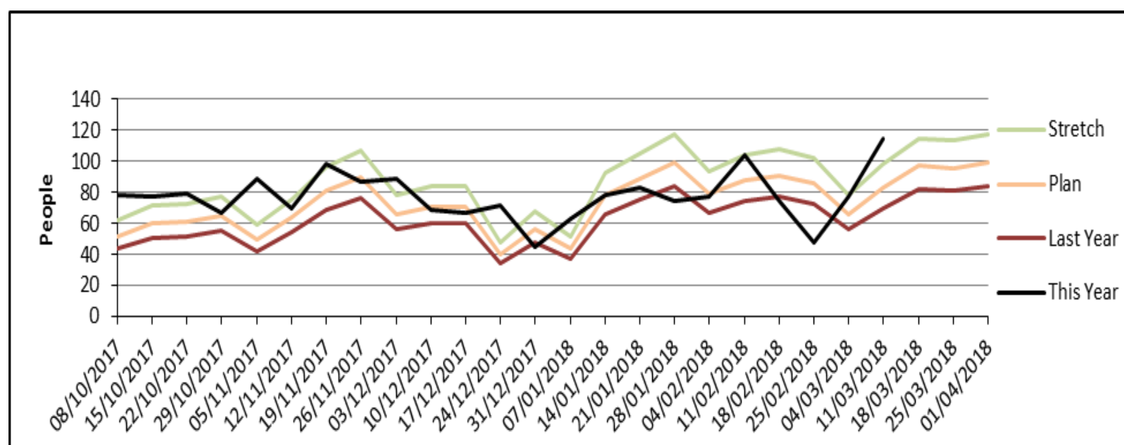
3.5 Both inside and outside hospital, the need to maintain stable behaviour and stable capacity whatever the time of year is therefore a significant outstanding issue. This creates a system that is much easier to manage. Once instability starts to develop, the degree of fluctuation week by week can pendulum further, and the queue of people waiting to leave hospital increases.

3.6 However it is important to note the differences between this winter and last winter. Although Delayed Transfers of Care are similar numerically this winter to last winter, there are a number of positive factors that give cause for optimism.

- Firstly, discharge planning on hospital wards continues to improve, with an programme of activity designed to develop “Gold Standard Board Rounds”. Board Rounds are coordinated activity carried out by ward staff to ensure timely discharge planning.
- Secondly, coordination between Sheffield Teaching Hospitals, Sheffield Clinical Commissioning Group and the Council continues to improve. There have been a number of examples over this winter when all three organisations have undertaken collective “escalation” actions to deal with current issues or imminent risks.
- Thirdly, adult social care capacity has been greater this winter than last winter. Between October and the start of January offered capacity was 40% higher than over the same period in 2016-17. The graph below illustrates this, and also shows that although performance has been more mixed so far in 2018, offered capacity remains higher than in the same period in 2017 overall.

3.7 The graph below sets out the Adult Social Care performance in offering homecare capacity to help people leave hospital and return home. People are initially supported by the Council's Short Term Intervention Team (STIT) and are then

transferred to longer-term arrangements with independent sector homecare providers if their needs determine this.



4.0 What we will be doing over the next year to improve performance

4.1 Sheffield's partners have agreed a vision for reducing Delayed Transfers of Care that is set out in Appendix One. The vision sets out what Sheffield people have a right to expect, and how people across the NHS and social care will work in their interests.

4.2 The immediate focus is on reducing the numbers of people waiting in hospital from current levels, and restoring Sheffield's performance to the same or better levels as in summer 2017. There has been recent success here, with the numbers of delays having markedly decreased from the middle of March.

- STH, the CCG and the Council have been working together to find new opportunities that help people leave hospital more quickly than would otherwise have been expected. Most recently this was achieved via a "Gold Command" initiative where staff from all three organisations worked intensively over a weekend
- Adult social care capacity has been increasing so a greater number of people have been able to return home with care
- There has been more rigour in understanding what people are waiting for, and expediting this as quickly as possible

4.3 The focus is now moving to the strategic actions that will be necessary to ensure that performance does not slip again once next winter approaches. These relate to the national High Impact Actions set out in Appendix Two with specific focus on:

- Further development of discharge planning from the point of hospital admission so that arrangements are made to ensure people leave hospital on the day their need for acute treatment concludes
- Developing the right skill mix to support ward staff in ensuring people leave hospital with maximum independence, with particular emphasis on the role of therapy
- Consistent practice within hospital and consistent capacity out of hospital so that queues do not develop around holiday periods because of the a

mismatch between people needing return home and the availability of support to enable this to happen

- A clear capacity plan for community provision, particularly homecare

4.4 Sheffield has recently been subject to a “System Review” carried out by the Care Quality Commission (CQC) on our health and care arrangements for older people. Delayed Transfers of Care were part of the scope for this review. Sheffield was chosen by CQC because of a combination of a number of measures including Delayed Transfers of Care but also incorporating a broader, preventative focus. Most obviously, the number of people waiting to leave hospital can be reduced if more are supported in preventative ways so that they do not need to come to hospital in the first place. Sheffield will receive a report of the CQC findings in June and will then organise a local summit to set out improvement actions. This will include operational measures to ensure Delayed Transfers of Care reduce, but also preventative action so that a greater number of older people stay safe and well at home.

