Manchester City Council
Report for Information

Report to: Health Scrutiny Committee – 5 September 2017

Subject: Delayed Transfers of Care

Report of: Executive Director Strategic Commissioning & Director Adult Social Services (DASS)

Summary

Delayed Transfers of Care (DToC) represent a major operational challenge for the health and social care system nationally and locally in Manchester. Patients who are unable to leave a hospital setting when they no longer require acute care prevent the effective flow through the hospital system and impact on other standards such as the 4-hour accident and emergency wait times and ambulance performance. The health and social care system in Manchester is under significant pressure resulting in high levels of DToC and there are several initiatives aiming to address these pressures.

This report details the current situation with Delayed Transfers of Care within Manchester's acute hospital system city wide and provides information on actions taken within Adult Social Care (ASC) to improve performance. Whilst this brief focuses on DToC it should be noted that this work links with wider system initiatives that not only focus on delays on transfer but also on the support people before they need an admission as well as work required to support people home from accident and emergency departments.

Further details and an overview of the complete Urgent Care performance and improvement system are available in the previous report to Health Scrutiny 'Manchester Urgent Care System' provided on 2 February 2017.

Recommendation

Members of the Committee are requested to note the content of this report.

Wards affected: All

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Background documents (available for public inspection):

The following documents disclose important facts on which the report is based and have been relied upon in preparing the report. They are available up to 4 years after the date of the meeting. If you would like a copy please contact one of the contact officers above.

None

1. Introduction

1.1. DToC represents a major operational challenge for the health and social care system. This is a national problem and the recent quarterly report1 by Association of Directors of Adult Social Services (ADASS) indicates that Manchester's levels of Delayed Transfers of Care are the highest in the region. The report also indicates that Manchester has the highest non-elective hospital admissions and non-elective bed days across the Greater Manchester region.

1.2. Whilst the number of DToC is relatively low compared to the number of hospital beds the high level of bed occupancy means that the impact of DToC is significant in the system. Patients unable to leave hospitals in a timely manner when no longer requiring acute care impacts across the patient flow system and affects other hospital and system targets (such as waiting times in A&E and ambulance turnaround times). The percentage target of occupied beds across each of the three hospitals is 3.3%, meaning that each of the three acute Trusts should have no more than 3.3% of their bed base occupied by patients classed as DToC at any one time. For the hospitals these targets translate as below for numbers of Manchester citizens delayed in hospital:

- University Hospital South Manchester (UHSM) 10 people
- Central Manchester Foundation Trust (CMFT) 21 people
- North Manchester General Hospital (NMGH) 7 people

1.3. Achieving timely safe and effective discharges requires effective partnership working across the whole health and social care system including ward, community and hospital discharge teams. For patients with multiple health and social care needs this can be challenging due to the numbers of professionals and organisations required to be involved in decision making regarding future care. In addition it is essential that citizens and their families are fully involved in the process and any decisions made regarding future care and actions required.

2. Factors impacting upon timely discharges

2.1. There are a number of factors that may result in an individual's transfer from hospital becoming delayed, some (although not all) of these are listed below:

[1]ADASS North West quarterly performance benchmarking update: Q4 2016/17

- Requirement for further assessment to determine future longer term care needs (such as 24 hour nursing or residential care) and can include Continuing Health Care (CHC)
- Further non acute care to optimise rehabilitation (such as intermediate or rehabilitative care)
- Availability of appropriate move on residential or nursing accommodation – particularly when individuals require specialist nursing care for conditions such as complex dementia or mental illness.
- Adaptations to property before a safe discharge can be achieved
- Funding screening, assessment and decisions
- Waiting for a package of care in an individuals' own home
- Choice of home by an individual or family when an individual lacks capacity to make the choice themselves
- Requirement for a new or different type of housing / accommodation (i.e. sheltered or Extra-Care style supported housing)

3. Current Performance

3.1. Daily tracking enables performance to be measured and whilst there have been changes across each of the three hospital sites all are now reporting on the same measures as proposed by the 'Monthly Delayed Transfer of Care Situation Reports Definitions and Guidance version 1.09, October 2015'.

3.2. This reporting was strengthened by agreement with the Greater Manchester Combined Authority (GMCA) in February 2017 (2).

