Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Glen Garrod, Executive Director of Adult Care and Community Wellbeing	
Report to:	**Adults Scrutiny Committee**
Date:	**19 October 2016**
Subject:	**Adult Care Acute Delayed Transfers of Care - First Quarter 2016**

Summary:

This report highlights current delayed transfer of care for the first quarter of 2016 /17. There is an improving performance for Adult Care, but the system in ULHT continues to need further support to significantly improve performance particularly around the flow of people through the acute hospital. There are a number of actions highlighted which are intended to have short term and longer term impact on reducing delays.

Actions Required:

The Adults Scrutiny Committee is requested to consider and comment on the content of the report.

1. Background

The challenge in all acute hospitals is to improve the flow of people through the hospital, which is mainly impacted by the health professionals in the acute hospitals; working with Adult Care and community health. Best practice guidance has consistently stated over the past decade the following key steps and principles to enable appropriate discharges which include:

- Starting discharge and transfer planning before or on admission to hospital, to anticipate problems, to put appropriate support in place and agree expected discharge date.
- Involving patients and carers in all stages of the planning, providing good information and helping them to make care planning decisions and choices.
- Effective team working within and between health and social care services to manage all aspects of the discharge process, including assessments for social care, continuing health care and, where necessary assessments of mental capacity.
- Community-based health and social care practitioners should maintain contact with the person after they are discharged, and make sure the person knows how to contact them when they need to.

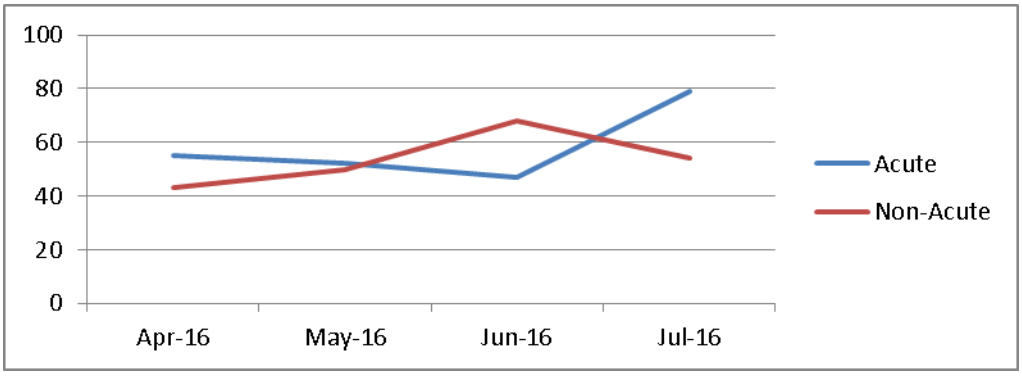
Guidelines published by the National Institute for Health and Care Excellence in December 2015, on transition from inpatient hospital settings for adults with social care needs; also recommend that a single health or social care professional should be responsible for co-ordinating a person's discharge.

In Lincolnshire the transitional care pathways (Appendix A) shared with Scrutiny Committee in the April 2016 report; identifies the current discharge pathways. Further documentation shared between health and social care details how, when and who takes responsibility for discharges as agreed by health and social care at the 'hubs' in all ULHT and Peterborough hospitals. This gives Health and Care clarity on the discharge arrangements and for Adult Care the transfer from hospital worker to area worker is managed on an individual basis.

