Avon and Wiltshire Mental Health Partnership NHS Trust

Trust board meeting Appendix to the Quality & Standards Committee Chair report to Board	Date:	27 September 2017

Agenda item	Title	Executive Director lead and presenter	Report author
BD/17/136	**Delayed Transfers of Care**	**Mathew Page**	**Kate Webb**

This report is for:	
Decision	
Discussion	X
To Note	X

History

Nil

The following impacts have been identified and assessed within this report	
Equality	X
Quality	X
Privacy	X

Executive summary of key issues

Delayed Transfers of Care (DToC) is a system wide issue and AWP plays a critical part in reducing the number of cases. This paper outlines all of the work undertaken by the Trust to reduce the level of DToCs.

Over the last few months, we have witnessed an increase in the number of DToCs in some of the Localities; the increase has been more acute in Bristol, Swindon and Wiltshire. A focus on this area from the work that the Trust has undertaken is resulting in a reduction in the level of DToCs and this appears to be on a downward trajectory. The Trust is, however, also dependent on its partners in achieving this target.

The data available for DToCs (explored in section 2.6) identifies that there has been a notable increase in non-healthcare DToC reasons over the past two years. The total for 2016/17 is 38% higher than 2015/16 and 85% higher than 2014/15. Whilst the Trust is working hard to ensure that internal processes are being adhered to, this will only have a limited impact on the level of DToCs. Further work is required with system partners to address this issue.

A programme of work is being instigated by Bristol, North Somerset and South Gloucestershire (BNSSG) Clinical Commissioning Groups (CCGs) to address DToCs. The Trust will play a key part in this work and is keen for this to progress so that system wide action is taken, which should result in a lower level of DToCs, ultimately leading to achievement of the regional control targets. The Operations Directorate were well represented at the first meeting of the BNSSG Mental Health Enabling Discharge Group, which took place 7th September 17.

This paper provides the definition of a DToC and how these are measured following the recent changes in April 2017. The impact that delayed transfers can have on patients, families, beds and finance is explored. The Trust's performance for DToCs is provided and set in the context of other providers' performance for BNSSG.

The paper captures the work undertaken to date to improve DToC performance and the future work planned through internal means and engagement with the BNSSG CCGs programme of work.

This report addresses these strategic priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X
We will use our resources wisely	X
We will be future focussed	X

1 Introduction

This paper provides detail of the actions taken by AWP in respect of reducing Delayed Transfer of Care (DToC). It also provides an overview of further work planned with partners.

2 Definition of Delayed Transfer Of Care (DToC)

2.1 What is a DToC?

The NHS England definition of a delayed transfer is:
A 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) A clinical decision has been made that patient is ready for transfer; **AND**
b) A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
c) The patient is safe to discharge/transfer.

A multi-disciplinary team (MDT) in this context should be made up of people from different professions, including social workers where appropriate, with the skills and expertise to address the patient's on-going health and social care needs. If there is any concern that a delay has been caused by the actions or inactions of a Local Authority, they should be represented in the MDT. The way that the team is organised and functions is fundamental to timely discharge and to the patient's wellbeing.

2.2 How are DToCs measured?

The report "Improving acute inpatient psychiatric care for adults in England" published in February 2016 recommended that the collection, quality and use of data should be radically improved so it can be used to improve services and efficiency, ensure evidence-based care is delivered and improve accountability. As part of this recommendation, DToC data was determined as not being fit for purpose for mental health and a review of the DToC data needed to take place.

As a result, NHS England has made changes to:

- Mental Health Delayed Discharge Reason code list values; and
- Mental Health Delayed Discharge Attributable To Indication Code list.

As of April 2017, data on the number of patients delayed on the last Thursday of the month is no longer being collected. This measure has been replaced in the Delayed Transfers of Care publication files by a similar measure called DToC beds.

When Trusts submit monthly DToC returns they include the number of days delayed within the month for ALL patients delayed throughout the month, by attribution (NHS, Social Care, Both) and by Reason Code. This figure is then divided by the number of calendar days in the month to work out the DToC bed days per day (the daily delays).

This provides a similar figure to the patient snapshot, but is more representative of the entire month rather than providing a view on one particular day.

