AGENDA ITEM NO:

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST
BOARD OF DIRECTORS
THURSDAY 22 SEPTEMBER 2011

Title:	**PROGRESS REPORT ON DELAYED TRANSFERS OF CARE (DTOCs)**
Responsible Director:	Kevin Bolger, Chief Operating Officer Viv Tsesmelis, Director of Partnerships
Contact:	Viv Tsesmelis, Director of Partnerships

Purpose:	In order to ensure the most efficient use of acute beds, patients need to be discharged from an acute setting as early as possible following the completion of their acute episode.
Confidentiality Level & Reason:	N/A
Medium Term Plan Ref:	Aim 1: Always put the needs of the patient first
Key Issues Summary:	
Recommendations:	The Board of Directors is asked to: 1. **Note** the contents of this report. 2. **Receive** a further update on the position in six months time.

Signed: Chief Operating Officer	**Date:**

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PROGRESS REPORT ON DELAYED TRANSFERS OF CARE (DTOCs)

PRESENTED BY THE CHIEF OPERATING OFFICER AND DIRECTOR OF PARTNERSHIPS

1. Background

In order to ensure that we make the most efficient use of acute beds, patients need to be discharged from an acute setting as early as possible following the completion of their acute episode.

However, for a number of patients, there will be a period of time during which they are assessed for ongoing care needs, when they will continue to occupy an acute bed after their acute episode has ended. Legislation dictates that this process of assessment should not begin before the person is medically fit, as the outcome of such an assessment can often include life changing decisions such as a move to residential or nursing care homes. However, the legislation does not require that the assessment occurs in an acute setting.

Prior to April 2009, the average number of patients delayed in UHB beds at the end of their acute episode would be approximately 25 patients. This was generally lower than the national 'target' for DTOCs of 3.5% of available bed capacity. Since that time there has been a steady increase in the number of delays with an average across the two years of approximately 50 patients at any time, although there was a peak last autumn when the number of delays rose to over 70 patients.

Over recent years there have been many schemes nationally that have looked to develop different models/pathways of care, particularly for frail elderly people, that have introduced interim 'enablement' facilities that have allowed for a transfer of care at the end of the acute episode. The patient is transferred home or into a community setting where there is an opportunity for targeted rehabilitation to regain functioning capacity, before being assessed for ongoing care needs. These schemes have generally resulted in a reduction in the numbers of people eventually moving into long term residential accommodation.

These schemes only presently meet the needs of those people who are assessed as having 'capacity for enablement' and have excluded people with dementia. At the same time, there has been a reduction across the city in residential facilities that meet the needs of people with dementia, which has

inevitably created a cohort of patients for UHB who have an extended stay in the Trust while we attempt to plan adequate discharge arrangements.

As a result of both the increase in the number of DTOCs overall, and taking account of the particular needs of this cohort of patients with dementia, the Trust has developed a ward that is used to provide services for people who are medically fit but do not have a discharge plan in place; the majority of whom also have dementia. Presently this ward, E2B is in the old hospital building and will be moving to Bournville Ward (old Oncology ward) by the end of September 2011.

2. Actions to deal with the level of Delayed Transfers of Care

Over the last year the Trust has introduced a range of actions to deal with the overall situation and this paper summarises the key aspects of this action.

2.1 Escalating the Situation

Although we are performance managed on the level of DTOCs, most of the actions are the responsibility of other agencies, so we have set up a regular forum with the Local Authority, the Community Trust and the PCT commissioners to review the situation and determine actions that are required.

Despite agreeing action plans with the Local Authority, the required action has not always been taken. We have therefore escalated the situation to the Strategic Health Authority and to the Government Office department that performance manages the Local Authority. We have also asked for the National Support Team to be brought in to review the situation.

2.2 Local performance

Mindful that we need to take all necessary local actions, we have revised our own Discharge Policy and Procedures and are undertaking 'rapid spread' training with nursing staff to reinforce the need for tight adherence to the processes.

As the fifth floor wards have the majority of frail older people, which is the group most affected by DTOCs, we have introduced a short term 'task and finish' group for the fifth floor which has reviewed all the components of the process and introduced improvements such as daily Consultant ward rounds.

We have also initiated weekly meetings at a senior level, with the Local Authority Social Work team, where we review all delays and agree actions to improve the situation. These have had limited success as the actions agreed are not routinely followed by the Local Authority. These issues are then escalated at the more senior level meetings described above. We have now extended an invitation to

the Community Trust to be involved with these meetings, in order that we can expedite the transfer of patients into community hospital beds.

2.3 Service Change

As we identify gaps in the existing system, we have worked with our partners to introduce changes in the services offered locally, both to enable us to move patients on more efficiently, but mainly to ensure that our patient population benefits from the range of services on offer.

Over the last year, this work has resulted in the following service change:

2.3.1 Enablement Home Care

Patients can now return home with intensive support for up to six weeks post discharge, before they are assessed for long term care needs.

2.3.2 Kenrick Centre

This is a 32 bedded residential facility where patients with enablement potential can move fully funded for up to six weeks, to receive care and rehabilitation. This has already resulted in a marked reduction in ongoing care needs, post this stay. UHB provides the therapy input into this Centre, with the daily care needs provided by social care staff.

2.3.3 Residential care for people with dementia and challenging behaviour

Commissioners and providers have now agreed that on a city wide basis from October this year we are opening 20 short stay/interim beds for people with dementia and challenging behaviour to receive services post acute care, with their care being provided by specially trained psychiatric nurses. During this episode of care, they will then be assessed for ongoing care needs. Hopefully by being cared for in a more appropriate care setting, more patients will be able to return to their own homes.

We are also working with a number of independent care providers to develop proposals for a domiciliary care service that has the additional expertise to be able to provide services for people with dementia but without challenging behaviour, that could enable them to be discharged home and receive the assessments for their ongoing care needs in their own homes.

3. Present Situation

Over the last few weeks we have seen a reduction in the numbers of delays, although they are still at an unacceptable level.

The Local Authority is facing extreme financial pressure and it has been agreed by our PCT cluster that they will be transferring resource to the Local Authority, via Section 256 reablement funding, to assist the Local Authority with these pressures. However, the cluster has also agreed that it will attach 'conditions' to this transfer and that the level of DTOCs must be reduced further and maintained at the lower level, as a condition of receiving this funding.

Locally we have seen a small injection of resource into our local hospital team to facilitate improved processing and this has started to have a positive impact on the numbers.

We have discussed with the Local Authority the possibility of managing the overall assessment process in a different manner, and this will be progressed over the coming months.

Many of the delayed transfers occur with patients who were admitted originally because of social care problems, rather than because of an acute need. We have initiated work at the front door to divert people back to appropriate community services in an attempt to reduce inappropriate admissions, which will also reduce the complex discharge processes for such cases.

4. Recommendation

The Board is asked to

4.1 **NOTE** the contents of this report.

4.2 **RECEIVE** a further update on the position in six months time