NORTH YORKSHIRE COUNTY COUNCIL

CARE AND INDEPENDENCE OVERVIEW AND SCRUTINY COMMITTEE

19th JANUARY 2017

DISCHARGES FROM HOSPITAL

1. **Purpose of Report**

1.1. The purpose of this report is to provide Care and Independence Overview Scrutiny Committee members with information about delayed discharges from hospital across North Yorkshire and plans to build upon the progress made to address delays jointly with NHS partners.

2. Background

National Context

2.1. Unnecessary delays in discharging people from hospital are a long standing issue nationally. It is a particular issue relating to older people (aged 65 and over) because according to a report by the National Audit Office[1]:-

- Older patients account for 62% of the total bed days spent in hospital
- The number of emergency admissions of older people has increased by 18% between 2010/11 and 2014/15
- 50% of older patients are admitted following a visit to accident and emergency and
- Using the only official data relating to delays in discharging patients i.e. 'delayed transfers of care' (DToC) it is estimated that 85% of patients captured by this measure are aged 65 and over.

2.2. The National Audit Office report identifies a substantial increase in bed days taken up by patients with a delayed transfer in acute hospitals of 31% over the two year period 2013 to 2015.

2.3. The main drivers for the increase are attributed to the number of days spent waiting for a package of home care and waiting for a nursing home placement or availability.

2.4. The cost to the NHS of treating older patients who no longer need to be in hospital is estimated to be £820million a year.

2.5. The impact on older people is also significant. The muscle strength that older people can lose per day of treatment in a hospital bed the report states is around 5%. The subsequent impact on a person's independence is therefore evident along with the impact on the wider care system of needing to provide support earlier than would otherwise have been the case.

[1] Discharging older patients from hospital NAO May 2016

2.6. The 2015-16 Better Care Fund (BCF) policy framework required that local areas set targets against five key metrics one of which was delayed transfers of care from hospital.

2.7. The focus on reducing these delays has been further reinforced by the 2016/17 BCF policy framework which introduced two new national conditions that required local areas to fund NHS commissioned out-of-hospital services and develop a clear, focused action plan for managing delayed transfers of care, including locally agreed targets. These conditions needed to be met along with a number of other conditions for local BCF plans to be assured by NHS England.

2.8. While 2017-19 BCF guidance has not yet been published, indications are that there will no longer be a national condition relating to DToC. It is likely however that the national DToC metric will remain. Notwithstanding this, addressing delays will continue to be an important part of local social care and health improvement plans moving forward.

What is a delayed transfer of care and how are delays reported?

2.9. A delayed transfer of care occurs when a patient is considered ready to depart from their acute or non-acute health care and is still occupying a bed. A patient is considered 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.

2.10. There are currently two main ways of reporting delayed transfers of care. The first reports on the **number of delayed days.** NHS England compiles monthly delayed transfers of care data through a central return that is split into two parts:-

- the number of patients whose transfer of care is delayed at midnight on the last Thursday of each month.
- the total number of delayed days within the month.

2.11. Delayed transfers of care are categorised by:-

- The organisation responsible for the delay – NHS, Adult Social Care or Both;
- The reason for delay;
- The type of care the patient receives – acute or non-acute.

Data are published approximately 6 weeks after the end of each month.

2.12. The second reports on the **number of patients** affected by delayed transfers using an average number of patients per month against local population figures and is part of the Adult Social Care Outcomes Framework (ASCOF).

2.13. The Care and Support (Discharge of Hospital Patients) Regulations 2014 enables the NHS to recover reimbursement from local authorities in respect of a patient's delayed transfer of care where the local authority; namely Adult

Social Care is responsible for the delay. This is however generally seen as counter to joint working and as such few reimbursements have been sought by Hospital Trusts over the past few years.

3. Delayed Transfers of Care in North Yorkshire

3.1. Attached as appendix 1 is a performance briefing covering both the number of delayed days and the number of patients affected by delayed transfers. The report covers full year data for April 2015 to March 2016 and current performance up to October 2016. Please note the different data timeframes in the headings.

3.2. The headlines from this report are as follows:-

Financial Year Performance [April 2015- March 2016]

- For the year April 2015 – March 2016 data indicates there were **14,290** delayed transfer **days** for patients resident in North Yorkshire who were the subject of a transfer of care from hospital. [Table 1 Page 5]

- The NHS was solely responsible for **60%** (8,596) of the total delayed days with social care being solely responsible for **34%** (4,801) Both the NHS and social care were jointly responsible for the remaining **6%** (893) i.e. the patient requires both health and social care support upon discharge. [Table 2 Page 5]

Current Performance [November 2015-October 2016]

- Month by month data up to May 2016 highlighted a level of volatility in delayed days attributable to adult social care. The period June to October 2016 however shows that there has been a steady and significant increase in the number of days attributable to social care. [Chart 1 Page 1]

- Within this the following three hospital trusts currently account for **91%** of adult social care delayed days attributable to North Yorkshire
    - York 46% [70% in 2015/16]
    - South Tees 25% [0% in 2015/16]
    - Tees Esk and Wear Valleys (TEWV) Mental health provider trust 20% [20% 2015/16]

- This increase is in part explained by South Tees Hospital Trust beginning to report adult social care delays for the first time since 2014. The Trust reported 237 days attributable to social care in June 2016 which accounted for 63% of the increase in that month, and has continued to report high levels of adult social care delays rising to 460 in October 2016.

