Health and Adult Social Care Overview and Scrutiny Committee

20th November 2017

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Delayed Transfers of Care (DTOC)

Behind each number is a personal story…

The Last 1000 day Video

When is a delay a delay?

"…and then he can go onto the DToC list …"

- **M**edically **F**it **F**or **D**ischarge
- MDT agreement
- Safe to transfer

- A delayed transfer of care occurs when a patient is Still in hospital beyond agreed date.

Monthly Reporting

Number of days delayed in the month attributed to:

- Social Care
- NHS Care
- Joint

There are 9 categories for a delay

Delay Codes

- A – Awaiting assessment
- B – Awaiting Funding
- C – Awaiting further non acute NHS care incl. CHC
- D – Awaiting placement in Residential or Nursing home short or long term
- E – Awaiting home based care short or long term
- F – Equipment
- G – Family/Choice
- H – Dispute between agencies
- I – Housing, only if no social care needs

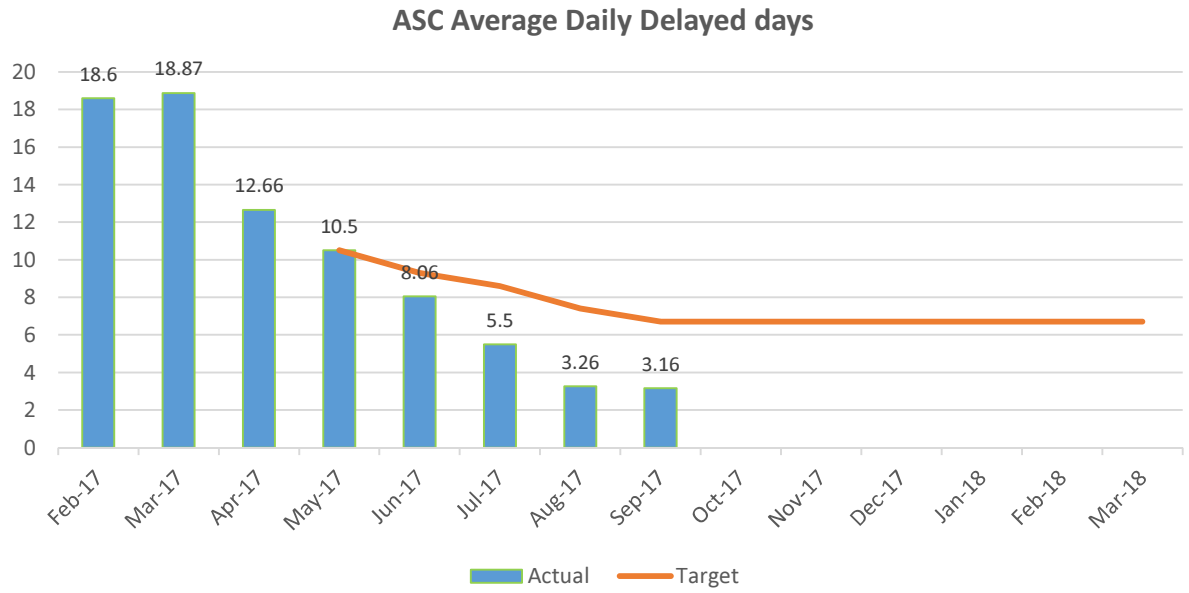
Shropshire Performance

Shropshire partners across health and social care have agreed to:

- Avoid situations where people are put at risk by remaining in the acute sector when they no longer need acute care
- Reinforced partnership working (MDT hubs each day)
- Better discharge planning – proactive instead of reactive
- System of notification is now common practice in terms of communicating across the system.