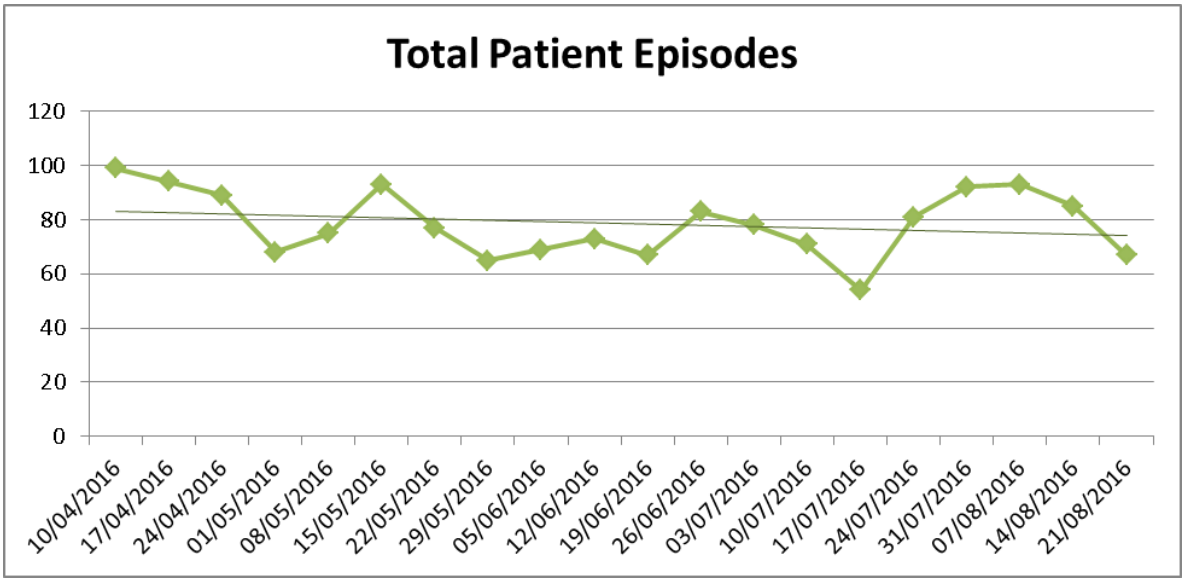
The predicted date of discharge (PDD) for each ULHT patient remains a challenge for the acute trust. Adult Care staff do attend ward board rounds daily, when they take place, to ascertain when a realistic PDD will be. It is the responsibility of the acute trust to inform the patients and their relatives of their PDD as they talk through why they remain in hospital and the plans for their diagnosis / treatment in the acute hospital.

Delayed Transfers of Care 2016 (DTOC)

The table below gives the nationally published figures for DTOC for Lincolnshire for the number of patient episodes delayed per month both the acute and non-acute discharges. Nationally Lincolnshire on this July data is ranked 116 out of 150, within the East Midlands Northants and Nottingham are ranked lower than Lincolnshire.

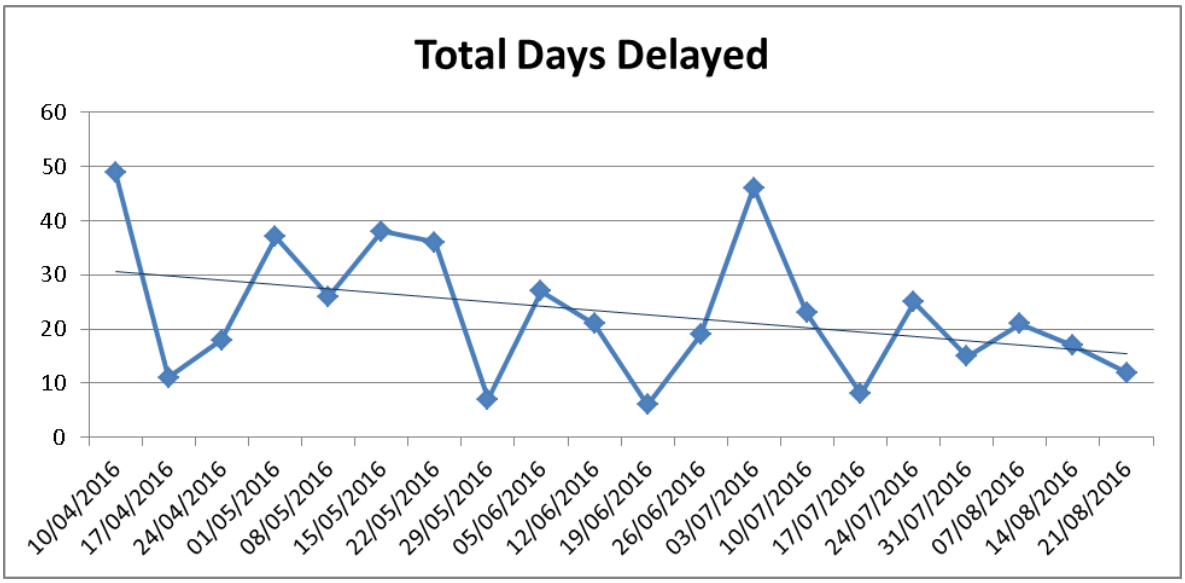


We monitor all United Lincolnshire Hospital NHS Trust (ULHT) delayed discharges within Adult Care ongoing; the current system performance is represented in the graph below. This does show the fluctuations caused by individuals with long delays. Importantly it also shows the downward trend in patient episodes.