- Reporting of adult social care delays by York Teaching Foundation Trust, which covers York, Malton, Selby and Scarborough Hospitals has continued to be relatively consistent month on month. [NB the Trust is part of the Emergency Care Improvement Programme, a clinically led programme that offers intensive practical help and support to improve care]

- There has been a steady and significant rise over the year in adult social care delays reported by TEWV from 58 in April 2016 to 338 in October 2016.

Comparative Performance [April 2016-October 2016]

- In respect of **delayed days** North Yorkshire's performance compares better against shire counties than with regional authorities though rankings have slipped across all categories since April 2016.

- Compared with other counties, as at October 2016 North Yorkshire is ranked 9th lowest out of 27 (4th in 2015/16) for total delayed days and 17th (12th in April) for days attributable to adult social care [Chart 2 Page 2]

- Compared with regional authorities, as at October 2016, North Yorkshire has remained ranked 3rd highest* for days attributable to adult social care and 3rd highest (5th in 2015/16) for total delayed days [*Highest means higher number of delays] [Chart 3 Page 2]

- Comparative rankings for total delayed days are good but poorer for delays attributable to adult social care.

- Comparative performance follows a similar pattern when using the Adult Social Care Outcome Framework measure which reports the **number of patients** affected by delayed transfers. [Chart 6&7 Page 4]

Reasons for Delay [April 2015- March 2016]

- For 2015/16 the three most prevalent reasons for delays account for **56%** of **all** delayed days as follows:-
    - Patient family choice
    - Awaiting a care package in own home
    - Awaiting nursing care

  [Chart 8 Page 6]

- For **social care** delays three reasons account for **81%** of delayed days:-
    - Awaiting care package in own home **39%**
    - Awaiting residential home placement or availability **22%**
    - Awaiting nursing home placement or availability **21%**

4. Plans to address delays jointly with NHS partners

4.1. A locally agreed target and action plan for reducing delayed transfers of care has been developed as part of the 2016/17 North Yorkshire Better Care Fund plan on the basis of maintaining the outturn position for 2015/16.

4.2. This is **14,290** delayed days across the North Yorkshire and gives a rate per 100, 000 population 18+ of **244.8.** Consequently maintaining the same rate will result in a 2016/17 outturn of no more than **14,330.** See table 1 below

Table 1 Historic performance and target outturn for 2016/17

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Annual	10,970	13,939	12,004	13,225	14,290	14,330

DToC days						
Monthly average	914	1161	1000	1102	1191	1194
Population Base	484,100	484,432	487,301	489,218	486,577	487,856
Rate per month	188.8	239.8	205.3	225.3	244.8	244.8

4.3. In setting the target, consideration was given to historically good performance, the current financial context, the expected increase in population and in particular the ability of social care providers (the care market) to respond to demand and provide the right service, in the right place, at the right time and at the right price.

4.4. The care market in North Yorkshire is already operating at 90-97% capacity in different localities, five years ahead of nationally projected occupancy levels. Near full employment makes recruitment and retention particularly challenging and the transactional costs and logistical requirements of remote rural and coastal areas, means that the normal market assumptions that apply to most of England do not apply in large parts of the County.

4.5. While partners agreed that a stretch target would not be realistic at this time, there remains a strong ambition across the partnership to further reduce delayed transfers of care and improve the health and independence of local people in line with the aims of the Better Care Fund and the Joint Health and Wellbeing Strategy.

4.6. A summary action plan, which outlines the governance arrangements for each locality, is in place as part of the Better Care Fund Plan. More detailed plans are being developed and agreed at locality level jointly through transformation boards, and operationally through newly established A&E Boards (previously Systems Resilience Groups). This approach recognises the diversity of each locality within North Yorkshire.

4.7. Locality plans will reflect local population needs and ensure that all relevant acute and community trusts are engaged. Each locality will have identified delayed transfers of care leads for both health and social care who will be responsible for ensuring that progress is monitored, understood and shared.

4.8. Locality plans will address issues affecting the efficiency of existing discharge processes, and drive a better system of discharge planning by encouraging the development of proactive rather than the reactive planning that still exists in some areas.