Shropshire Council

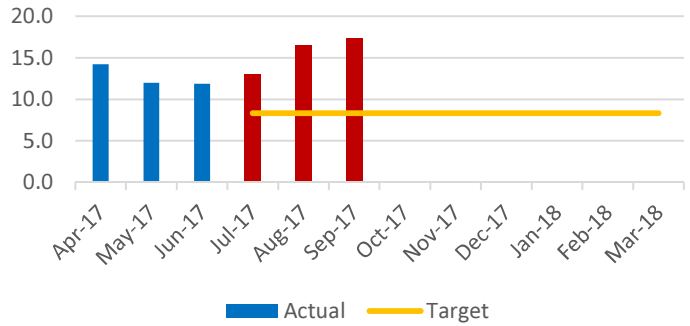
The new targets to reduce bed delays in Shropshire attributed to Adult Social Care required a 60% improvement. This is based on the Feb – April 2017 baseline figures. There has been a 75% reduction between the April 2017 result and the September 2017 result.



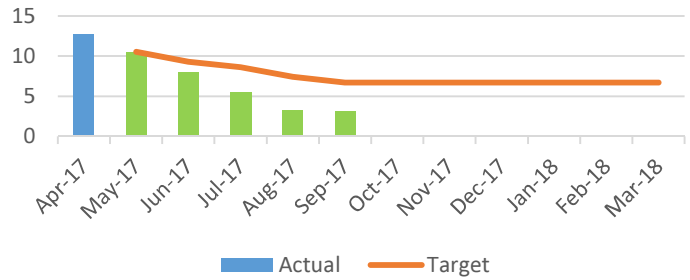
Calculated using number of delayed days in month attributable to Social Care divided by the number of days in the calendar month.

Better Care Fund (BCF) Performance

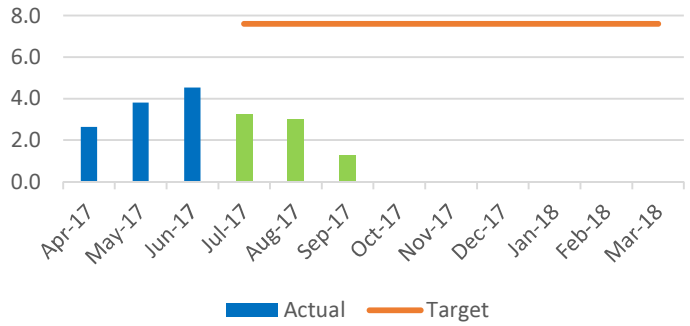
BCF Delayed Days - NHS



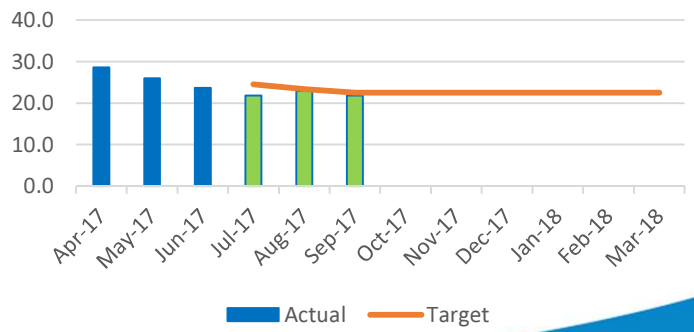
ASC Delayed Transfers - average per day



BCF Delayed Days - Joint



BCF Delayed Days - All



Improving Performance
Actions to achieve a reduction in NHS delayed transfers of care

Daily monitoring across organisations ensuring reporting accuracy, scrutiny and application of the national DTOC guidelines to all reported delayed transfers of care.

Enhance Community Hospital admission criteria and services to support specific cohorts of patients who could access non acute NHS care within the available community hospital capacity

Monitor and report the impact of delays attributable to specialist neurological rehabilitation, commissioned by NHS England. Implementation by NHS E to recruit a Specialist Practitioner to review demand and capacity requirements and improve flow and discharges within the specialist setting aiming to reduce delayed transfers of care to within current commissioned resources.

Agreed formal processes with complex care to ensure prioritisation of acute hospital referrals.

Newly Commissioned complex care Nursing Home beds and domiciliary care providers for fully NHS funded patients will expedite discharge from hospital settings.

