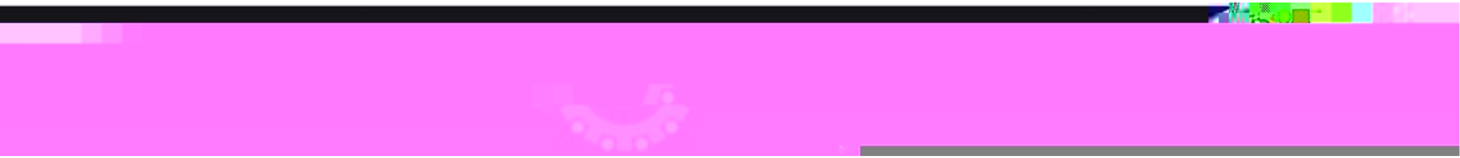
Delayed Transfers of Care

A report from Overview & Scrutiny

Birmingham City Council, 11th January 2011



Report of Health and Adults Overview and Scrutiny Committee 11 January 2011

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Further information regarding this report can be obtained from:

Rose Kiely on 0121 303 1730, email rose.kiely@birmingham.gov.uk

Tony Green on 0121 303 1520, email tony.green@birmingham.gov.uk

Reports that have been submitted to Council can be downloaded from www.birmingham.gov.uk/scrutiny.

Summary

Delayed Transfers of Care are a longstanding and intractable national issue and have been a problem in Birmingham for many years. Although Birmingham figures for delayed transfers have been broadly improving over the last year, they remain higher than planned. Progress has been made but there is a long way to go to ensure that this progress continues consistently and at the necessary rate to meet targets. Whilst the evidence presented to the review highlighted many examples of good practice it is clear that tackling this issue effectively will require clarity about how existing good practice can be identified, built on and rolled out on a consistent basis across the City.

In many ways delayed transfers of care represent the point at which the health and the social care economies meet - the point at which the demand generated through the acute trusts, in terms of occupied beds, meets the resources available to assess and place those with on-going social care needs. Because of this, the issue has been identified as a significant performance issue by City partners. It is an important area where whole system ownership of the problem and effective joint working with improved integration between health and social care will be particularly important in order to bring about the necessary improvements.

The delays carry a cost to the City Council and to the NHS. As a result of the Community Care (Delayed Discharges) Act 2003, the authority can be fined for delayed discharges which are found to be solely its responsibility at a cost of £100 per patient per day including weekends. The Comprehensive Area Assessment noted in December 2009 that in an average week about 150 Birmingham people are still in hospital when they could have been discharged.

The problem is often thought of primarily in connection with older people but the effects of delayed transfers are felt by a wide range of patients. Although National Indicator 131 only measures delayed transfers of care relating to those aged 18 and over, evidence was presented to the review of the significant detrimental impact of delayed transfers of care on children and young people and their families.

Ultimately the issue needs to be urgently tackled as a matter of priority because delayed transfers impact on the quality of care and subsequently on the quality of life, of some of the most disadvantaged, vulnerable and frail people in the city. There are many risks associated with being in hospital longer than is necessary, particularly for vulnerable older people. These include increased risk of infection and loss of independence and mobility. The delays also have a knock-on impact amongst the rest of the community through delayed urgent admissions, cancelled operations and overall problems with emergency and elective access to beds. The delays affect a wide range of patients and can create frustration and uncertainty and delay the opportunity for restoring independence to patients.

Any delay in discharge is bad for patients, their families, for carers, the NHS and the Council. Minimising delayed transfers of care is fundamental to a person-centred approach to health and social care that treats individuals with dignity and respect as well as meeting their needs to secure the best outcomes possible.