4.9. In particular, patient journeys will be carefully scrutinised to identify improvements against the eight areas in the 'High Impact Change Model' designed to reduce delayed transfers of care as follows:-

- Early Discharge Planning
- Systems to Monitor Patient Flow
- Multi-Disciplinary Discharge Teams including the voluntary and community sector

- Home First/Discharge to Assess
- Seven-Day Service
- Trusted Assessors
- Focus on Choice and
- Enhancing Health in Care Homes.

Appendix 2 shows a more detailed description of the High Impact Change Model

4.10. Appendix 1 (Page7) shows that a number of specific actions are being taken by Health and Adult Services to address social care delays. More recent and focussed work being undertaken by the County Council to better understand performance in relation to social care delays includes the following improvements:-

- Daily communication with acute hospitals over those in DToC situations and the general position of the hospital
- Working with Hospitals to improve patient flow for non DToC patients especially over the Christmas period
- Improved communication channels at senior management level between the trusts and Health and Adult Services
- Production of a daily Health and Adult Services Situation Report.
- Weekly resilience meeting now attended by all Care and support Heads of Service and Assistant Directors
- Development of specific locality plans by Health and Adult Services to address social care delays

4.11. Performance against delayed transfers of care is reported to the North Yorkshire Health and Wellbeing Board (NYHWB) via the Joint Health and Wellbeing Strategy Performance Dashboard quarterly via a Better Care Fund briefing note to the North Yorkshire Commissioner Forum

5. Conclusions

5.1. While delays are increasing month on month it should be recognised that this is in the context of a worsening situation across the country and comparative performance in North Yorkshire remains good.

5.2. The provision of social care is critical to preventing unnecessary delays in discharge from hospital but there are some significant challenges for social care in North Yorkshire, in particular capacity within the care market and the ability of social care providers to respond to demand.

5.3. Partners are actively working together to address delayed discharges in North Yorkshire through locality transformation boards, systems resilience groups and the HWB

6. Recommendations

6.1 Care and Independence Overview Scrutiny Committee members note the content of the report and the action being taken with partners to address delays transfers of care in North Yorkshire.

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Background Documents:
Discharging Older Patients from Hospital National Audit Office May 2016
Better Care Fund Policy Framework 2016/17 DOH & DCLG Jan 2016

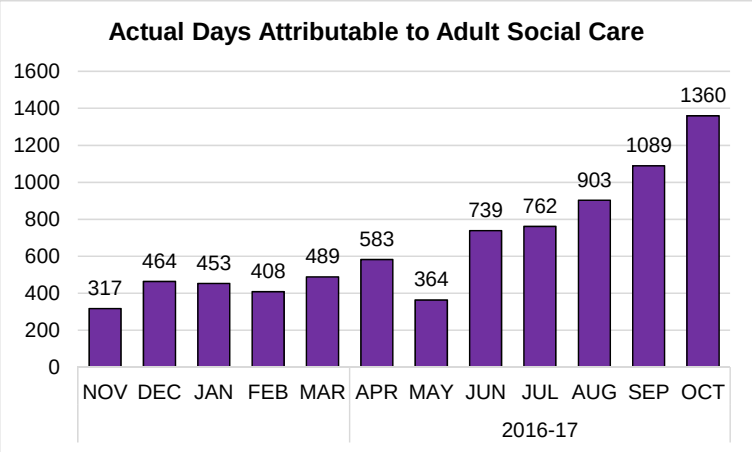
Annexes: Appendix 1 Delayed Transfers of Care Performance Briefing
Appendix 2 High Impact Change Model

Appendix 1

DELAYED TRANSFERS OF CARE PERFORMANCE

Current Performance: November 2015-October 2016

Key Trends Chart 1



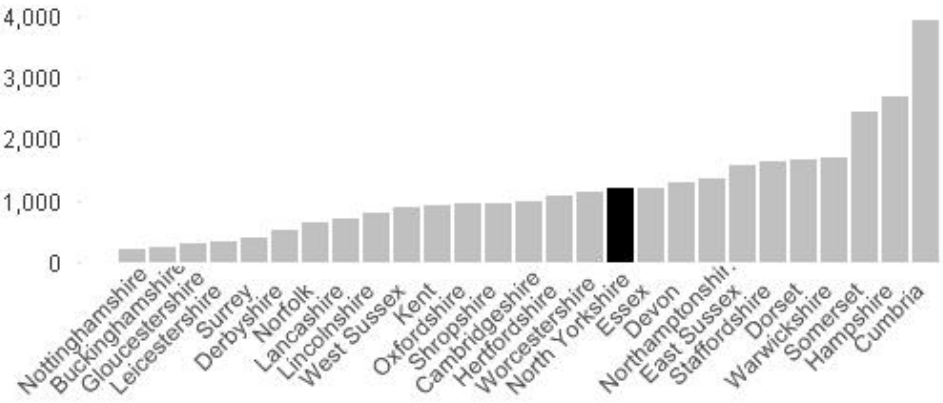
- Month by month data up to May 2016 highlighted a level of volatility in delayed days attributable to adult social care. Since June however there has been a steady and significant increase each month in the number of days attributable to adult social care.
- Within this three trusts account for 91% of adult social care days attributed to North Yorkshire: York Teaching Hospitals - 46%, South Tees - 25%, and the mental health provider trust, Tees Esk and Wear Valleys (TEWV) - 20%.
- In June 2016, South Tees reported 237 days attributable to adult social care, the first time the trust had reported adult social care days since April 2014. This accounted for 63% of the increase in June, and the trust has continued to report high levels of adult social care days each month since, rising to 460 days in October.
- The York trust accounted for 46% of North Yorkshire's adult social care days for the year to October, down from 60% in Q1 (70% in 2015/16). South Tees' share increased to 25% in October from 14% in Q1 (0% in 2015/160. York's reporting of adult social care days has been relatively consistent month on month.
- TEWV's adult social care days have shown a steady and significant rise over the year, up from 58 in April to 338 in October. TEWV is showing a significant increase across all categories of days year on year.