Prioritisation of hospital referrals to expedite equipment requests.

How do we monitor DTOC performance in Shropshire

Daily Local Monitoring Sheet

HOSPITAL	DELAY	01/11/2017	02/11/2017	03/11/2017	04/11/2017	05/11/2017	06/11/2017	07/11/2017	08/11/2017	09/11/2017	10/11/2017	11/11/2017	12/11/2017	13/11/2017	14/11/2017	15/11/2017	16/11/2017	17/11/2017	18/11/2017	19/11/2017	20/11/2017	21/11/2017	22/11/2017	23/11/2017	24/11/2017	25/11/2017	26/11/2017	27/11/2017	28/11/2017	29/11/2017	30/11/2017	
PRH	SOCIAL CARE	0	0	0	0	0	0	0	0																						
PRH	JOINT	0	0	0	0	0	1	0	0																						
RSH	SOCIAL CARE	1	0	0	0	0	0	0	0																						
RSH	JOINT	0	0	0	0	0	0	0	0																						
COMMUNITY TRUST	SOCIAL CARE	0	0	0			0	0	0																						
COMMUNITY TRUST	JOINT	0	0	0			0	0	0																						
RJAH	SOCIAL CARE	0	0	0			0	0	0																						
RJAH	JOINT	1	1	1			0	0	0																						
OOC	SOCIAL CARE	0	0	0			0	0	0																						
OOC	JOINT	0	0	0			0	0	0																						
REDWOODS	SOCIAL CARE	0	0	0			0	0	0																						
REDWOODS	JOINT	0	0	0			0	0	0																						
																															NOV Total
TOTAL	SOCIAL CARE	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
DAILY TARGET ASC		7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	7.4	
DAILY RAG ASC		1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	JOINT	1	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
DAILY TARGET JOINT		7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	7.6	
DAILY RAG JOINT		1	1	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4

SaTH FFA to discharge Week Commencing 30/10/2017 - Summary

Start	**30/10/2017**
End	**05/11/2017**

FFA Breakdown	
Total Logged	34
Not Proceeded	2
Change of Pathway	0
Family/Client	0
Remaining	**32**

Referrals to Care	
Care within 48 hr	26
Care outside 48 hr	6
Total	**32**

Rate of 48 hr target met	
Excluding health	*89.66%*
Overall	**81.25%**

	Delays Breakdown	
Health	NMFFD	3
Health	Medication	0
Health	Equipment	0
Health	Transport	0
ASC	Not Sourced	0
ASC	Provider	3
	Total	**6**

Ward Summary for Health Delays

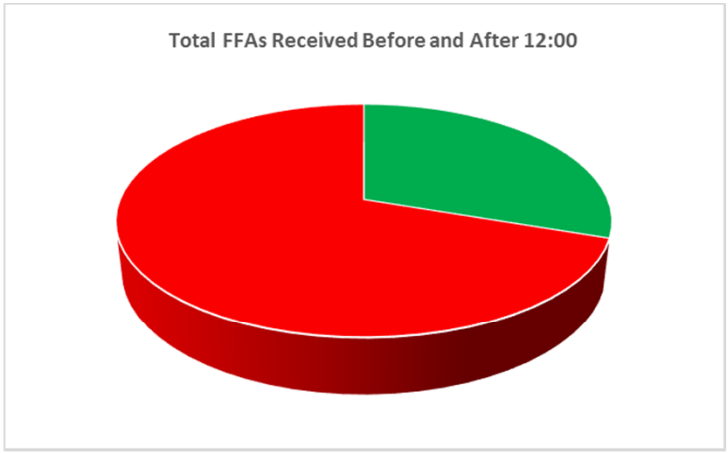
PRH	*Ward No*	**3**	**4**	**7**	**8**	**9**	**10**	**11**	**15**	**16**	**17**	**OTR**
PRH	NMFFD											
PRH	Medication											
PRH	Equipment											
PRH	Transport											
RSH	*Ward No*	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**32**	**33**	**OTR**
RSH	NMFFD			***1***				***1***	***1***			
RSH	Medication											
RSH	Equipment											
RSH	Transport											
Total	***3***											