The graph below shows the total days delayed due to Adult Care alone. Although this does fluctuate the trend is very definitely downward. Since 10/4/16 the average days delayed per week attributable to Adult Care has dropped from 50 to 12 on the 21/8/16, this is a 75% reduction in days delayed attributable solely to Adult Care.

The main reasons for these delays remain Reablement and Home Care unavailability immediately (four people a week) for a person when they are medically fit for discharge. The next reason is awaiting for care homes to assess (three people a week).



Within Adult Care each hospital Principal Practitioner signs off the weekly agreed delays by team within ULHT and Peterborough. This enables management and teams to understand the reason for any delays and to take actions as required to ensure all delays are minimised, this does mean on occasions people are

discharged to a bed rather than their home for a short while until care at home is in place for their safe return home.

Overall the percentage of people delayed attributable is to Health is 66%, to Adult Care is 24% and to both Health and Adult Care 10%. Lincolnshire East Clinical Commissioning Group reported to the Health Scrutiny Committee in September that: “DTOC rates had fallen over the first quarter of 2016/17 with performance in June delivering 3.6% of bed days lost. The system is on track to achieve the target of 3.2% by the required date of October 2016.” It is also notable that ULHT have detailed information of which wards have the longest delays and actions need to be taken to address these points. With regard to housing issues Adult Care has in place contacts with all District Housing Officers the ability to refer and discuss, but it remains an issue for Adult Care that wards do not alert or refer some people early enough in their hospital stay.

Ongoing Actions

We are working with health colleagues, Age UK, and a range of organisations and providers across the county to focus everyone on:- Home First; the principles are:

Think HOME FIRST — Think HOME FAST

Can the person stay at home instead of going to hospital?
Can the person be discharged from hospital and go home, first and fast?
Think how we can work in partnership with colleagues to give our patients, great care, close to home.

The current thinking of how to describe this initiative to everyone is attached in Appendix B. This principle is aimed at reminding everyone involved with people / patients that they have a bed in their own home and health and care professionals need to work together with the person and their family and Carers to return to this bed! We are challenging all Health and Care professionals to think differently and closely examine risks, put simply why cannot this person go home? Then consider, from a strengths based approach what is stopping the professional from making this happen. Rather than focusing on what we do not have to support the person we are reminding professionals to consider what the person does have and how risks could be managed to achieve them going HOME FIRST.

This is the start of a whole social movement in Lincolnshire this will be an ongoing target for all Adult Care and Health Practitioners to challenge each other and some of their systems to achieve more people going HOME FIRST.

Following the HOME FIRST principles leads professionals to improve their working relationships, focus on discharge to assess. This means what is the minimum safe assessment we can undertake in an acute hospital to enable the person to go home for a further detailed assessment.

Lincolnshire County Council has supported the extension of the Care Homes Trusted Assessors to now include Pilgrim, Grantham and Peterborough hospitals.

This should further reduce any delays due to waiting for a Care Home to come to hospital to asses a person for admission to their home.

Lincolnshire County Council through the Carers First contract is establishing Carers first in the ULHT and Peterborough hospitals to enable direct engagement with Carers and assist with support to go safely home.

Healthwatch Lincolnshire View

"Healthwatch Lincolnshire recognises the challenges delayed transfers of care place on the services and importantly for us the impact it has on patients and their families. We also recognise that challenges around having the capacity to ensure planned and timely discharge for patients is not unique to Lincolnshire. On the 19 September 2016 Healthwatch Lincolnshire invited partners to attend a meeting to discuss DTOC. We talked about the issues faced both in the current environment but also sought assurance that a reduced DTOC was a partnership approach at every level.

Following the meeting where Lincolnshire County Council, Lincolnshire Partnership NHS Foundation Trust, United Lincolnshire Hospitals NHGS Trust and Lincolnshire Community Health Services NHS Trust all attended and contributed to the discussion, we as local Healthwatch felt more assured that all partners were working together and striving to embed a pathway which supports both patients and services, the statistical overview provided would support statements that improvements are being achieved, but we would also echo the sentiments that there is still a way to go.