Regional control totals have been set based on a local improvement trajectory setting methodology. The target for the BNSSG area is to reduce the DToC rate to 4.5% by September 2017 and 3.5% by March 2018.

2.3 Impact of DToCs on patients, families, bed usage and finance

Though often seen to be an issue primarily for acute physical health care, DToCs are a widespread and significant problem in mental health settings and for those experiencing mental health problems.

There is much common ground between the analysis of factors contributing to delayed transfers of care in acute and mental health settings. However, there are specific challenges that face mental health service users due to their individual circumstances and characteristics.

Service users can be homeless, live alone, have no recourse to public funds, or be part of a mobile or migrant community. Alongside this they will often suffer complicating factors or comorbidities in terms of physical health problems. Additionally, drug and alcohol misuse or behaviours can also extend the length of stay due to perceived risk of discharging or having the appropriate setting to which to discharge.

Impact on patients & families

Safely home: What happens when people leave hospital and care settings? Published by Healthwatch England in July 2015 included a review of the impact on people with mental health conditions. Their findings concluded:

1) Patients are experiencing delays and a lack of coordination between different services - a significant number of people are being kept in a mental health setting longer than necessary due to delays arranging their aftercare, housing and support. Delays are usually caused by the inability of care coordinators or social workers to secure funding and commitment for ongoing support in the community.
2) Patients are feeling left without the services and support they need after discharge – patients were stating that the first couple of days after discharge were the most important for building confidence, routines and networks for everyday life. However, many described their return to the community as isolating, distressing and disorientating, lacking the continuity of care that would enable them to manage their condition. In many cases, this leads to a readmission shortly after discharge.
3) Patients feel they are not involved in decisions about their care or given the information they need – patients involved in discussion about their condition and care plans fed back that they found the conversations confusing. Family members said that they had not been properly informed about their relatives' conditions or consulted about the level of support they could provide for them.
4) Patients feel their full range of needs is not considered – People expressed their frustration that their full range of needs including their physical and mental health, housing, care responsibilities and financial situation were not all taken into consideration at point of discharge.

5) Patients have intensified feelings of isolation - delaying their discharge had increased the risk of further institutionalisation. An unexpected delay can knock already fragile confidence and build unnecessary dependency on routines and practices used within the setting, like medication or restricted use of space.
6) Patients kept in hospital longer than required can have a number of detrimental effects – Long stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections. A recent study of healthy older adults showed that 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life. Other studies have found a faster reduction in muscle strength of as much as 5% per day. Effects on mobility can be particularly felt by older patients. One study found that 12% of patients aged 70 and over saw a decline in their ability to undertake key daily activities (bathing, dressing, eating, moving around and toileting) between admission and discharge from hospital, and the extent of decline increased with age.

Impact on beds

DToCs can affect the flow of patients through a hospital. Between 1987/88 and 2016/17, the average daily number of available hospital beds has reduced by 56% to 130,000. The largest reduction in bed numbers has been in specialist beds for people with learning disabilities, mental illness and for longer-term geriatric care.

When beds are at capacity and delays are suffered, there is nowhere for new admissions to go resulting in costly out of trust placements. At the end of quarter one, out of trust bed usage had cost the Trust £1m. It also means that patients who are unwell and in desperate need of care are placed in a hospital in an unfamiliar area usually not close to home. The support network of family and friends is not close by yet they are instrumental to recovery.

Impact on finance

In 2016/17 there were 2.3 million delayed transfer days in England, an average of around 6,200 per day with around 3,600 of these attributable to the NHS. The average number of delayed days for 2016/17 was 25% higher than the previous year. NHS providers' audited accounts for 2016/17 estimated that delayed transfers of care cost NHS providers £173 million, up 19% from 2015/16 estimate of £145 million. These are the figures quoted in the House of Commons Library Briefing Paper 'Delayed Transfer of Care in the NHS' June 2017.

An estimated one in 20 bed days are used by people experiencing a delayed discharge in a mental health setting. This means that over 6,000 patients per year remain in hospital longer than is clinically necessary. Healthwatch estimated that every additional day that these patients spend in hospital costs the NHS in excess of £2m a year.

