Oxfordshire
Clinical Commissioning Group

Oxfordshire Joint Health Overview & Scrutiny Committee
Thursday, 5 December 2013 10.00am

Delayed Transfers of Care

1. Introduction

Oxfordshire has a history of patients experiencing delays in the transfer of their care between hospitals and other care services. The Health Overview and Scrutiny Committee will meet with leaders of the local health and social care community on 5th December 2013 to discuss progress on this issue.

Represented at that meeting will be:

Oxfordshire Clinical Commissioning Group (OCCG) – from 1st April 2013 this has been the GP-led body that commissions hospital and community services in Oxfordshire and jointly commissions and purchases a range of services with the County Council

Oxfordshire County Council (OCC) – the Council has responsibility for carrying out assessments of people who may require social care services and for arranging on their behalf long term care services such as domiciliary care (care in peoples own homes) and residential care. It jointly commissions and purchases some services with the CCG.

Oxfordshire University Hospitals NHS Trust (OUH) – the provider of acute hospital services in Oxfordshire, OUH's performance is crucially affected by delayed transfers of care.

Oxford Health NHS Foundation Trust (OH) – the provider of NHS continuing healthcare assessments, community hospital services, the management of referrals and assessments for post-hospital services and also the delivery of some post-hospital services.

The design and delivery of safe and timely discharge in the County is a joint responsibility of all 4 organisations.

A number of other organisations make a valuable contribution to effective discharge, for example, SCAS (South Central Ambulance Service) and providers of long-term care services.

2. Delayed transfers of Care

2.1. A delayed transfer of care occurs when a patient remains in a hospital bed after

- A clinical decision has been made that patient is ready for transfer from that hospital bed **and**
- A multi-disciplinary team decision has been made that patient is ready for transfer from that hospital bed **and**
- The patient is safe to discharge/transfer from that hospital bed

2.2 Delays in transferring care are important because of their impact on the patient concerned, on other/potential patients and in terms of costs to the local health and social care economy. Across the country it is estimated that some 10-15% of hospital beds are used by people who could be discharged.

2.3 Patients who are in a hospital bed when they are medically fit for discharge prevent other people being able to be admitted to a hospital bed. At times of excess demand on the hospital system this rarely means that people will not be admitted in an emergency, however, waiting times may lengthen, people may be held in less than ideal facilities until a bed becomes available e.g. on trolleys and ambulance hand-over becomes very difficult as there is no capacity to receive incoming patients. A hospital system experiencing capacity issues may also have to cancel non-urgent operations in order to re-allocate available beds.

2.4 The impact of delayed transfer on patients affected is also of great concern. For all patients there is a quality of life issue associated with remaining in a hospital bed when ready to move into a lower intensity care setting. However, in addition, older people who spend excess time in hospital are more likely to lose their independence, becoming less likely to return to independent living in their own homes and more likely to require admission to a nursing or care home. In principle, there is also a risk of hospital-acquired infection, although a recent audit has shown that this is not evident in our local hospitals.

2.5 For healthcare commissioners, there is a fixed tariff they must pay hospitals for each type of condition with which a patient is admitted which is based on length-of-stay. When that patient stays for longer the healthcare commissioners must pay for these “excess bed days” thus increasing the cost-per patient. For hospitals which are paid on an anticipated length of stay basis, the day rate reduces for excess bed days. Thus, there is a negative impact on hospital finances.

2.6 For social care, the main impact of delays is in the numbers of people who require long-term residential care instead of being able to return to their own homes supported with a much lower cost domiciliary care package

3. Discharge performance in Oxfordshire

3.1 Work is underway to clarify the detail of the admissions from 1st October 2012 to 30th September 2013 to an acute hospital bed in Oxfordshire.

3.2 In the same period, 2339 people were admitted to a community hospital bed in the County. Of these**,** approximately 534 returned home with no further care need.

3.3 In the period 01/10/12 to 30/09/13, 2096 Oxfordshire residents were not able to return home on the day they were fit for discharge from hospital. However, what this means is that 90% of all patients admitted were not in fact delayed.

3.4 The average length of delay was 16 days with the majority of delays (64%) being under 15 days and a smaller proportion (13%) being significant delays of 31 days or more.