In our watchdog role we will remain focussed on the statistical data and patient/family feedback going forward and remain vigilant. We see both providers and patients functioning in a difficult climate with real challenges around community and care home capacity to support our most vulnerable and with this in mind we will continue to appraise the system particularly as it enters the winter period and beyond. We have welcomed the cooperation of the providers and commissioners to help us better understand the challenges and achievement going forward.

Finally we feel that we can and have offered to help disseminate and educate the public via a factsheet on the ways families can help themselves by planning and preparing for the future earlier with a greater degree of knowledge and awareness, the development of a factsheet has been taken back to the Lincolnshire County Council Communications Team."

2. Conclusion

This paper describes the improving position for Adult Care in Lincolnshire in reducing delayed discharges. But Adult Care has a great deal of further work to undertake in support of partners and the whole system to improve flow and further reduce delays.

3. Consultation

a) Policy Proofing Actions Required

n/a

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Transitional Care Pathway
Appendix B	Home First Defined

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Lynne Bucknell, who can be contacted on 01522 554055 or lynne.bcuknell@lincolnshire .gov.uk.

APPENDIX A

Pathway 1 **ASSESSMENT PATHWAY** **RECOVERY AND REASSESSMENT** *Medium to High Complexity* Assisted discharge: Support at home Community Hospital Residential or Nursing Homes **Individual requires a period of recovery (including non weight bearing) and / or assessment to determine ongoing needs and / or funding.** Short Term intervention – up to 14days *Home is an option at the point of transfer.* *or* *Home is not an option but permanent residential care is not an inevitability.* *or* *A placement where patients needs are very complex and where long term nursing and or care is very likely.* **Non Chargeable to the patient**	**Pathway 2** **REHABILITATION / REABLEMENT PATHWAY** *Medium to High Complexity* Reablement / Rehab: support at home Community Hospital, Residential or Nursing Homes **Individual requires a period of rehabilitation, motivation, confidence building. Optimising individuals levels of independence** Short Term intervention – determined by the individuals progress – will be transferred on once they have reached their optimum levels. *Home is an option at the point of transfer.* *or* *Home is not an option but permanent residential care is not an inevitability.* **Non Chargeable to the patient**
Pathway 3 **ADULT CARE PERSONAL BUDGET** *Medium - High Complexity* **Brokered home care services** **Residential and Nursing Homes** Individual has met their optimal levels and/ or is not going to make any further progress, therefore ongoing needs are identified and clear at point of discharge *Home is an option with a package of care.* *or* *Residential care home where long term care is very likely.* **Chargeable to the patient (adult care)**	**Pathway 4** **Palliative Care Pathway** **End of Life Pathways** *Medium – High Complexity* Supported discharge home Residential and Nursing homes Community Hospitals Hospice Day therapies Individual has palliative care needs and requires an identified level of specialist support on returning back to their usual place of residence Individual has been identified as being 'end of life' and follows the Fast Track process **Non Chargeable to the individual**

- **DISCHARGE TO ASSESS IS A PRINCIPLE and would apply to Pathways 1 and 2.**
- **An individual has complex needs on discharge, and requires multi professional support.**
- An individual who no longer requires acute hospital care is returned to their usual place of residence as soon as it's safe to do so.
- The community (Neighbourhood Team) respond by ensuring the right skills and support are in place to assess, identify and meet the individual's immediate and longer term needs.
- **This principle will reduce the demand on adult care and CHC assessments to be completed in an acute setting, and will move the responsibility to the community.**

Home First

Home

We will support people to remain in their own homes wherever possible and if they are not at home we will strive to ensure they return home as swiftly as possible.

Outcomes

We will work with people to understand what is important to them and support them to achieve the outcomes they identify

Empower

We will recognise that people are individuals, not patients or conditions. Our role is to support people to be stronger, more confident and in control of their own lives.

Innovative

We will not match people to services, but will build on the permission we have to develop and utilise new ways of supporting people to meet their goals

Risk

We will be positive in our identification of risks and support people to make their own choices about how and where they wish to live their lives.

Strengths

We will recognise that everyone we work with has strengths and assets. We will support people to identify these assets and work with them to utilise them in the best possible way.