3.3. Reporting on delays uses the following definition:

"A 'reportable' delayed transfer of care 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 clinical decision has been made that patient is ready for transfer
AND
A multi-disciplinary team decision has been made that patient is ready for transfer
AND
The patient is safe to discharge/transfer."

3.4. To ensure an agreed and accurate picture of performance as mentioned above reporting has been standardised so that each of the three acute hospitals in Manchester report on the same activity.

3.5. Reporting includes reason for delays as well as length of delays in acute and non-acute beds. Reporting also includes achievements against the 3.3% target highlighted above.

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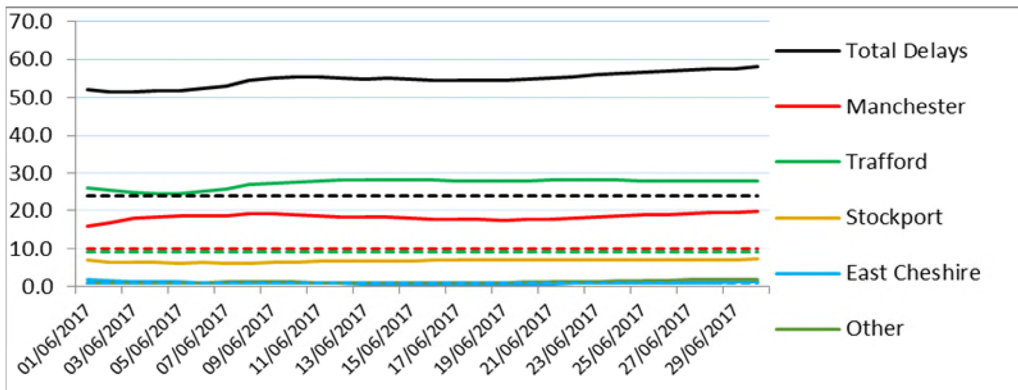
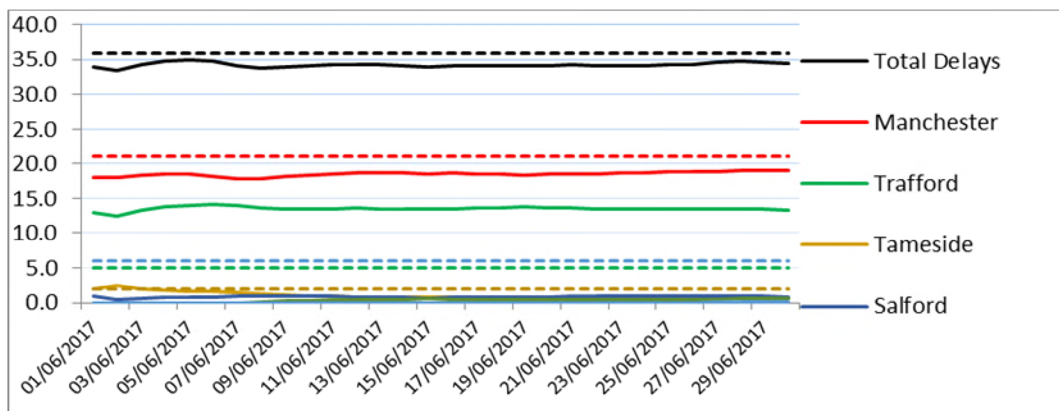
[2] Letter from Joh Rouse Chief Officer, Greater Manchester Health & Social Care Partnership 25th February 2017

3.6. The three graphs below indicate Manchester’s current position as at June 2017 for each of the acute hospitals. The figures shown relate to numbers of people awaiting a discharge.