Comparative Performance: April-October 2016

<u>Shire Counties</u>

- Rank has slipped from 12/27 in April to 17/27 in October for days attributable to adult social care (below), maintaining mid-table performance despite the slow shift towards the worse end of the performance rankings.
- Ranked 9th lowest (best) for total delayed days, compared with 4th for 2015/16.
- Ranked 4th lowest (best) shire county for NHS days, compared with 1st for 2015/16.

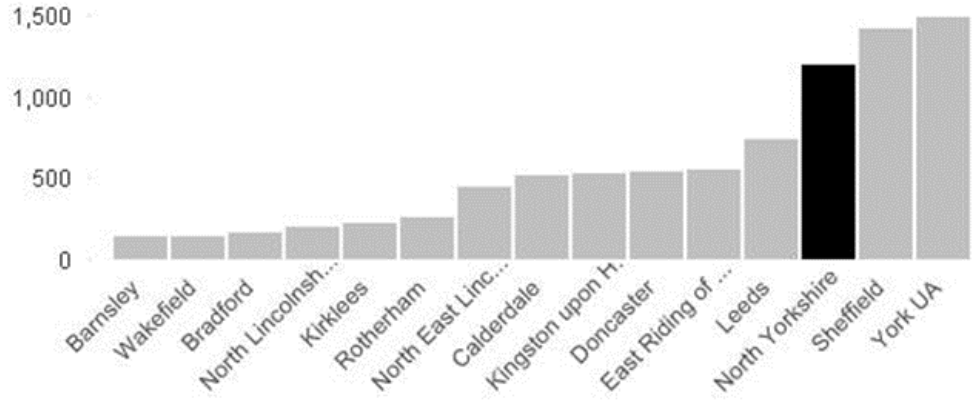
Chart 2



Regional Authorities

- Rank has remained consistently at 3rd highest (worst) for days attributable to adult social care (below), with the gap between local performance and mid-table performance increasing steadily over the year.
- Rank has worsened from 5th highest in April to 3rd highest in October for total delayed days.
- Rank down from 7/15 to 11/15 for NHS days.

Chart 3



2015-16 Financial Year Performance

Overview

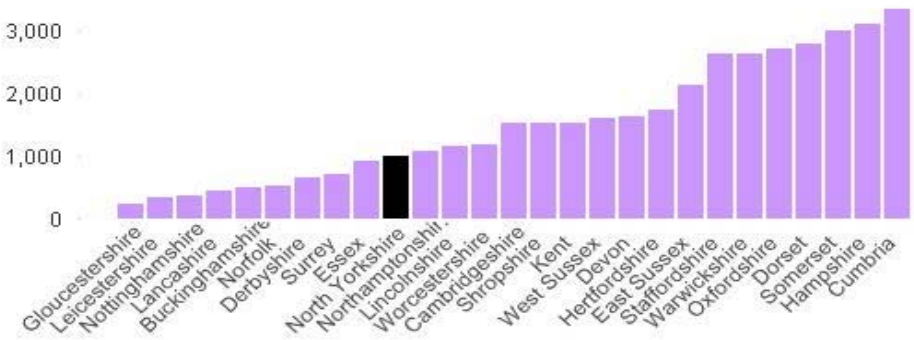
- Comparative rankings for the rate of total delayed days per 100,000 population are good, but comparative performance for days attributable to adult social care is poorer (see below).
- Delayed days attributable to adult social care were up 20% month on month in March, and total delayed days were up 7%. Year on year, adult social care days were up 83% in March compared with 45% nationally and across the region.
- North Yorkshire continued to be well below the national average for all categories of delay in March.
- Days attributable to the NHS were up 4% month on month in March, accounting for 64% of all days. NHS days were up 64% year on year in March compared with 14% nationally and 11% across the region.