2.4 AWP DToC days for Bristol, North Somerset (BNSSG) and BANES, Swindon & Wiltshire Unitary Authority

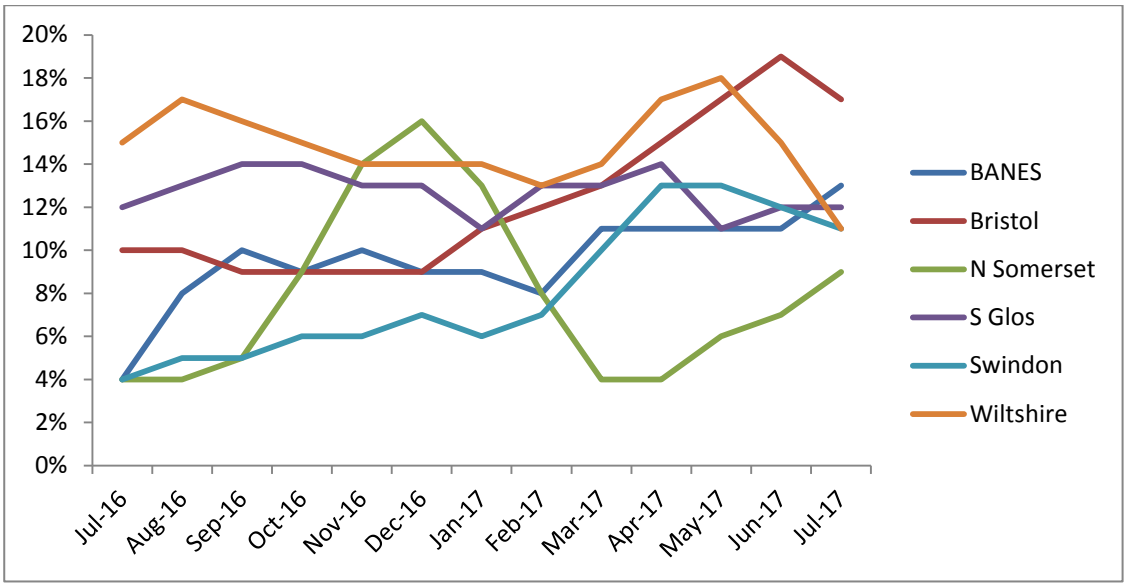
The 2016/17 DToC data below shows the split of DToC days for BNSSG and BSW Unitary Authorities.

	NHS Bed Days	**%**
Bristol		
AWP	849	19%
North Bristol NHS Trust	1,931	44%
University Hospitals Bristol NHS Foundation Trust	1,624	37%
Weston Area Health NHS Trust	13	0%
Royal United Hospitals Bath NHS Foundation Trust	2	0%

North Somerset		
AWP	69	2%
North Bristol NHS Trust	983	21%
University Hospitals Bristol NHS Foundation Trust	493	10%
Weston Area Health NHS Trust	3,182	67%
South Gloucestershire		
AWP	890	22%
North Bristol NHS Trust	2,453	61%
University Hospitals Bristol NHS Foundation Trust	383	9%
Royal United Hospitals Bath NHS Foundation Trust	227	6%
Other	101	2%

2.5 AWP more detailed breakdown by Locality

The chart below shows DToC performance over the last 12 months for each Locality.



Each locality has usually been in excess of the 7.5% target. Some localities have had a more consistent level of DToCs but at the beginning of the new financial year, levels of DToC started to increase across most areas. The latest information is showing a slight reduction in DToCs in most localities and overall the Trust has seen DToCs reduce month on month for the last three months.

2.6 Causes of DToCs

In the PowerPoint document from NHS England entitled 'Reducing Transfers of Care - A regional approach to setting improvement trajectories', March 2017 DToC data showed the following:

Total Delayed Days	Number of days in the month	Daily delayed days / day	Daily blocked beds
199,260	31	6,428	**6,428**

NHS attributable	Both	Social Care attributable	Average daily delays

3,357	506	2,366	**6,428**

Acute Delays	Non-acute delays	Average daily delays
4,279	2,149	**6,428**

From the March 2017 data, the top 3 reasons for delay were as follows:

1) Delay due to awaiting care package in own home (Code E)
2) Delay awaiting further (non-acute) NHS care (Code C) Only NHS attributable.
3) Awaiting completion of assessment (Code A).