List of Recommendations

	Recommendation	Responsibility	Completion Date
R01	That each Trust develop systems and protocols for implementing an effective multidisciplinary filtering process to be based in each Accident & Emergency Department to avoid inappropriate admissions to the acute hospital system, with the aim of diverting patients who would be more effectively treated by their GP.	Chief Executives of NHS Acute Trusts PCT Chief Executives	30 June 2011
R02	That a single director or senior manager in the Council, one in each PCT and one in each Hospital Trust be given specific authority and responsibility to resolve and decide inter-budgetary or other disputes quickly where these are causing or contributing to a delayed transfer of care.	Cabinet Member for Adults & Communities; Cabinet Member for Children Young People and Families; PCT Chief Executives; & Chief Executives of Hospital Trusts	30 June 2011
R03	That the evidence-based good practice which has developed in some areas which is emerging from the work on the Optimal Care Initiative be captured, communicated to partners and buy in sought from partners, with a view to implementing the same as standard practice across all relevant partner agencies on a citywide basis.	Birmingham Health & Wellbeing Partnership	31 March 2011
R04	That a Citywide 'Community Based Budget' approach be developed to identify evidence based best practice for the development of intermediate care, with a view to implementing this common approach through the creation of pooled budgets for intermediate care. The budget must be used in a way that will significantly reduce delays whilst providing best outcomes and enhancing the quality of life.	Birmingham Health and Wellbeing Partnership	30 June 2011
R05	That a scoping exercise be undertaken in relation to the commissioning strategy for the frail elderly to establish the commissioning requirements for EMI beds across the City, with the aim of alleviating problems with the availability of EMI (Elderly/Mentally/Infirm) beds.	Cabinet Member for Adults & Communities	31 March 2011
R06	That each hospital trust creates a system to ensure that discharge planning starts on admission and that	NHS Hospital Trust Chief Executives; Cabinet Member	31 March 2011

1 PART 1: What is the problem?

1.1 Reasons for the Review

1.1.1 The issue of Delayed Transfers of Care is not new. It has been a problem in Birmingham for many years. In an average week up to 150 Birmingham people are still in hospital even though they are considered medically fit to be discharged. The delays affect a wide range of patients and can create frustration and uncertainty and delay the opportunity for restoring independence to patients. The delay is bad for patients, their families, for carers, the NHS and the Council.

1.1.2 Delayed Transfers of Care has been repeatedly identified as an area needing improvement, because Birmingham is not performing well. The problem has repeatedly and consistently been raised by external agencies over a number of years including the Audit Commission and the

2 What the performance data tells us

2.1 Performance monitoring data

2.1.1 The Hospital trusts send weekly data about delayed discharges to the Council's Business Information Unit ('BIU'), listing the causes of delay, which hospital the patients are in, the category of service provision that covers their needs for hospital stay and post-discharge care or support, characteristics such as the patients' ages, and the lengths of delays. BIU staff email the data each week to a range of Council officers and to NHS trusts.

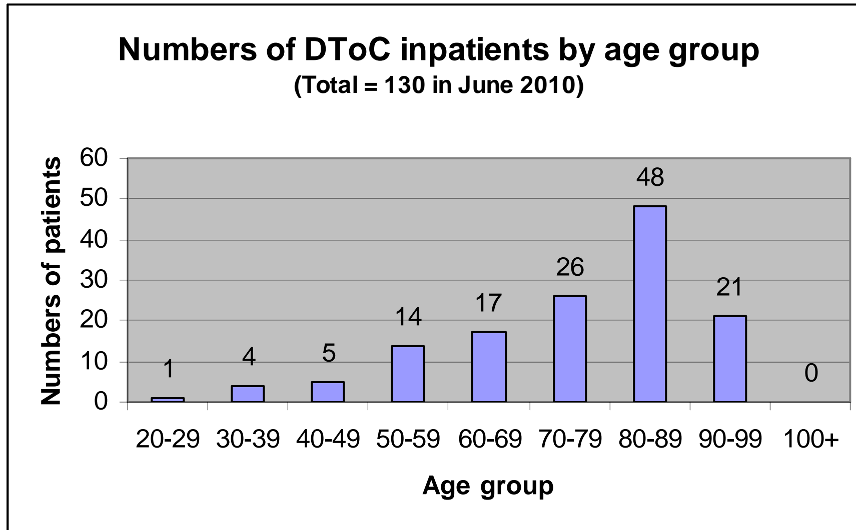
2.1.2 A consolidated monthly Delayed Transfer of Care Report, which includes historical data to show trends, is submitted to the Citywide Delayed Transfers of Care Group.

2.2 Numbers of patients experiencing delay is rising

2.2.1

shows whether delays under each heading can be attributable solely to social care services ('SC'), which is the only category for which acute trusts could claim reimbursement, or to the NHS, or to both.