3.5 Reasons for delays are various. For example, in the local figures for a typical week, in this case, the local report of 17th November 2013 shows the following breakdown for a total of 129 delays:

- 22 (17%) people awaiting an assessment (17 NHS delays, 2 Social Care delays and 3 delays awaiting joint assessment)
- 20 (16%) people waiting for a community hospital bed
- 3 (2%) waiting for a community NHS package
- 1(1%) waiting for an intermediate care bed
- 17(13%) waiting for a reablement service
- 2(2%) of people waiting for equipment
- 23(18%) of people waiting for a care home placement
- 19(15%) of people waiting for a long-term care package
- 2(2%) of people delayed for housing-related issues
- 17(13%) waiting as a result of choice delays
- 3(2%) of people waiting for other reasons

The issue of choice is an interesting one. The figures above understate the impact of choice in the County. In addition to patients staying in hospital beds until they can move to the exact residential home of their choice, there is another cohort of patients who have refused to move to a community hospital bed unless it is in the location of choice. Oxfordshire does not have an exact geographical

match of community hospital beds to areas of demand, so patient choice is an ongoing challenge to the local health economy. Public awareness of this issue appears to be low.

A further issue not directly illustrated within the above report is that of people awaiting different types of housing. Many people can maintain independent living if appropriately housed e.g. in Extra Care Housing or in housing where major adaptations have been carried out, often using Disabled Facilities Grant (DFG) funding. An appropriate supply of appropriate housing and application of DFG funding is a District Council responsibility. There is partnership working on these issues that includes, for example, the County's Extra Care Housing Strategy.

4. Comparisons with other areas

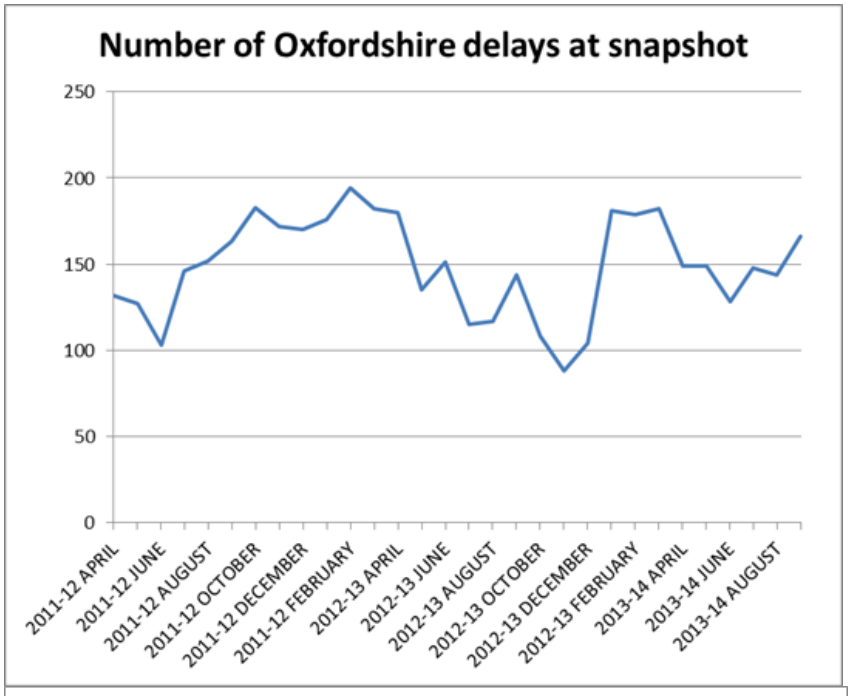
4.1 The Department of Health has published figures on delays since 2001. Originally these were weekly figures for acute hospitals only. During 2007/8 the figures were extended to include all hospital beds, including community hospital beds, beds in mental health hospitals, specialist hospitals for people with a learning disability and any sub-acute beds in an acute trust. From April 2011 reporting moved to monthly. Figures are published on a snapshot of the number of people delayed at the end of the month and the total number of days delayed in the month, for each hospital trust and local authority in the country. Guidance is given on the coding of reasons for delays so that this information should be consistent across the Country.