**OTR covers other wards including AMU, CDU, CCU etc.*

FFAs Received into Adult Social Care (ICS) from October 2017

Target of 60% to be received by 12:00

		FFAs Received by Timeband						
Week Start	Week End	Before 12:00	Between 12:00 and 14:00	After 14:00	Total FFAs Received	% Received Before 12:00	% Target Received By 12:00	
02/10/2017	08/10/2017	13	9	21	43	30%	60%	
09/10/2017	15/10/2017	13	7	13	33	39%	60%	
16/10/2017	22/10/2017	17	13	16	46	37%	60%	
23/10/2017	29/10/2017	7	16	12	35	20%	60%	
30/10/2017	05/11/2017	26	12	16	54	48%	60%	
		76	**57**	**78**	**211**	**36%**	**60%**	



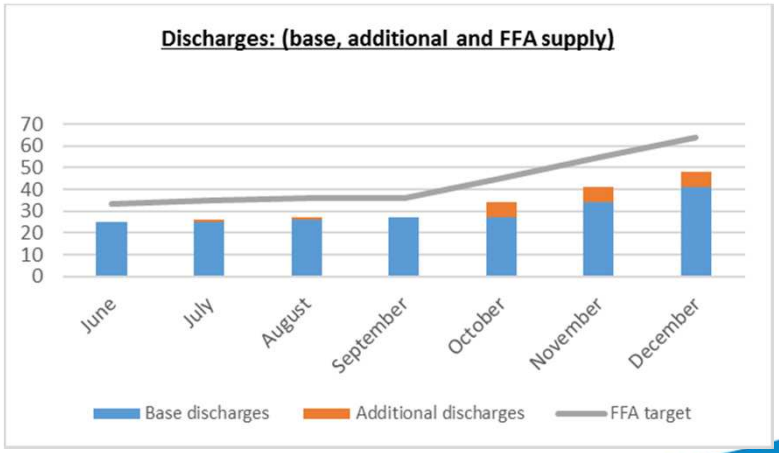
Hospital Discharge Target and Trajectory

SaTH Discharges

		Planned Discharges				Actual Discharges			Target		
Week Start	Week End	RSH	PRH	Total	RAG	RSH	PRH	Total	Total	Var	RAG
02/10/2017	08/10/2017	31	5	36		27	5	32	34	-2	
09/10/2017	15/10/2017	28	3	31		26	3	29	34	-5	
16/10/2017	22/10/2017	28	8	36		26	8	34	34	0	
23/10/2017	29/10/2017	23	11	34		17	7	24	34	-10	
30/10/2017	05/11/2017	38	12	50		33	8	41	41	0	
		148	**39**	**187**		**129**	**31**	**160**	**177**		

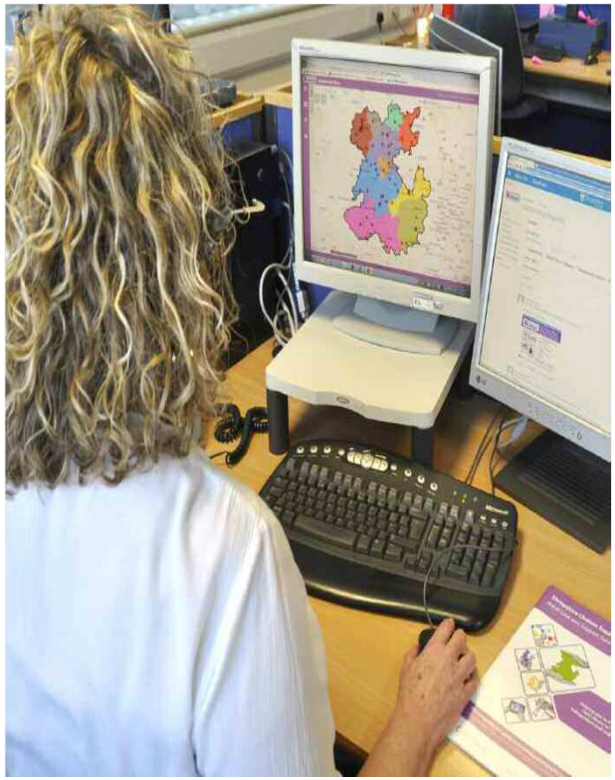
SaTH all pathways trajectory and FFA feed