Comparative Performance

Counties

- Ranked 10/27 for days attributable to adult social care (see below – rate per 100,000).
- Ranked 4th lowest (best) for total delayed days.
- Despite the sustained increase in NHS days in March, ranked as the lowest (best) shire county.

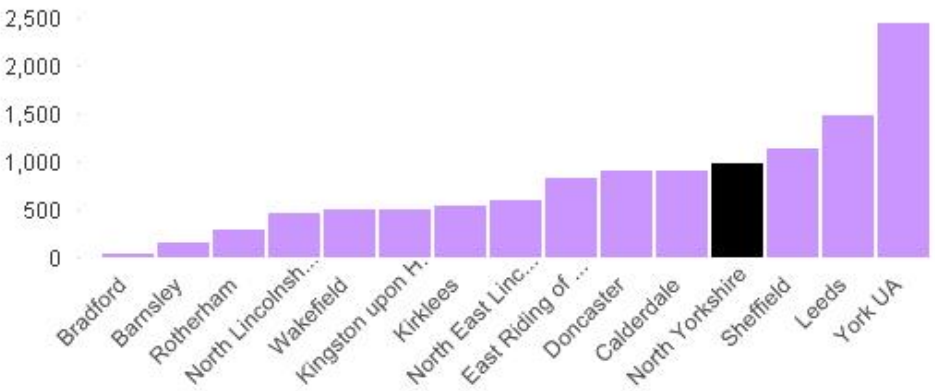
Chart 4



Regional Authorities

- Ranked 4th highest (worst) for days attributable to adult social care (see below – rate per 100,000).
- Ranked 9/15 for total delayed days.
- Ranked 6/15 for NHS days.

Chart 5



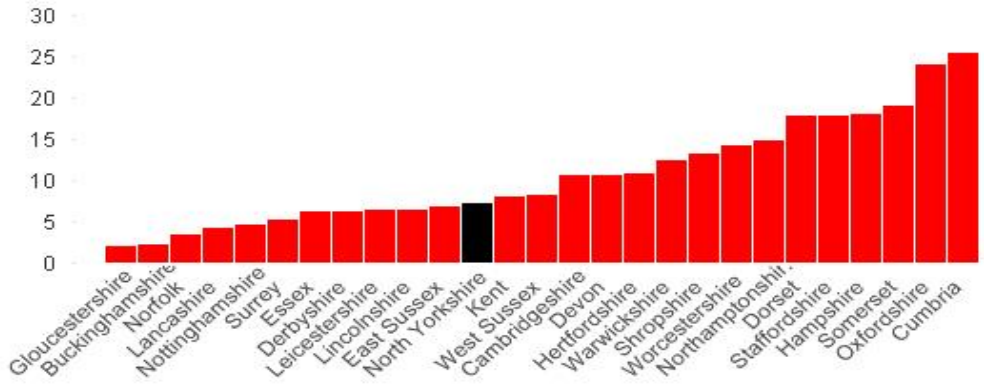
ASCOF Measures

The ASCOF measures report on the number of patients affected by delayed transfers of care, using an average number of patients per month against local population figures.

Shire Counties

- Ranked 12/27 for 'adult social care' and both adult social care and health' patients (see below). Performance as at May 2016 has improved ranking to 10/27.
- Ranked 4th lowest (best) for 'all patients'.

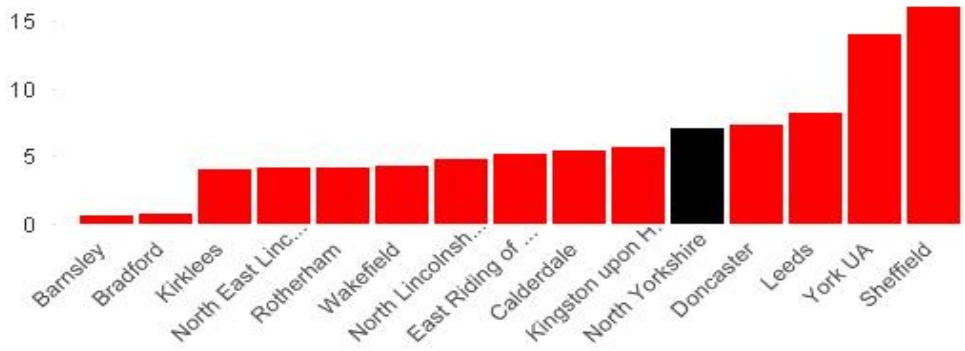
Chart 6



Regional Authorities

- Ranked 11/15 (5h worst) for 'adult social care and both adult social care and health' patients (see below). Performance as at May 2016 shows no change to ranking at 11/15.
- Ranked 8/15 for all patients.

Chart 7



2015-16 Financial Year Performance – Variations

The table below shows delayed transfer days for patients resident in North Yorkshire who were the subject of a transfer of care for the listed health trusts during 2015/16.

