READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF ADULT SOCIAL CARE AND HEALTH

TO:	**ACE COMMITTEE**		
DATE:	**3 FEBRUARY 2016**	**AGENDA ITEM:**	**14**
TITLE:	**DELAYED TRANSFERS OF CARE – PROGRESS REPORT**		
LEAD COUNCILLOR:	**Cllr HOSKIN & Cllr EDEN**	**PORTFOLIO:**	**HEALTH AND ADULT SOCIAL CARE**
SERVICE:	**ADULT SOCIAL CARE**	**WARDS:**	**All**
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 This report informs the Committee of the work undertaken to reduce delayed transfers of care from Royal Berkshire Hospital and develop "discharge to assess" pathways which reduce the need for long term care.

1.2 In particular the report informs the Committee of performance over the Christmas holiday period and the recent Junior Doctors strike on 12 January 2016.

2. RECOMMENDED ACTION

2.1 The Committee is asked to note the progress made in reducing delayed transfers of care and supporting individuals to regain their independence prior to making decisions about long term care needs.

3. POLICY CONTEXT

3.1 A Delayed Transfer of Care (DTOC) is a term used nationally to describe the situation where patients in an acute hospital bed setting are medically able to be discharged from hospital, but delays occur based on the availability of onward care and support.

3.2 This may be attributable to the need to organise a nursing home placement, ensure that the home environment is safe with any equipment in place where necessary, or for a transfer to a community hospital for ongoing intensive rehabilitation.

3.3 Delayed Transfers of Care are carefully monitored nationally through performance returns to ASCOF (Adult Social Care Outcome Framework) returns, through the Better Care Fund quarterly performance return and via Clinical Commissioning Groups reporting to NHS England.

3.4 All of these targets and indicators scrutinise the delays of those whose hospital stay has come to an end. However, the focus of supporting hospital capacity has to be managed with the same level of scrutiny at 'the front door' too.

3.5 This is known as the four hour target in which patients that arrive at Accident and Emergency should be attended to in a four hour period. The national target for this is 95% of people are seen within the 4 hour target.
The culmination of these two elements of monitoring and focus work towards better 'flow' through the hospital with minimal delay in care, treatment and discharge. This is monitored closely by the local System Resilience Group who work together to improve practice and outcomes based upon the performance data.

3.6 The work to minimise delayed transfers of care meets the following Reading Borough Council commitment

Enabling people to live independently and also providing support when needed to families

3.7 It is well documented that the winter period is a particularly pressurised period of time for the health economy. This is due to the type of health conditions that present themselves in the winter months, such as respiratory related conditions, brought on by the cold weather or through seasonal viruses. This alongside other Long Term Conditions can leave to complex health care needs. The average age of those who require hospital attention is also higher during this period, which can lead to a longer recovery time.

3.8 Finally, the position taken by Junior Doctors to strike on 12 January 2016, required health and social care to work closely together to ensure that individuals received appropriate care and minimal disruption.

4. ACTIONS TAKEN TO ACHIEVE TARGET

Current Position:

4.1 Many of the mitigating actions that have been taken over the Christmas period from community health and social care have focused around how we support people to leave the hospital setting in a timely manner. All of which are detailed below.

4.2 However the growth in the number of people who present at Accident and Emergency has to be a key area of focus to ensure that people do not stay in hospital when alternative care could have been provided. Locally, 25% of the activity from the Community Reablement Team is to support those who to stay at home who would have ordinarily been admitted to hospital.

The role of primary care and the '111' service, remains the key driver in reducing these unnecessary admission.

4.3 Adult Social Care presented a bid to the Clinical Commissioning Groups for winter resilience funding, the bid was successful and the service received £100,000. This has been used to temporarily recruit a Social Worker, Occupational Therapist, an additional Extra Care Sheltered Housing Assessment Flat and additional staff for The Willows.

4.4 The additional staff at the Willows is to support the discharge of older people with Dementia, for a period of assessment in a non-acute setting before decisions are made about their long term care. This extra capacity in the care management team and extra care housing will support reducing the delays in the Hospital and the length of stay.

4.5 Adult Social Care has undertaken significant changes to practice to ensure flow- through the Health and Social Care system is safe, efficient and timely and that individuals are offered reablement prior to any decision on long term care needs. This includes

- A Senior Social Worker role was created in the Intermediate Care Team, they have been based at the hospital with a social worker to strengthen relationships and ensure timely assessments
- Social worker cover in the hospital at the weekend
- Both of the above are designed to develop effective working relationship with Health colleagues, it has created more opportunities to meet families in order to progress ongoing support planning.
- A benefit from having social workers in the hospital is that the wards alert them to patients that will require support, this supports effective discharges
- A dedicated worker for both the Community Hospital and the Discharge to Assess service based at the Willows Residential Home ensures effective navigation from rehabilitation and reablement services
- The Discharge to Assess schemes funded by Better Care Fund includes a community and bed based Reablement. The community element offers short term care and reablement in people's own home. The bed based service at the Willows Residential Home is for those who cannot return home immediately. These services allow individuals to be assessed for long term care needs in the community after a period of reablement so that long term decisions about their care are made in a more measured way once they have reached their level of independence reducing length of stay on the fit list. These services ensure independence is maximised prior to any decision on the need for long term care reducing care home placements and domiciliary care packages, which in turn ensures capacity in commissioned services to meet the needs of those people who do require long term care.
- The Community Reablement Team also supports admission avoidance through the Rapid Response service which equates to 25% of the hours provided by the service. This provides intensive support from health and social care to individuals in their own home, who would otherwise be at risk of going to hospital.