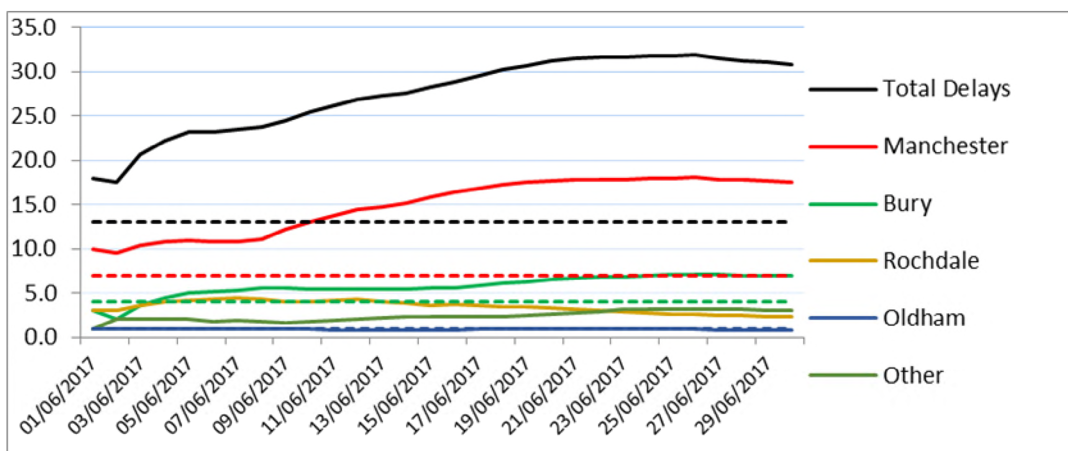
UHSM average daily performance



CMFT average daily performance



NMGH average daily performance



4. Changes to improve Performance

4.1. Over the past number of years there has been significant resource utilised from various sources in the system across Manchester to support transfers from hospital without any significant improvements in numbers of delays reported. Indeed there is now growing recognition that financial investment is no longer just required on a seasonal or ad hoc and single hospital site basis (as seasonal resilience monies) but that a system wide change is required if the system overall is to improve and provide a sustainable impact for Manchester (and Greater Manchester) citizens.

4.2. In support of this recognition various initiatives and alternative funding streams have been identified. The work sits across all health and social care organisations in the city and is jointly owned and overseen by an Urgent Care City Wide Board.

4.3. Adult Social Care (ASC) at MCC is fully involved in this work and has moved towards a city wide practice approach to ensure standardisation of systems and reduction in duplication of processes and oversight. This city wide approach is now focusing on why individuals become delayed in the system and is aiming to work 'up stream' to identify people before their care and transfer becomes delayed.

5. Utilising Local and National Standards

5.1. During April 2017 a self-assessment and national guide was developed and issued by the Department of Health, NHS England, ADASS and the Local Government Association (LGA) called 'High Impact Change Model – managing transfers of care between hospital and home'. This model detailed 8 High Impact Changes that could support the work of improving levels of delays across health and social care systems.

5.2. The introduction to the model states:

'*It builds on lessons learnt from practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to supporting timely hospital discharge. Whilst acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working.*

For reference the 8 High Impact Changes are detailed below:

- Early Discharge Planning
- Systems to monitor Patient Flow
- Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector
- Home First/Discharge to Assess.
- Seven-Day Service
- Trusted Assessors

- Focus on Choice
- Enhancing Health in Care Homes

5.3. In addition the Greater Manchester Combined Authority (GMCA) have developed standards for Trusted Assessor, Choice and Discharge to Assess. These documents are currently in process of being signed off across the city. Once signed off the Choice policy – which relates to how people are supported to make choices re move on from hospital - will be implemented across all three acute hospital sites (due September 2017). Relating to the Trusted Assessor and Discharge to Assess standards work is already underway city wide to implement these and the GMCA principles are fully incorporated within this work.

6. ASC Contribution

6.1. There are several work streams across the city focusing on improving the delayed transfer position and ASC at MCC is fully involved in these. In addition there are some specific measures being undertaken immediately to stabilise the current situation. These measures are part funded via the seasonal resilience monies and part by the ASC grant monies.

6.2. It is to be noted that all of the work currently underway and planned in quarters three and four is aligned to the 8 High Impact Changes and the GMCA standards highlighted above.

6.3. A brief summary of the work streams are detailed in brief below:

- Development of integrated discharge teams (IDT) in all three acute hospitals - work is underway to ensure all three sites have fully integrated discharge teams; North are most developed with a manager in place managing staff from several different organisations; South is underway with recruiting to a manager post and agreement to centralise staff into one coordinated integrated team; Central are currently working towards full integration and plans are in place to develop further the integrated team on this site.

- As part of the integrated discharge teams there are plans in place to have experienced social workers fully embedded within ward teams as well as within the discharge teams. The role of these workers is to meet and assess people as they are admitted onto wards to identify any possible requirement for Adult Social Care support and to start the ASC processes for discharge sooner in people’s journey.