Heading	% DToCs caused	DToC could be attributable to
		SC or NHS or both
		SC or NHS or both
Awaiting a residential care home placement	17%	SC or NHS but not both
Awaiting assessment	14%	SC or NHS or both
Awaiting public funding	9%	SC or NHS or both
Awaiting further non-acute (including PCT and Mental Health) NHS care (includes intermediate care, rehabilitation etc.)	8%	Only NHS



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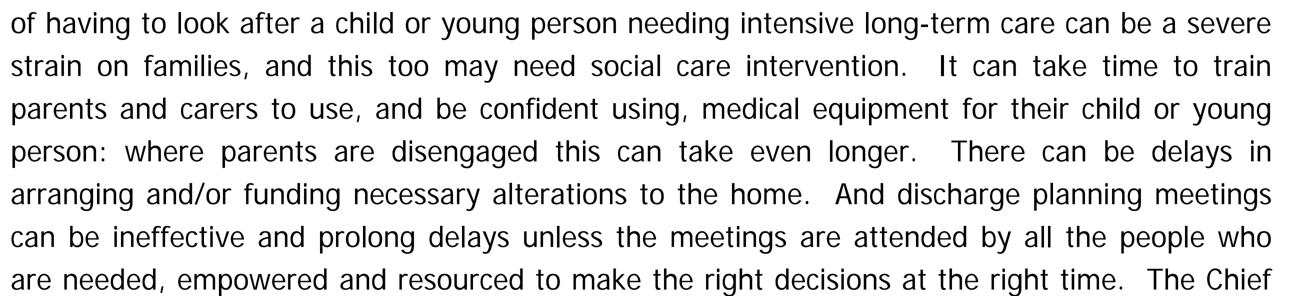

of having to look after a child or young person needing intensive long-term care can be a severe strain on families, and this too may need social care intervention. It can take time to train parents and carers to use, and be confident using, medical equipment for their child or young person: where parents are disengaged this can take even longer. There can be delays in arranging and/or funding necessary alterations to the home. And discharge planning meetings can be ineffective and prolong delays unless the meetings are attended by all the people who are needed, empowered and resourced to make the right decisions at the right time. The Chief

2.7 Different types of care and beds

2.7.1 As we began to receive evidence we heard several different descriptions of care and/or beds, including acute, intermediate, step down, step up, interim, community and enhanced assessment. The distinctions between them were gradually clarified to us.

2.7.2 Acute beds are those in acute hospitals where skilled medical treatment is used. Delayed discharges of patients in those beds is potentially reimburseable.

2.7.3 Intermediate care beds are also known as 'step down' or sometimes 'step up' beds. The Department of Health ('DH') [Department of Health (2001a) *Intermediate care*, HSC 2001/001, LAC (2001)1] said intermediate care should be regarded as describing services that meet all of the following criteria:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care, or continuing NHS inpatient care;
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home;
- Are time-limited, normally no longer than 6 weeks and frequently as little as 1-2 weeks or less;
- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

2.7.4 According to a DH fact sheet [*Community Care (Delayed Discharges etc.) Act Frequently asked Questions on Reimbursement*] "Interim care is for those awaiting their home of choice or other provision following completion of the multidisciplinary assessment, which may have included a period of intermediate care. (Though it can involve using interim beds it) could involve alternative NHS or social care provision, including an enhanced care package at home. Interim care arrangements should be properly commissioned and…may or may not be subject to a charge."

2.7.5 Community beds are in local, often relatively small, non-acute community hospitals. GPs can refer patients to them directly.

2.7.6 The DH does not define enhanced assessment but we were told the term is used to cover assessing the patient's ability to cope whilst staying in a non-acute environment that is safe yet has many of the features of home life. This could be done towards the end of intermediate care, or during interim care, or in some community bed settings. It allows as many normal living skills

as possible to be observed and assessed. The thinking is that in an acute hospital patients do not have opportunity to obtain their own services such as making themselves a meal or a hot drink, so only by taking them away from that environment can their ability to do such tasks safely can be assessed. The assessment is used as the basis for planning a care package where necessary to enable the patient to move on to living independently.

2.7.7 Beds can be converted from one use to another, though different uses may require different resources such as equipment, services and staff skills and time.

3 Impact of delayed discharges

3.1 Impact on Birmingham people

3.1.1 In addition to the financial cost to trusts – from having to pay for food, drink and laundry that they would not need to pay for after discharge – and to local authorities – which can be required to reimburse the acute trusts – delayed transfers of care can cause needless distress and suffering to a range of people involved.