5 What does this report mean for the people of Sheffield?

5.1 National research has shown that older people lose both confidence and physical strength at a significant rate if they stay in hospital longer than they need to. This leads to greater risks for them once they return home. For some it may mean that they are unable to return home at all because their reduced ability leads to a move into a care home. Therefore ensuring that older people are able to leave hospital on the day their medical treatment has finished is of the utmost importance to their wellbeing.

6. Equality of Opportunities

6.1 The Council has a duty under section 149 of the Equality Act 2010 (the public sector equality duty) in the exercise of its functions to have regard to the need to:
a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

6.2 Although an Equality Impact Assessment (EIA) has not been undertaken for the production of the report, this duty has been taken into account during consideration of key change activities detailed in the report..

4 Recommendation

4.1 Scrutiny members are asked to review the information provided in the presentation and appended documents and provide comments about performance and plans for improvement.

Appendix One: Sheffield's Vision for Delayed Transfers of Care

SHEFFIELD DTOC PROGRAMME

WHY NOT HOME? WHY NOT TODAY?

When you need hospital treatment, there is no better place to be than in hospital. Once hospital treatments are completed, research suggests that you will do better at home, so getting you back there without delay is important. We will ensure that our services work together, are simple to use and will be available when they are needed, so that you have the help and support to get you home.

Sheffield Teaching Hospitals NHS

NHS Sheffield

Sheffield

SHEFFIELD DTOC PROGRAMME
DELIVERING THE SHEFFIELD VISION

What do we want to do?

1. Very soon after you are admitted to hospital we will start working with you to plan when you can go home and get back to your normal life.
2. We will make sure that you have the right information and keep you updated.
3. We will ensure that every day that you spend in hospital is valuable for you by only keeping you in hospital whilst we are giving you treatment that can't be accessed from your home.
4. Staff from different professions (eg. doctors, nurses, therapists, social workers, carers) will work closely together so that your care is coordinated and you only need to tell your story once.
5. We will do all of this seven days a week.

How do we want to do this?

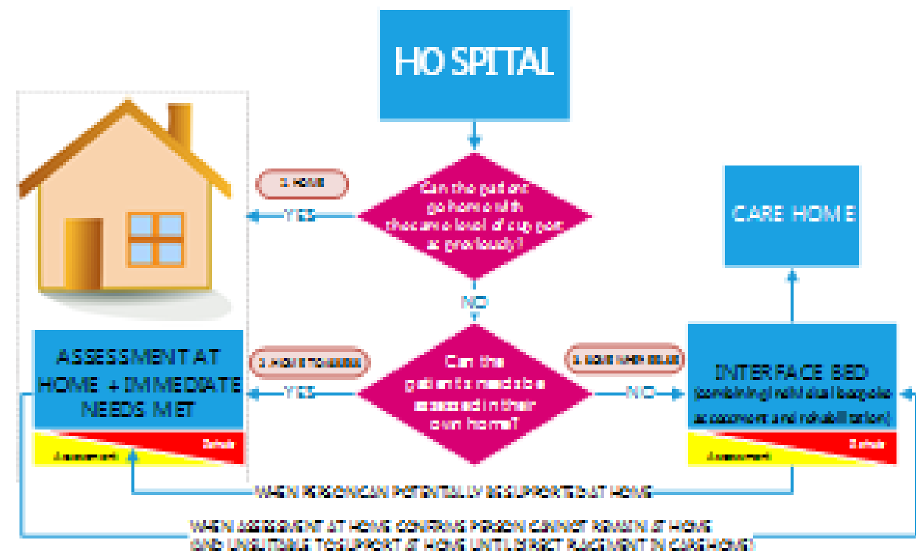
1. If you can't go home immediately we'll want to discuss a planned date with you within two days of your arrival in hospital.
2. We'll review your care and treatment every day.
3. If you had care or support at home, we will restart this so it is ready for you when you get back home. For most people, returning home will be very straightforward.
4. For those people who need a period of extra support at home, we will arrange for help to be there. There will be further discussion with you, in your own home, about what will help you settle in safely.
5. You may be one of the very small number of people who may not be able to return home once they have completed their hospital care. We'll arrange for you to get support in one of our rehabilitation and assessment units and work with you to try and get you home again.

SHEFFIELD DTOC PROGRAMME
DELIVERING THE SHEFFIELD VISION

What difference will this make?

1. Staff working in both health and care services will have clearer arrangements for working closely together. This will improve the coordination of care and their job satisfaction.
2. We will all have a shared understanding that patients staying in hospital when they do not need hospital treatment, is not right. It reduces their chances of a full recovery, increases their risk of complications and makes it harder to give other patients the treatments they need.
3. We will ensure that our services, which help people at home, are responsive and able to meet people's needs without delays. They will be safe and there will be no increased risk of patients having to be readmitted to hospital.
4. A greater proportion of people will be able to return safely to their own home. The small proportion of people who are unable to go home will be transferred to one of our rehabilitation and assessment units.

SINGLE SYSTEM PROCESS MAP TO OPTIMISE INDEPENDENT LIVING AFTER HOSPITALISATION



Appendix Two: national guidance on high impact changes

High Impact Change Model

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.