	Baseline Ave Per Week	Additional Average Per Week	Average Per Week Total	Average Weekly FFAs Needed to Support Discharge Trajectory	Average Weekly FFAs Received
June	25	0	25	33	36
July	25	1	26	35	38
August	26	1	27	36	35
September	27	0	27	36	34
October	27	7	34	45	40
November	34	7	41	55	
December	41	7	48	64	



Brokerage

The brokerage team ensure that the council are able to expediently and fairly source providers for our domiciliary care package requirements.



All dom care packages are brokered in the same way

New requests into brokerage are **published same day** – a total of 74 providers.

Alerts are sent directly to providers each day as and when new packages are published or changed

Rates are **monitored and renegotiated** where needed.

In most cases, the package **requests are open to all providers** which means that the **opportunities for expansion and business development** are at their finger tips.

Reablement - Preferred Providers

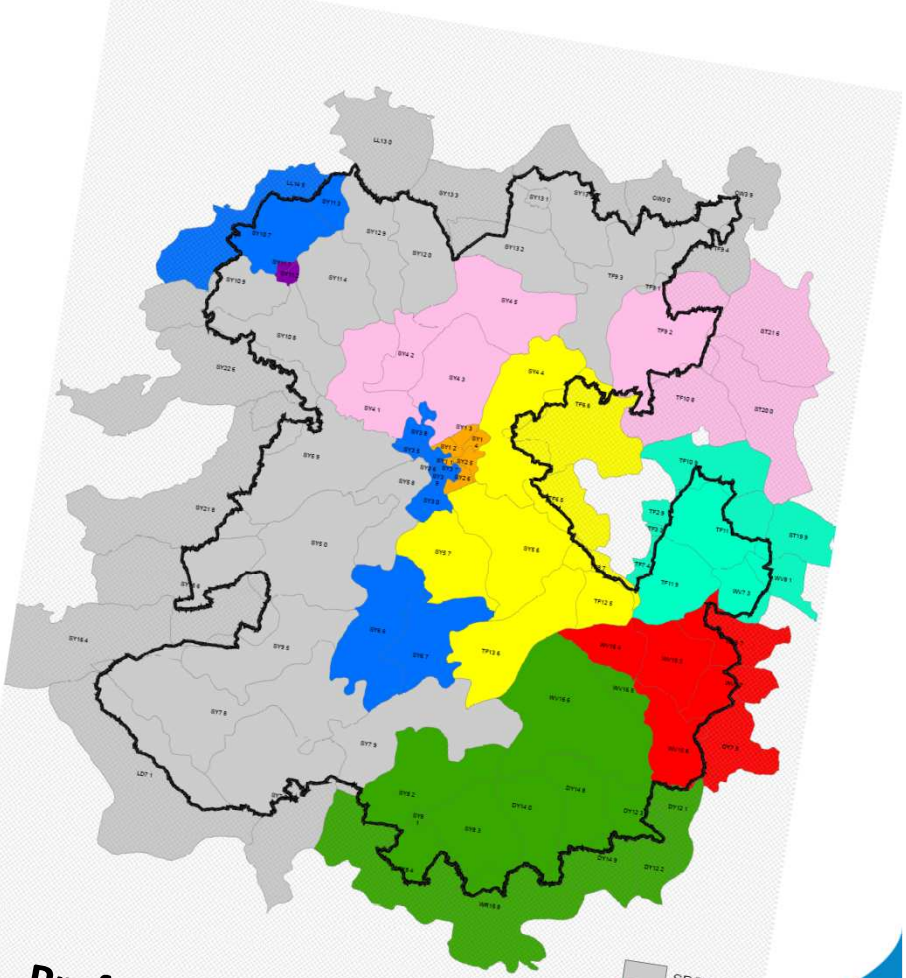
Some services we broker need a specific approach; for reablement we have a **'Preferred Provider**' model.