This is consistent with the total delayed days by reason for 2016/17:

Reason	Delayed Days	Proportion of total delays
Awaiting care package in own home	456,447	20.3%
Awaiting further non-acute NHS care	386,028	17.1%
Awaiting completion of assessment	380,832	16.9%
Awaiting nursing home placement or availability	342,982	15.2%
Patient or family choice	245,033	10.9%
Awaiting residential home placement or availability	231,994	10.3%
Awaiting public funding	81,327	3.6%
Housing	52,431	2.3%
Awaiting community equipment and adaptations	52,121	2.3%
Disputes	24,641	1.1%

Source: Delayed Transfers of Care Statistics for England 2016/17 Annual Report.

From a review of the most recent AWP data for the period 30 May to 29 August 2017, there was a total of 3,696 DToC days. The reasons for the delays were as follows:

DToC Reason	Total of DToC days
Awaiting nursing home placement	1,197
Awaiting residential home placement	1,085
Awaiting completion of assessment	456
Awaiting further (non acute) NHS care	224
Housing-clients not covered by NHS & CCA	191
Awaiting care package in own home	154
Client or family choice	153
Disputes	125
Awaiting public funding	111
Total	**3,696**

In 2016/17, the daily average number of delayed transfers of care attributable to social care only or both NHS and social care per 100,000 population (aged 18 and over) was 6.3, which compares to 4.6 in 2015/16.

The number of delayed days attributable to social care had been in decline until August 2013, after which the figure began to rise sharply. When looking at the specific reasons for delayed transfers of care, notable increases in non-healthcare reasons over the past two years can be identified. The total for 2016/17 is 38% higher than for 2015/16, and 85% higher than 2014/15 according to the House of Commons Briefing paper 'Delayed Transfer of Care in the NHS', June 2017.

Although much of the recent rise in the number of delayed transfers can be attributed to social care, the majority of delayed transfers overall for 2016/17 were attributable solely to the NHS. However, the proportion of NHS only delays has decreased throughout the year. In quarter 4 of 2015/16, 61.1% of all delays were attributable to the NHS, which decreased to 55.8% in quarter 4 of 2016/17.

3 Action taken by AWP to date

3.1 Acute Care Pathway (ACP)

The Acute Care Pathway was established to deliver an improved flow and efficiency of acute services across the Trust in partnership with Clinical Commissioning Groups (CCGs). Related programmes of work within the ACP programme also aimed to improve flow and minimise DToC. These included:

- Implementation of Patient Flow Huddle meeting (previously known as SAFER Patient Flow Bundle)
- Reduce patients identified as DToC by having an intended date of discharge identified on admission
- Revisions to operational processes for patient flow by Operations Team
- Implementation of 15 day standards for admission
- Implementation of the Choice Protocol

3.2 Discharge Countdown Tool

As part of the advice provided by Meridian Productivity to achieve consistent discharge management and assist in the reduction of length of stay, the Discharge Countdown Tool was introduced across the Trust. This tool is a spreadsheet which contains brief details to identify all patients on the ward and the 14 barriers to discharge for each patient. This tool is designed to support the effective running of the Patient Flow Huddle meeting.

Compliance with the Discharge Countdown Tool was tested in a recent DToC Internal Audit and variation in the completion of this tool by wards was identified. As a result, since 14 August 2017, the bed management service has been undertaking a weekly audit of the discharge countdown tool to ensure the 9am Patient Flow Huddle meetings are being held daily (twice weekly for rehabilitation and dementia wards) and the Discharge Countdown Tool is being updated at each meeting.

The results are circulated to Localities and are discussed as part of the Operations Directorate Overview Meeting which takes place every Monday morning. Non-compliance is discussed at this call and improvement is expected from those wards that are non-compliant.

3.3 DToC Task & Finish Group

A DToC Task & Finish Group was established, to manage DToC from a Trust wide perspective. The group has representation from the Trust Operations Directorate, Localities, CCGs and Local Authorities. This group meets on a monthly basis and to date has contributed to:

- The production of a Trust wide Standard Operating Procedure for DToCs;
- improved the DToC report which was generated to be reviewed at meetings;
- reviewed the NHSI DToC coding list which is in the process of being updated on Rio;

- Pressed for the implementation of the Choice Protocol across the Trust which is now in place.