3.1.2 Firstly the **patient** can be harmed. Despite strenuous efforts to make hospitals clean and pleasant places, some risks and discomfort can never fully be eliminated. Most patients feel mentally and physically better off at home once they are clinically fit to be discharged. If a patient has to remain in hospital for a long period after that, with no clue as to when they can leave, boredom, loneliness, hopelessness and depression can develop. Long stays in hospital can have adverse unintended physical effects such as increase susceptibility to infection and pressure sores. Some patients, such as those who are elderly or have dementia, may be able to cope at home before their admission to hospital. However if they have to stay in hospital for an extended period, they may permanently lose that ability to cope, perhaps years earlier than they might otherwise have done.

3.1.3 Secondly it can sometimes harm the interests of a **patient who needs hospital inpatient treatment** but cannot be admitted because the bed they need is 'blocked', that is, occupied by someone who clinically no longer needs it. The Government statistics web site (www.statistics.gov.uk) says that in 2008-09 the mean average waiting periods in England for main hospital treatment ranged from 21 days for kidneys to 84.1 days for hips[1]. Some of these delays may be awaiting suitably skilled clinical staff such as consultants, but others may be waiting for a hospital bed.

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[1] www.statistics.gov.uk, 'Hospital 28.6(ey io46 D0.0u-0.t105.9(e)1o)]sJ1098(oc)er nsJ1098: Head su01 -1.4111.591 Tc0.1661

3.1.7 We are pleased that the Cabinet Member for Housing has asked his officers to look into the Housing aspects mentioned in the story.

3.2 Financial Impact: Costs to Birmingham City Council

3.2.1 In 2003 Community Care (Delayed Discharge) Act 2003 (the Act) was published and was aimed at tackling the issue of delayed transfers of care from NHS bedded settings.

3.2.2 The Act introduced a system of reimbursement for delayed discharges. It entitled acute hospitals (and also provides capacity to extend this to other NHS provider services) to effectively fine a local authority and levy a daily charge for persons delayed from being discharged where the local authority was responsible for the delay. More specifically the Act states that:

- NHS bodies have a duty to notify the relevant local authority of patients likely to need community care services and their proposed discharge date.
- Local authorities have a duty to pay the set payment (£100 or £120) for each day of each delay for which they are responsible (as defined in the regulations).
- Reimbursement is paid to the Acute Trusts.

3.2.3 From 2003 local authorities received a grant, known as the Reimbursement Grant (RIG), of funding which was top sliced from the NHS for the purpose of assisting whole system approaches to increasing the range and volume of services to reduce delayed transfers of care. The aim was to facilitate joint working between local authorities and NHS bodies to encourage them to agree and fund joint schemes.

3.2.4 Acute trusts and local au-3.9n4(u[(-3.943-1.972Tw[(forSc272Tw[v.q17 TD5.4(u-3.9nw[((andow4c)3ec5
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3.2.7 In 2009/10 just under £2m RIG-equivalent funding was spent. Just over half of that was spent in Birmingham East & North, mainly on interim or specialist beds or community-based step-down beds but also on funding a third sector organisation to prepare inpatients homes ready for their return. £350,337 was spent in South Birmingham

Disease. The two main conditions leading to Chronic Obstructive Pulmonary Disease are emphysema and chronic bronchitis, and smoking is the main cause of both conditions.

4.2.2 Some forms of circulatory disease, respiratory disease, heart disease and diseases of the digestive tract are caused wholly or partially by poor diet, obesity, overuse of alcohol and lack of physical exercise, all of which are being addressed by Birmingham Health & Wellbeing Partnership and/or the Primary Care Trusts. It is hoped that the planned creation of a Health & Wellbeing Board and the proposed concentration of public health responsibilities with upper-tier local authorities – which includes Birmingham - should help to bring about faster improvements in public health.

4.3 Rapid Response Teams

4.3.1 Members were told that sometimes patients go into hospital because of a short term temporary deterioration in their health, which could potentially be treated outside hospital by a rapid response team to avert the need for admission. The Chief Executive of NHS South described how one such team operates in her PCT's area.