* Reablement packages need to be procured within 2 hours and to be delivered by companies that understand reablement.

*Care providers had to bid to be a preferred provider for a certain postcode.

*We allocate these based on quality and price and take a careful look at how many packages each provider has so we don't have too much dependency on one company.

*The map shows the current providers. We will be tendering the unallocated areas in the near future.



Additional Improved Better Care Fund Grant

Additional IBCF Grant Background

- Spring 2017 Budget Government announcement

- Paid to Local Authority for purposes of:
  - Adult social care needs
  - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when ready
  - Ensuring the local social care provider market is supported
- Non recurring

Shropshire Additional IBCF Funding

Allocation

2017/18	2018/19	2019/20
£	£	£
5.976m	3.959m	1.967m

Hospital Discharge and Admission Avoidance Initiatives

Two Carers in a Car

- Provision of support during the night 10pm to 7am
- Pilot only in the Shrewsbury area (predominately SY1, SY2, SY3 some SY4 if local) so the service need and outcomes can be tested but if successful will expand to other market towns.
- Avoid hospital admission
- Avoid the need to move into a placement as night care is often the trigger for this and will enable hospital discharge to be timely.

Hospital Discharge Support Service

- Surecare and SLR care, operating a ‘Step Down bed in the community’
- 140 hours available as a block for direct access by ICS (70 in North West, 70 in the South, specific areas to be determined)
- To provide intense support to individuals in their own homes who may have otherwise required step down
- Care to be reduced over a short period of time and reviewed with allocated ICS worker using ‘Observation review’
- For care to be moved as a block once ongoing care needs have been identified

Discharge To Assess

- **What:** Trusted assessors complete assessment in the hospital setting
- Decisions about care and support needs made away from hospital
- Review within 48 hours of discharge
- Home First is the starting point for assessment

- **Why:** The Acute setting is not the best place to assess need
- To enable people to get home as soon as possible
- To reduce avoidable harm that can be caused by prolonged stays in hospital
- To reduce the number of people admitted to permanent care
- To maximise peoples capacity to live independently

CTFA Admission Avoidance

- Carer's Trust For All providing emergency only domiciliary care support for the out of hours period.
- Unplanned support available for urgent situations dealt with by ICS and EDT.
- Carers Trust 4 All have access to assistive technology to use in these situations and the pilot will test the use of this equipment in more urgent situations.