Table 1

	Total Days		NHS Days		Social Care Days		Both Days	
Provider Organisation	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
York Teaching Hospital NHS Foundation Trust [1]	5667	40%	2133	25%	3367	70%	167	19%
South Tees Hospitals NHS Foundation Trust [2]	3338	23%	3338	39%	0	0%	0	0%
Harrogate & District NHS Foundation Trust	2287	16%	1955	23%	281	6%	51	6%
Tees, Esk & Wear Valleys NHS Foundation Trust	1674	12%	84	1%	952	20%	638	71%
Airedale NHS Foundation Trust	652	5%	652	8%	0	0%	0	0%
Mid Yorkshire Hospitals NHS Trust	287	2%	249	3%	38	1%	0	0%
Leeds Teaching Hospitals NHS Trust	113	1%	23	0%	90	2%	0	0%
Other	272	2%	162	2%	73	2%	37	4%
Total	**14290**	**100%**	**8596**	**100%**	**4801**	**100%**	**893**	**100%**

[1]Includes York and Scarborough hospitals. [2] Includes James Cook University and The Friarage hospitals

- Two health trusts accounted for 63% of delayed days in 2015/16 (York 40% and South Tees 23%). Four trusts accounted for 91% of delayed days.
- 90% of social care days were accounted for by two trusts – York and TEWV. Whilst York accounted for 40% of total days, but accounted for 70% of social care days.
- Similarly, two trusts accounted for 90% of 'both' days – York and TEWV, with TEWV accounting for 71%.

Table 2

Provider Org Name	NHS Days	Social Care Days	Both Days
York Teaching Hospital NHS Foundation Trust	38%	59%	3%
South Tees Hospitals NHS Foundation Trust	100%	0%	0%
Harrogate & District NHS Foundation Trust	85%	12%	2%
Tees, Esk & Wear Valleys NHS Foundation Trust	5%	57%	38%
Airedale NHS Foundation Trust	100%	0%	0%
Mid Yorkshire Hospitals NHS Trust	87%	13%	0%
Leeds Teaching Hospitals NHS Trust	20%	80%	0%
Other	60%	27%	14%
Total	60%	34%	6%

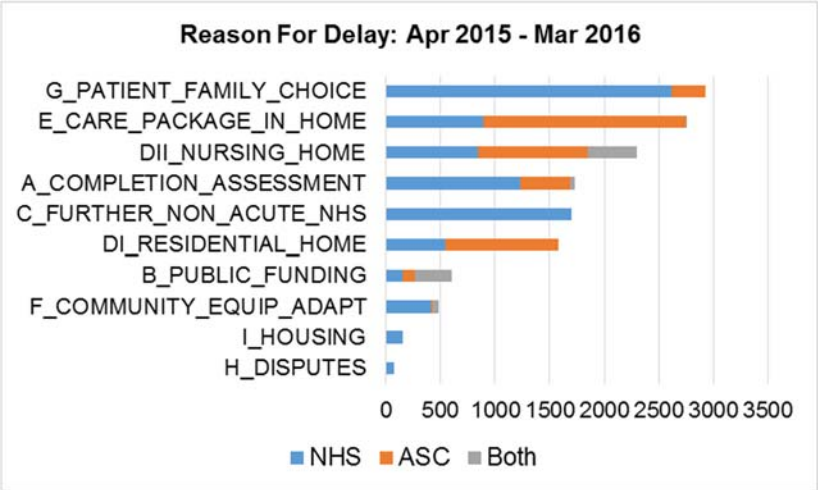
- NHS days accounted for over 60% of total days and social care days for 34%.
- Two trusts accounting for a significant proportion of total delayed days reported a majority of their delayed days as being attributable to social care – York (59%) and TEWV (57%).
- The South Tees and Airedale Trusts reported all days as being NHS attributable days.

- Only TEWV (38%) reported a significant proportion of delayed days as being attributable to both health and adult social care.

2015-16 Financial Year Performance – Reasons for Delay

- The three most prevalent reasons for delay account for 56% of all delayed days. Whilst health accounts for 55% of these days, the pattern of attribution for individual reasons is markedly different (see below).

  Chart 8



- Three reasons account for 81% of delayed days attributable to social care, with one accounting for almost half of this total:

E) Awaiting care package in own home	39%
Di) Awaiting residential home placement or availability	22%
Dii) Awaiting nursing home placement or availability	21%

  - York and Harrogate broadly follow this pattern;
  - TEWV has significantly fewer delays due to E) Awaiting care package in own home (6%) and significantly more due to B) Awaiting public funding – 11% compared with 2% for the county. The latter possibly reflects the trust's policy change, whereby it wants to be involved in the review/reassessment of all cases.
  - For the Leeds Trust, all social care delays are due to A) Awaiting completion of assessment.