- A key area of work is to develop further links with community and equipment teams that will enable discharge planning before admission for those people coming to hospital for elective treatment.

- Development of a new city wide Reablement pathway to enable swifter acceptance and discharge to and from the service utilising a ‘Trusted Assessor’ approach. Plans are also in place for an enhanced complex care pathway that will include a significant Reablement offer, although this work has yet to be finalised and agreed.

- The commissioning pathway for adult social care commissioning has been amended to create a centralised system and to eliminate time delays when seeking packages of care and / or placements in the community

- As an acute hospital setting is often over stimulating this can exacerbate some conditions such as dementia or delirium and can lead to increased confusion and distressed behaviour as a result, often meaning individuals needs cannot be accurately assessed for long term care. The development of Neighbourhood apartments based either in sheltered accommodation or as part of the extra Care housing offer has enabled time for a more detailed assessment and to enable proper recovery planning. By discharging from an acute setting into a more 'home like' supported environment individuals and their families are supported to make realistic Choices about their future care – this can lead to improved outcomes for individuals and where appropriate can prevent long term care being inappropriately sought. This is a relatively new initiative and performance metrics include length of stay, deflection from 24 hour care as well as user satisfaction in order to measure the effectiveness of this intervention

- Improving information systems is vital to provide accurate data and up to date information on any individuals delayed in hospital. By developing city wide trackers there is now immediate oversight of capacity that includes beds in care and nursing homes, capacity in neighbourhood apartments and any discharge to assess and recover capacity, Reablement and home care capacity as well as actions outstanding for individuals identified as delayed.

- Implementing the successful elements of the Community Assessment Service (CASS) based on North Model across the other two sites in the city (south and central). This is a very successful service integrated service of intermediate care and Reablement developed initially in North of the city and that has demonstrated the following:

    - Reduction in DTOC
    - Reduction in admission to permanent 24 hour placements
    - Avoidance of Non elective admissions
    - Increased numbers of citizens remaining at home

    - In addition it is recognised that resource out of hospital is essential to enable the system to flow and that this work requires a new focus on commissioning options for the city and for Greater Manchester. This work is already underway and work streams include piloting new models of Home Care (including a Trusted Assessor approach); improving GP and health links with residential and nursing homes to keep people out of hospital wherever possible; supporting homes and care providers to improve quality of care with support and training as well as ensuring appropriate funding; developing new models of care with providers of both 24 hour and home care.

    - Alongside this, work is also underway to develop increased provision and models of care that will support a discharge to assess and recover model –

ensuring that Manchester's strategy of '**home first' or 'discharge to assessment and recovery'** is maximised.

7. Governance [3]

7.1. Manchester's Urgent Care Transformation and Delivery Board was established in September 2016 to maximise the clinical, operational and financial effectiveness of the Manchester urgent health and care system, including its interface with neighbouring economies, in particular Trafford. Key functions of the Board are to:

- Develop and implement urgent care strategies for the city to support delivery of Government policy including the urgent and emergency care review and the A&E improvement plan
- Be responsible for the delivery of the urgent care transformation programme within the Manchester Locality Plan
- Ensure the effective implementation of existing urgent care work programmes, particularly Urgent Care First Response
- Develop innovative commissioning and provider models for urgent care
- Ensure consistent standards in urgent care services across the city
- Ensure sharing of best practice
- Act as a citywide A&E Delivery Board for when action should be taken at city rather than locality level.

8. Conclusion

8.1. The urgent care system and in particular delays in safe and effective transfers of care is a significant area of challenge both across Manchester and Greater Manchester as well as nationally.

8.2. Partners within Manchester's health and social care system are working together to provide system changes to bring about sustainable changes.

8.3. These changes are in line with national standards, measurable and have performance indicators that include a focus on individuals, their families and the quality of their care.

8.4. Once improvements are identified and maintained the health and social care system in Manchester will have to identify how these changes can be sustained going forward and within the system's financial constraints.

8.5. The members of Health Scrutiny are asked to note the content of this paper.

[3] Report to Health Scrutiny 'Manchester Urgent Care System' provided on 2nd February 2017