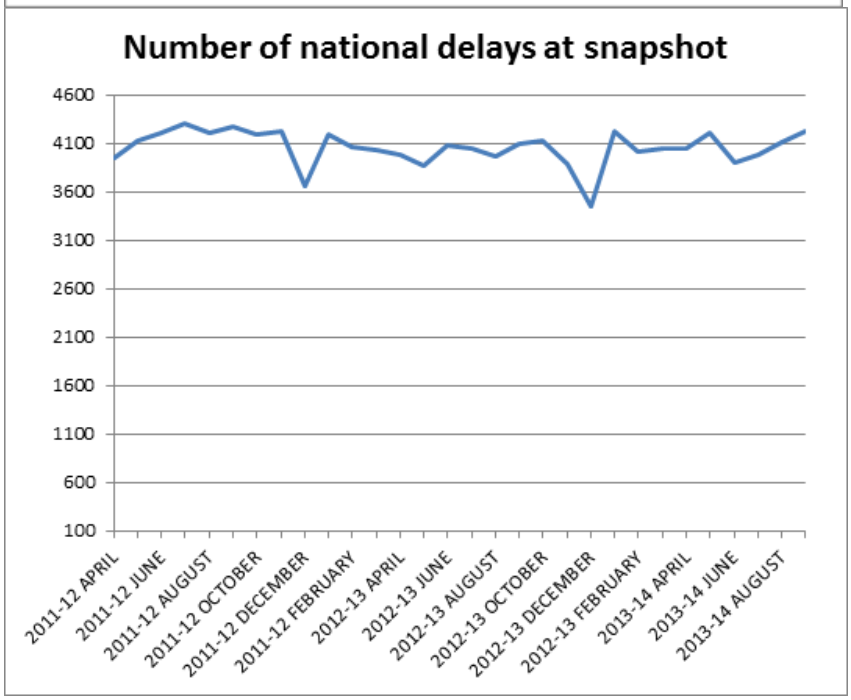
4.2 Partners within the health and social community in Oxfordshire have traditionally believed that some other areas of the Country do not code correctly and thus are shown in a more favourable light. This is a concern that has been raised elsewhere. In July 2013 the Health Select Committee said *'The national data available on delayed discharges contradicts the evidence of clinicians and managers across the acute sector. The Committee believes that the data is incredible and we recommend that Ministers swiftly investigate the method of data collection in order to understand whether the available figures genuinely reflect the situation on the ground*.'

4.3 However, there is one distinct difference between Oxfordshire and most of the advanced health and social economies that report DTOC data. In these locations, the intermediate care layer has been redefined in recent years and the vast majority of patients move swiftly into an intermediate care service when they are fit for discharge. Oxfordshire has not delineated bedded intermediate care services (that don't count within the DTOC figures) from other forms of sub-acute and community hospital beds (that do count within the DTOC figures). Therefore, even if the data from every other health economy was being reported strictly according to the guidelines, Oxfordshire would be still is at a disadvantage.

4.4 Other differences include the fact that Oxfordshire has 2.8 beds per head of population against an average of 2.4 nationally (more beds from which to discharge). In addition, in some health economies, acute and community provision is combined under one provider such that transfers between the two sectors do not lead to “double-DTOC” which is the case in Oxfordshire.

4.5 The graphs below show the number of delays taken from the monthly snapshot since April 2011 for Oxfordshire and nationally. Nationally, excluding the December snapshot (which reflects different practice of discharge over Christmas and New Year) delays have remained fairly constant varying only by 5% from the average. Although Oxfordshire's figures appear to have varied more, the main drop and subsequent increase in 2012-13 reflect more accurate reporting.





4.6 The latest published figures are for the end of September. Oxfordshire had the highest absolute number of delays in the country (166) and the highest per head of adult population.

5. Historical and cultural perspectives

5.1 For over 10 years, Oxfordshire has experienced high numbers of delayed transfers of care and has continued to have high levels of delays attributed to patient choice.

5.2 A succession of health and social care leaders have come under strong criticism for discharge performance from politicians, the public and the media.

5.3 There have been many programmes, projects and initiatives whose purpose was to reduce delays but which have not been successful in achieving that aim.

5.4 Historically, there have been times when organisations have not worked effectively together to achieve change and it has been difficult to achieve progress. However, the current phase, which started over two years ago, has been successful in respect of building consensus, achieving joint leadership from across the health and social care community and starting to work together on improvement planning and implementation.

5.5 The lasting legacy of past failures are, however, ever-present; a disincentive to local leaders in respect of taking risks, trying new approaches and committing to timescales for delivery of performance improvements.