The Task & Finish Group is now in the process of reviewing its terms of reference to ensure that the Group remains fit for purpose.

3.4 DToC Standard Operating Procedure (SOP)

As stated above, the DToC Task & Finish Group was created to focus resources on reducing these high levels of DToCs by improving the management of these cases. A number of issues were identified which if resolved could lead to a reduction in the number of DToC cases. The cause of many of these issues was determined to be an inconsistent approach to DToC across localities or ambiguity of the process to be followed.

A SOP was designed to provide clear operational guidance around DToC, to ensure a consistent Trust-wide approach towards the categorisation and management of DToC cases both internally and when dealing with external stakeholders and partners such as Local Authorities and CCGs.

3.5 Operations Directorate Senior Management Team

The DToC position is sent to all Localities on a Monday morning and a review of the report is undertaken with a focus on those cases that are nearing the 4 week escalation point. Any issues that need to be discussed with respect to DToCs are addressed at the Operations Directorate Senior Management Team call where DToC is a standing agenda item.

In addition, any DToC case must be escalated if they cannot be resolved before the 4 week escalation point. Localities are required to complete a DToC escalation template so that a letter to the relevant partner can be produced and sent from the Chief Operating Officer.

The Operations Directorate are reviewing the DToCs that are close to escalation and are working with Localities to ensure that escalations are taking place and at the appropriate time.

3.6 Internal Audit Review

Internal Audit recently undertook a review of DToCs. In their report, they raised two exceptions:

- Completion of the discharge countdown tool – as alluded to above, inconsistencies were found in the way this tool was being completed and stored. The recommendation was for monthly audits to be conducted on the completion of the tool to ensure compliance by wards. As specified earlier, weekly audits are being undertaken to review compliance.
- Escalation of DToCs – a number of exceptions were identified where DToC cases exceeding 4 weeks after the delay start date had not been escalated. A process has been put in place to address compliance and performance has improved in this area.

3.7 Review undertaken by SSG Health

SSG Health were asked to provide assistance in this area using their expertise to help highlight further action that could be taken to lower the level of DToCs. In conjunction with the Operations Directorate, SSG Health met with the Bristol Locality to understand the local DToC process. A number of areas were identified that could be pursued with local partners, these were:

- **Adherence to response times** - Allocation of a social worker to the case (within 48 hours of referral) and assessment under the Care Act by a social worker (five working days) is not always adhered to. SSG proposed that if a social worker is not

allocated within the prescribed time frame then AWP should have the latitude to complete the assessment and write the support plan either by means on a member of nursing staff specially trained to undertake Care Act assessment (as is the case in BANES) or by means of an agency social worker. The cost associated with this should be picked up by the local authority.

- **Visibility of the support plan** – AWP do not have visibility of the support plan produced as a result of the Care Act Assessment. If the assessment has missed any important factors in relation to matching a support package to the service users' needs, this may not come to light until the Provider Assurance Assessment takes place. A delay could ensue whilst the support plan is rewritten. SSG proposed AWP should have visibility of the draft support plan for review to ensure that no factors affecting support needs have been overlooked. They also proposed that AWP should have read only access to the Dynamic Purchasing System (DPS) in order to see that the support package reflected is congruent with the needs of the service user to enable them to anticipate the next steps in the process.
- **Support package approval** – Senior Manager approval within the Local Authority is required for the support package to be tendered on DPS. Once a Provider registers interest and undertakes an assessment, then the resulting Care Options Appraisal will also require approval. There is no agreed response time for making these approvals. SSG recommend that the approvals process should be subject to further analysis and discussion between system partners to see if it is possible to streamline the process.
- **Brokerage** – The support package is tendered on DPS so that providers can bid. Often no providers bid but no feedback is received as to why a provider decided not to tender. It is therefore not possible to understand whether there is a support plan mismatch, whether the provider is cherry-picking cases or whether there is a genuine commissioning gap. Additionally, staff have indicated that providers tender to provide a package of care, but do not have that capacity immediately available, wittingly or unwittingly creating a pipeline of work perhaps even denying other providers the opportunity who have capacity available much earlier.
  We understand that there are no agreed response times for any of the stages after the provider responds to a specification on DPS. SSG recommends that those parts of the process that do not currently have an agreed service standard should be reviewed so that this is in place. Feedback should be sought from providers as to why they have not tendered for a placement to help identify commissioning gaps. SSG also recommend that a system level discussion needs to be facilitated on how to adjust the market dynamic and implementing measures to penalise providers for rejecting service users without giving a reason, missed response times, cherry picking cases, accepting cases before a place is available and therefore any resulting delays should receive a fine.