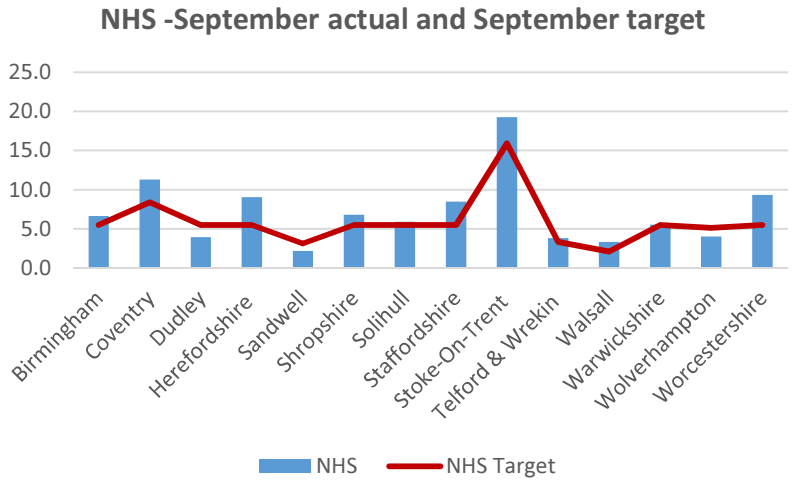
Step Down in Extra Care units

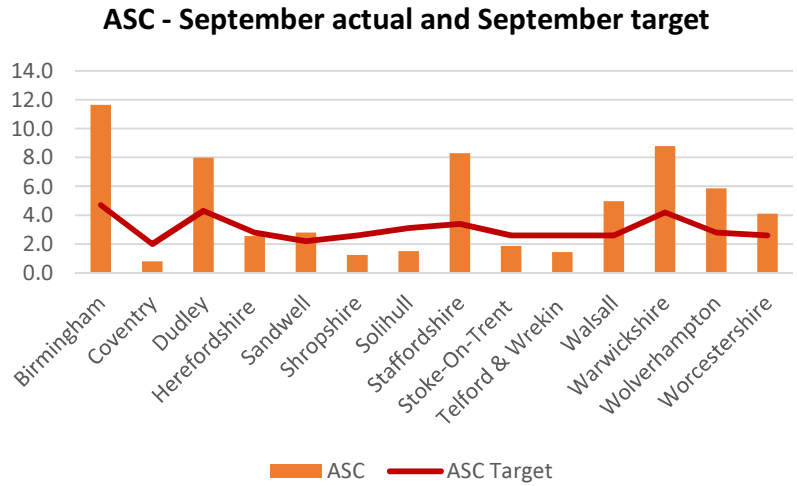
- 4 extra care units in Shrewsbury used as reablement support in the community following hospital admission for those individuals who are not ready to return home, but do not require the level of support offered by the residential step down beds.
- These properties can be used for individuals and their carers to move into together so that carers who have not previously had to provide care can do so in a supported environment, grow in confidence and enable them to return home and continue to provide informal care

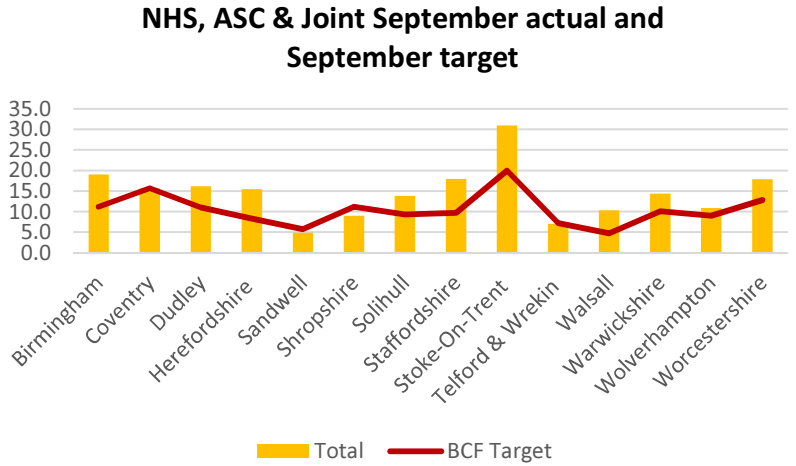
Frailty A&E Project

- A dedicated Frailty Team at Front Door actively working to support frail patients
- Social Care part of a truly integrated multi-disciplinary team
- Aims to reduce avoidable admissions
- Aim to reduce length of stay
- Ensuring rapid community support when the patient not admittied
- More appropriate and effective triage at front door which identifies right care, right place and treatment
- Aim to reduce conversion of A&E attendances to admission by 8% and readmission rates at 90 days by 7%

Regional Performance







- 3 NHS Trusts below target and 1 on target
- 6 Social Care authorities below target
- 4 authorities below the BCF target – Coventry, Sandwell, Shropshire and Telford

Meet the team

Shropshire Council

www.shropshire.gov.uk

Any questions?