6. Short-term improvement plans

6.1 The local health and social care community has been working in partnership to identify areas for improvement and to implement improvement plans in terms of patient flow through our hospitals and into ongoing services.

6.2 Activity to reduce unnecessary hospital admissions is subject to a separate plan and a comprehensive set of measures have been put in place to ensure that care is put in place in the community at the right time and thus people do not end up in crisis and in need of hospital admission. At present, emergency admissions in Oxfordshire are rising, but community providers are busy at present rolling-out Oxfordshire's EMU's (Emergency Multidisciplinary Units) programme. This roll-out will be carefully monitored to measure impact on reducing avoidable admissions and delayed transfers of care.

6.3 For patients who are admitted to hospital, the in-hospital discharge pathway has already been redesigned and the new pathway implemented earlier in 2013.

6.4 Within the new pathway, partner organisations are still working towards:

- incorporate Continuing Care criteria and End-of-Life care into the pathway
- achieving a 14 day turn-round for Continuing Healthcare assessments
- earlier notification by hospitals to Social Care of the requirement for assessment/ongoing services
- consistent presence of social care staff in hospitals 7 days a week

6.5 Considerable investment has been made in reablement services which are recognized nationally as an important after-hospital service. The number of people going through reablement continues to rise month-on-month and partners are continuing to work together to ensure that all patients who can benefit from reablement are referred to these services.

6.6 Partners have agreed to audit the performance of the new discharge pathway. The first audit was reported in September 2013. It contained useful insights but also indicated areas for improvement in terms of process. A second audit has just been carried out and will form the basis of refinements of the new pathway and an indication of progress in implementation and also of improvements that can still to be made. All partners that are represented at the HOSC meeting on 5th December share a high degree of confidence that they can bring the performance within the discharge pathway up to best-in-class standards.

6.7 The second aspect of improvement planning on which partners are currently working is preparing for Winter 13/14 and the anticipated surge in demand of patients over the Winter period as hospital admissions rise and pressure to achieve timely discharge increase. Oxfordshire was awarded over £10M in central funding to ease Winter pressures, much of which is focused on initiatives to achieve admissions-avoidance. However, there are many initiatives that are targeted at eliminating delayed transfers of care. Examples of investments being made with Winter pressures funding include:

- Additional hospital discharge coordinators and consultant cover in acute hospitals
- Pharmacists available on Saturdays and Sundays to facilitate weekend discharges
- Additional hospital transport available at weekends to facilitate supported discharge
- Additional social care staff to ensure care assessments are completed in a timely manner when people are discharged from hospital
- Additional funding for equipment and technology to enable safe discharge to home

6.8 From a patient perspective, there is a focus on ensuring that delays at the next stage of the pathway are minimised and that care delivers the best long-term outcomes for the patient rather than simply moves them on.

6.9 The challenge to the implementation of the new pathway using one-off Winter pressures funding will be how to make improvements in performance sustainable into 2014/15, especially given the deficit position of the CCG commissioner and the severe cuts in funding being anticipated by the County Council.

6.10 The combination of pathway changes and investments of Winter pressures monies are aimed at improvements within the discharge process itself. They will not address the major difficulty that Oxfordshire faces with discharge i.e. overcoming delays by ensuring smooth progression for patients into post-hospital services.

7. Strategic plans

7.1 A number of plans are being put in place that will have long-term impact on reducing delayed transfers of care. These are almost all managed through the Joint Management Group (JMG), ultimately reporting through the Health and Wellbeing Board.

7.2 The majority of plans will be delivered by joint commissioning of the CCG and County Council using pooled budget arrangements.

7.3 In respect of post-hospital *short-term* care services (intermediate care services lasting for up to 6 weeks), there is currently a plethora of services with different referral criteria and potentially some gaps and overlaps in service provision.

7.4 There have been a number of separate projects put in place to redesign the services that provide people with post-hospital recuperation, re-enablement and rehabilitation. More recently, it has started to be accepted that these projects are in fact inextricably linked. Work is now required not only on establishing the linkages between work-streams, but crucially the additional design elements required so that the Commissioning partners – Oxfordshire CCG and Oxfordshire County Council, can bring forward for public consultation, proposals to fundamentally re-shape intermediate care services in the County.