Specific Market issues affecting Scarborough and York Hospitals

Given that the hospitals in question cover a large geographical area, and that York District Hospital also takes in takes in a mix of patients from South Hambleton and Harrogate there are a number of reasons impacting the DToC days.

Currently, while there are a number of residential vacancies in Scarborough town, this is not reflected across the more rural parts of Scarborough District, Ryedale and Selby, with only 1 standard residential vacancy available in Selby District. Nursing vacancies are also scarce across the whole county and are often above scale rates. Geographical location and people's choice are often deciding factors in whether a vacancy is suitable or not. Two homes in Scarborough were given notice to close in mid-August

Domiciliary care is difficult to source around the county for a range of reasons, however the primary one being recruitment and retention. In Scarborough large numbers of people are employed in seasonal holiday work and across the county capacity is reduced because of holiday commitments. It is becoming increasingly difficult to source individual packages that are not in centres of population, with providers not willing to extend their services more than a few mile from these centres. The situation in Selby is further complicated by the fact that the number of main framework providers in that area has recently reduced from three to two. The loss of the bridge at Tadcaster is an on-going issue with providers reluctant to have split runs on both sides of the river.

Actions taken to reduce DToC.

- Additional assessment staff are now located in York and Scarborough Hospitals and availability of staff has been increased in the other acute hospitals.
- The “Reset” procedure for restarting existing Dom care packages following a short stay in hospital is up and working in Scarborough and Friarage Hospitals
- Some additional step down beds have been purchased at Station View as part of Harrogate Vanguard arrangements
- There is on-going work to develop the community care market (including Personal Assistant Networks) to reduce reliance on traditional home care services.
- We are working with Scarborough Hospital on a pilot “Discharge to assess” scheme for less complex cases.
- There is on-going joint work with the NHS in the Selby and Malton Hubs to reduce the numbers needing to go into hospital.
- START teams continue to rehabilitate people coming out of hospital and are supporting increased numbers of people.

More recent and focussed work being undertaken by the County Council to better understand performance in relation to social care delays includes the following improvements:-

- Daily communication with acute hospitals over those in DToC situations and the general position of the hospital
- Working with Hospitals to improve patient flow for non DToC patients especially over the Christmas period
- Improved communication channels at senior management level between the trusts and Health and Adult Services
- Production of a daily Health and Adult Services Situation Report.
- Weekly resilience meeting now attended by all Care and support Heads of Service and Assistant Directors
- Development of specific locality plans by Health and Adult Services to address social care delays

High Impact Change Model

Managing Transfers of Care

HIGH IMPACT CHANGES FOR MANAGING TRANSFERS OF CARE

- Ensuring people do not stay in hospital for longer than they need to is an important issue – maintaining patient flow, having access to responsive health and care services and supporting families are essential.

- We learnt valuable lessons from the Health and Care system across the Country last winter about what works well and we have built those into a High Impact Change model .

- This model has been endorsed in a joint meeting between local government leaders and Secretaries of State for Health and for Communities and Local Government in October.

- We know there is no simple solution to creating an effective system of health and social care, but local government , the NHS and Department of Health are committed to working together to identifying what can be done to improve our current ways of working.

A number of practical tools compliment the high impact changes for reducing transfers of care

- **NHS High Impact Changes :** Guidance for SRGs
- **Winter Pressures** : A Guide for Council Scrutiny
- **Safer, Better, Faster** : ECIST good practice guide
- **NHS England Quick Guides:** Solutions to common issues

It may also be helpful to consider:

- **Role of the Health and Wellbeing Board :** Oversight and system leadership
- **Mental Health :** Access to services and accommodation
- **Voluntary sector** : Capacity and capability
- **Telehealth and Telecare** : supporting people to remain independent

Working with local systems, we have identified a number of high impact changes that can support local health and care systems reduce delayed transfers of care…

Change 1 : Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

We have developed this tool as part of our winter resilience sector led improvement programme

- The 8 changes which are outlined have been developed through last year's Helping People Home Team's work (a joint DH, DCLG, NHS England, ADASS and LGA programme).

- They have also been tested within a number of local systems that the Emergency Care Intensive Support Team (ECIST) have worked with.

- Given the pressures on local health and care systems, especially around patients flow and discharge, we want to support local systems with practical support.

- This tool has been developed at pace with some co-design to help local systems over this winter. It is to encourage areas to consider new interventions for this winter, but also to assess how effective current systems are working.

- Support on how to implement any of these changes is on offer from the ECIST and the LGA Care and Health improvement Advisors.