- Prior to this service being developed, a high number of people would have been assessed as needing residential care. 73% of people who were admitted to the WiLs for rehabilitation were discharged home.

4.6 Historically the Christmas holiday period is challenging with higher numbers of people being referred to hospital. This Christmas was no exception with over 100 admissions over the bank holidays peaking at 135 on one day; the highest ever number of admissions.

Table 2 in section 4.3 evidences the reduction in the number of people recorded as a Delayed Transfer of Care on the monthly census. These are the number of people that are waiting to be discharged on the last Thursday of each month, with the target set of less than 5.

4.7 The Local Authority was thanked for its proactive response in preparation of the Junior Doctors strike on the 12th of January, the measures undertaken were:

- On the weekend before the strike an additional Social Worker worked in the hospital to ensure all possible assessments were undertaken and as many people were discharged prior to the strike
- On the few days before the strike a proactive review was undertaken of all those in reablement services and anyone who could move was moved to their long term package of care
- 2 additional beds in the Willows Residential Unit were used flexibly to support discharges
- Patients in the Community Hospitals were reviewed to enable discharges to maximise the inpatient bed capacity
- On the 2 days following the strike high volumes of referrals were anticipated so assessment staff were released to complete assessments and move on plans

4.8 On the day of the strike there were 5 people waiting to be discharged with 2 of these being discharged on the day. On the subsequent day there was 9 people referred for discharge, with 3 people being discharged on that day and 4 others having discharge plans put in place

As a result of these measures Reading's performance in relation to Delayed Transfer of Care (DTOC) has been consistently lower than the previous year, and although the target of 5 people has not been achieved it does show a significantly better position than 2014-15. The main contributing factor to this is the increase in admissions into the acute trust, which for 2015-16 is evidencing a 13% increase in non-elective admissions.

- The table below (1) details delays for both health and social care reasons

Table (1)

ALL DELAYS		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Monthly snapshot (number of people)	2014/15	7	8	15	8	27	20	19	21	11
	2015/16	4	15	18	3	9	9	6	14	

The table below (2) show the performance on delay attributable to Adult Social Care only

Table (2)

ASC DELAYS		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Monthly snapshot (number of people)	2014/15	2	4	7	5	21	9	12	12	5
	2015/16	3	5	10	1	7	3	5	3*	

**Note this is not yet verified by Dept of Health and is a reflection of Royal Berks Delays only*

In addition Discharge to Assess services have contributed to the significant reduction in the permanent placements in residential care per month as demonstrated in the table below, Table (3). December's data shows that in December 2014 22 people were permanently placed in residential care, in 2015 there were 5 placements made.

Table (3)

PERMANENT ADMISSIONS – OLDER PEOPLE		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cumulative	2014/15	16	33	43	59	75	88	95	102	124
	2015/16	7	16	24	29	37	46	52	62	67

5. Lesson's learned from this winter

5.1 An internal review of the Better Care Fund schemes was completed. These were discussed at the Reading Integration Board and agreement reached to take these forward. The areas to be reviewed are:

Community Reablement team

- Review of performance report to show hours of care delivered rather than number of people. The increase in Rapid Response and End of Life requires significant care time (usually 2 carers at least 4 times a day) is not reflected in a report which shows numbers of service users.
- Review of working patterns to maximisation utilisation of staff time
- Consideration of the impact of the generic worker role on the service, which is part of a West of Berkshire piece of work
- Development of Community Assessor role for the transfer to long term care providers
- Consideration of out of hours service requirements- both for short term support and for longer term proactive care requirements
- Consideration of the role of the service in meeting wider well-being reablement aims- e.g. tackling loneliness, health promotion and linking people to low level support such as shopping services.
- Consideration of the need for additional carer hours given the demand for more intensive packages of care. Again this would require realignment of funding

For Willows Unit

- Review of staffing mix to reflect the need for additional carer staff and fewer rehabilitation staff
- Option appraisal on transfer of long term care beds to reablement to allow individuals with dementia to be offered reablement. This will require a review of the staffing and funding arrangements given RBC would lose income from the use of long term beds and need to re-provide the beds the private sector. This work will be supported by the Integration Manager and be developed as part of the 2016-16 Better Care Fund submission.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 The work contributes to the following strategic aim

- To promote equality, social inclusion and a safe and healthy environment for all

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 The Reading Integration Group plans to integrate customer feedback in the 16/17 Better Care Fund schemes

8. EQUALITY IMPACT ASSESSMENT

8.1 The services are largely used by frailer older people and people with long term conditions

9. LEGAL IMPLICATIONS

9.1 The Care Act requires local authorities to carry out a needs assessment for any adult who appears to need care and support. The person will have eligible needs if they meet all of the following:

- They have care and support needs as a result of a physical or mental condition;
- Because of those needs, they cannot achieve two or more of the outcomes specified; and
- As a result, there is a significant impact on their wellbeing.
- The outcomes are specified in the Care Act regulations, and include people's day-to-day outcomes such as maintaining nutrition and managing toilet needs.

10. FINANCIAL IMPLICATIONS

10.1 The service is delivered within the core Adult Social Care budget, Systems Resilience winter funding of £100,000 and Better Care fund of £854,000.

11. BACKGROUND PAPERS

11.1 None