3.8 Research into those Trusts that have successfully reduced DToCs

A review has been undertaken of other mental health Trusts to understand their levels of DToC and where the levels of DToC are low, to understand what action has been taken to achieve this level of performance.

One of the initiatives identified involved social workers operating a 7 day a week service where the team provide ward based named social worker with a duty social worker out of hours. These social workers have commissioning authority and can purchase care packages at weekends thereby facilitating smooth discharge out of hospital in a timely manner. Nominated social workers are authorised to make out of panel decisions so they can enable 'discharge to assess' – these are then ratified by the next CCG panel but again, prevents further delay as decision making is quick.

This intelligence can be fed into the action planned by BNSSG CCG. Further information on this can be found in section 5.1.

The Trust is pursuing a number of the other initiatives identified such as:

- Red and Green bed days - a visual management system to assist in the identification of wasted time in a patient's journey;
- Theme days where there is a focus on specific areas depending on the day of the week; and
- Discharge Facilitators.

4 What next?

4.1 Action planned by BNSSG CCGs

Whilst there is some additional action that the Trust can take to ensure that all internal processes are being adhered to, the most recent AWP data shows that the top 3 DToC reasons were awaiting nursing home placement, awaiting residential home placement and completion of assessments; all of which are outside of the Trust's control.

It is therefore timely that the BNSSG CCG's are implementing a programme of work called, 'Mental Health Inpatient Care Pathway Review – Reduction in Out of Area Placements (OAP)', which will involve the Local Authority to address the issues of DToC and Out of Area Placements. The Trust will be a key member of the Programme Board and Project Teams for this work.
The project aim is to:

- Reduce OAPs for BNSSG patients requiring out of area mental health inpatient beds to zero by March 2018; and
- Reduce DToCs in all mental health beds in BNSSG services to 3.5% or below by March 2018 following nationally agreed trajectories of overall DToCs in 2017/18.

This programme is being put in place to create a joint delivery plan to address high levels of mental health OAPs and DToCs in BNSSG in the first instance, but which is also broadly applicable across the whole AWP footprint including Bath, Swindon and Wiltshire. This will require the active involvement of AWP, CCG commissioners and each of the respective Local Authorities.

BNSSG's target of 4.5% by September 2017 and by 3.5 % by March 2018 is underpinned by the Improved Better Care Fund process and related guidance.

The CCG has outlined three areas that needs to be implemented working closely with all stakeholders to achieve the target of 3.5% or below by March 2018. These are:

- **Corporate level** – working on improved checking, pathway monitoring/reporting and operational coding.
- **BNSSG/STP level** – working across services to ensure we have the right processes in place for managing DToCs, identifying the blockers and addressing these.
- **Individual patients** – working on the current high levels of DToC patients to move them as quickly as possible from the ward to the next step in their care pathway.

There are a number of working groups that are going to be put in place. These are as follows:

BNSSG MH Enabling Discharge Working Group - This will be a short term working group that will focus on achieving good discharge processes by looking at and implementing aspects of the Enabling Discharge work, principles and good practice to address the specific issues within mental health including:

- Improved pathway development;
- Improved monitoring data for DToCs;
- Integrated Discharge Hubs/Services;
- Effective management of expectations (user, carer and professional);

- The implementation of operational standards and a data driven approach to improving flow.

Data collection and coding task and finish group - This group will seek to clarify, identify and agree cross-provider discharge timescales along flow pathways for mental health inpatients, apply coding, set up weekly coding reporting and monitor implementation.

Discharge to Assess working group - This will scope the value of setting up a mental health Discharge to Assess approach across BNSSG.

Developing the Market Working group - This group will address some of the longer standing issues affecting the supply of care outside hospital, notably for those people with complex needs or dementia that that brokerage teams find difficult to secure care for.

DTOC Call - This is a twice weekly DToC call, where representatives from the localities are joined by the CCG and Local Authority to review all current DToC cases.