Changes

Change 1: Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place.	CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning.	Joint pre admission discharge planning is in place in primary care .	GPs and DNs lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team.
Discharge planning does not start in A+E	Plans are in place to develop discharge planning in A+E for emergency admissions	Emergency admissions have a provisional discharge date set in within 48hrs	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X% patients go home on date agreed on admission

Changes

Change 2 : Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Not yet established	Plans in place	Established	Mature	Exemplary
No relationship between demand and capacity in care pathways Capacity available not related to current demand Bottlenecks occur regularly in the Trust and in the community There is no ability to increase capacity when admissions increase – tipping point reached quickly Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Analysis of demand underway to calculate capacity needed for each care pathway Analysis of demand variations underway to identify current variations Analysis of causes of bottlenecks underway and practice changes being designed Analysis of admissions variation ongoing with capacity increase plans being developed Staff training in place to ensure understanding of the need to increase senior clinical capacity	Policy agreed and plan in place to match capacity to care pathway demand Analysis completed and practice change rolled out across Trust and in community Analysis completed and practice changes being put in place and evaluated Staff understand the need to increase capacity when admissions increase Staff understand the need to increase senior clinical support when necessary	Capacity usually matches demand along the care pathway Capacity usually matches demand 24/7 to match real variation Bottlenecks rarely occur and are quickly tackled when they do Capacity is usually automatically increased when admissions increase Senior clinical decision making support is usually available and increased when necessary	Capacity always matches demand along the whole care pathway Capacity always matches demand 24/7 reflecting real variations There are no bottlenecks caused by process or supply failure Capacity is always automatically increased when admissions increase Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7

Changes

Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients

Not yet established	Plans in place	Established	Mature	Exemplary
Separate discharge planning processes in place	Discussion ongoing to create Integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each others assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily MDT meeting in place	Discussion to introduce MDTs on all wards with Trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
CHC assessments carried out in hospital and taking “too” long	Discussion between CCG and Trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in peoples homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

Changes

Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Not yet established	Plans in place	Established	Mature	Exemplary
People are still assessed for care on an acute hospital ward	Nursing capacity in community being created to do complex assessments in the community	People usually return home with reablement support for assessment	People return home with reablement support from integrated team	All patients return home for assessment and reablement after being declared fit for discharge
People enter residential /nursing care too early in their care career	Systems analysing which people can go home instead of into care – plans for self funder advice	People usually only enter a care / nursing home when their needs cannot be met t through care at home	Most people return home for assessment before making a decision about future care	People always return home whenever possible supported by integrated health and social care support
People wait in hospital to be assessed by care home staff	Work being done to identify homes less responsive to assess people quickly	Care homes assess people usually within 48 hours	Care homes usually assess people in hospital within 24 hours	Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours

Changes

Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours 5 days a week	Plan to move to 7 day working being drawn up	Health and social care teams working to new 7 day working patterns	Health and social care teams providing 7 day working	Seamless provision of care regardless of time of day or week
OOHs emergency teams provide non office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
Care services only assess and start new care Monday – Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
Diagnostics ,pharmacy and patient transport only available Mon-Fri	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24hrs 7 days a week	Whole system commitment enabling care always to restart within 24hrs 7 days a week

Changes

Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Not yet established	Plans in place	Established	Mature	Exemplary
Assessments done separately by health and social care	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care	Integrated assessment teams committing joint pooled resources
Multiple assessments requested from different professionals	One assessment form /system being discussed	One assessment format agreed between organisations /professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign off
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each others behalf	Care providers share responsibility of assessment	Some care providers assess on each others behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

Changes

Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Not yet established	Plans in place	Established	Mature	Exemplary
No advice or information available at admission No choice protocol in place No voluntary sector provision in place to support self funders	Draft pre admission leaflet and information being prepared Choice protocol being written or updated to reduce < 7 days Health and social care commissioners co designing contracts with voluntary sectors	Admission advice and information leaflets in place and being used New choice protocol implemented and understood by staff Voluntary sector provision in place In the Trust proving advice and information	Patients and relatives aware that they need to make arrangements for discharge quickly Choice protocol used proactively to challenge people Voluntary sector provision integrated in discharge teams to support people home from hospital	Patients and relatives planning for discharge from point of admission All staff understand choice and can discuss discharge proactively Voluntary sector fully integrated as part of health and social care team both in the trust and the community

Changes

Change 8 : Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Not yet established	Plans in place	Established	Mature	Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
High numbers of referrals to A+E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
Evidence of poor health indicators in CQC inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care homes CQC rates reflect high quality care

Impact Change	Where are you	What do you need to do	When will it be done by	How will you know it is successful
Early Discharge Planning				
Systems to Monitor Patient flow				
Multi-Disciplinary Multi-Agency Discharge Teams (Including Voluntary and Community sector)				
Home First Discharge to Assess				
Seven-Day Services				
Trusted Assessors				
Focus on Choice				
Enhancing Health in Care homes				

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Better Care Exchange website

https://bettercare.tibbr.com/tibbr/web/login

Emergency Care Improvement Programme website

http://www.ecip.nhs.uk/