7.5 It has taken time to reach this level of agreement, but the commissioning partners are absolutely clear that getting this design-work right, and ensuring such services can be sustainably funded, is an absolute priority to ensuring that the County has the right intermediate care services, in the right places, with the right capacities, to ensure smooth flow out of hospital beds.

7.6 Proposals for the reshaping of post-hospital short-term care services (bedded and in people's homes) are expected to be made in the first half of 2014.

7.7 The Intermediate Care services referred to above are underpinned by another set of services - the services to provide minor adaptations in people's homes, to provide them with equipment (walking frames, toilet raisers etc.) and to provide them with assistive technology (telecare). Best practice is to have these services in place on the day that someone returns home from hospital.

7.8 There are projects in place under the auspices of the Older Peoples Programme to reshape equipment provision and the use of assistive technology in the County, with proposals coming forward in early 2014.

7.9 Providing the designs adopted for intermediate care services and for adaptations, equipment and technology, are the absolutely correct designs, these changes will have a major impact on facilitating safe and timely discharge in the County.

7.10 The challenges with respect to *long-term* care services, domiciliary care in people's homes and residential care in care homes and nursing homes, are very different and the County faces substantial challenges in terms of meeting future demand.

7.11 Levels of social care provided in Oxfordshire are currently the same as in similar authorities. However, more people are coming forward needing care than in previous years and they are coming forward with higher levels of need. The number of older people coming forward for long term care rose by 4.8% in 2012/13 and has risen by a further 7.9% in the first 6 months of 2013/14. The average amount of care provided a week has risen by 9.2% and 1.7% in the same period.

7.12 In addition, more people in Oxfordshire go directly from hospital to care homes than elsewhere in the Country and they stay for longer in care homes. Long stays in care homes generally indicate that people are entering residential care more quickly than average and questions arise as to whether too many patients are being discharged straight to a hospital bed without the opportunity for rehabilitation in an intermediate care service and a subsequent return to their own home.

	March 2012	March 2013	Sept 2013	% increase 11/12	% increase 12/13
At home via home care or direct payment	1,916	2,080	2,293	8.6%	10.2%
Average hours of care provided per week	10.9	11.9	12.1	9.2%	1.7%
In care homes	1,654	1,660	1,744	0.4%	5.1%

Total supported	3,570	3,740	4,037	4.8%	7.9%

7.13 It is currently taking longer to set up long term home care packages than we would wish. The council has put in places plans to develop the home care market to ensure packages can be set up more quickly. These plans include:

a. Setting up a new 24 hours fast response services specifically to provide support to people who are leaving hospital while their long term care needs are assessed
b. Developing small block contracts in areas where there have been difficulties placing people. This will ensure care is available in these areas and that care providers can respond more quickly to requests for service.
c. Set up arrangements to purchase care from new care providers in addition to those currently used
d. Working with neighbouring authorities to identify people who provide care just outside Oxfordshire to see if they would be capable and willing to also provide care in Oxfordshire

8. Future prospects

8.1 There are several Health and Wellbeing targets relevant to DTOC to which local partners are committed in the current year. These are:

- Reducing the number of patients delayed for transfer or discharge from hospital so that Oxfordshire's performance is out of the bottom quarter (current ranking is 151/151)
- Reducing the average number of days that a patient is delayed for discharge from hospital from the Oxford University Hospital (from 14.8 days)
- Reducing the average number of days that a patient is delayed for discharge from hospital from Community Hospitals (from 22 days)
- Developing a model for matching capacity to demand for health and social care, to support smooth discharge from hospital

8.2 Partners clearly believe that they have put in place short-term changes that will achieve these in-year targets.

8.3 With respect to the strategically driven improvements that can be expected to start impacting the system from mid - 2014 on, the questions which then arise are:

- How will the new pathway and the benefits derived from the implementation of that pathway be made financially sustainable beyond the current one-off Winter pressures funding, especially given the financial pressures on both CCG and County Council?
- To what extent, and at which date in the future, will there be a comprehensive portfolio of short-term post-hospital services for recuperation, reablement and rehabilitation, supported by adaptations, equipment and assistive technology, that have sufficient capacity to ensure smooth transfer from hospital services?
- To what extent, and at which date in the future, will there be adequate capacity of domiciliary and residential care services to ensure swift transfer of those needing to move into long-term care?