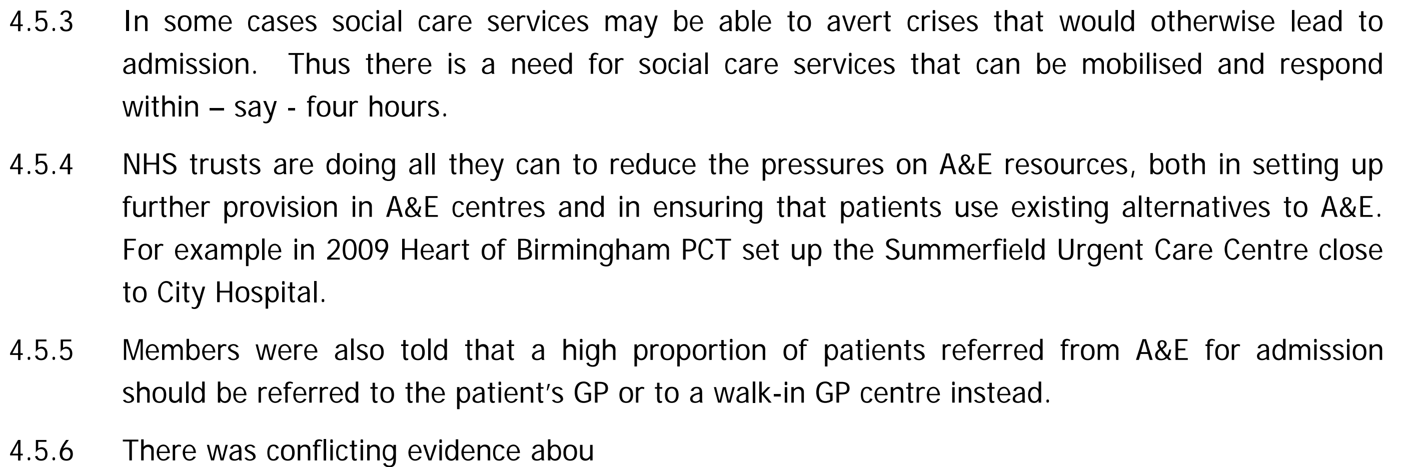
4.3.2 The Rapid Response Team is staffed by nurses who are able to go into the patient's home quickly to provide support as necessary for up to seven days. Often the need for support reduces or ends within the seven days, but any support needed after that is picked up by a Multi-Disciplinary Team.

4.3.3 Each of the other two PCTs has a dedicated Rapid Response Team that actively visits accident and emergency departments to find patients who could be treated successfully at home rather than being admitted. A continuing difficulty is that too few care homes are aware of the Teams and could refer patients to be given more health support in the homes.

4.4 Slips, trips and falls

4.4.1 Evidence was presented from South Birmingham Primary Care Trust outlining the case for gritting key pedestrian footways and pavements across the city during key periods during the winter months to help reduce the nunth10.98 0 0 10.98 2459 0 TDyehtrips asTT6o benths 0001 Tc-7rpbt

outside public buildings and other facilities, rail,



4.5.3 In some cases social care services may be able to avert crises that would otherwise lead to admission. Thus there is a need for social care services that can be mobilised and respond within – say - four hours.

4.5.4 NHS trusts are doing all they can to reduce the pressures on A&E resources, both in setting up further provision in A&E centres and in ensuring that patients use existing alternatives to A&E. For example in 2009 Heart of Birmingham PCT set up the Summerfield Urgent Care Centre close to City Hospital.

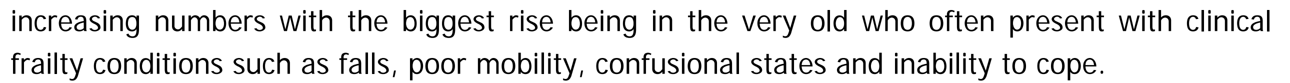
4.5.5 Members were also told that a high proportion of patients referred from A&E for admission should be referred to the patient's GP or to a walk-in GP centre instead.

4.5.6 There was conflicting evidence abou

4.7 Senior responsible officers to resolve budgetary disputes

4.7.1

4.9.3 There are some prospects for optimism. Medication reviews are done under new GP and community pharmacist contracts. Many nursing homes are covered by a GP practice given an enhanced payment to do medication reviews on residents registered with their practice and to improve health care systems in the Home. They can encourage, but not require, all residents to register with their practice. GP practices linked to care homes do not get an enhanced payment, and care homes do not have qualified nurses on their staff. Perhaps because of this, care home residents have a higher rate of emergency admissions despite having more stable health. Primary Care Trusts' (PCT) pharmacists also regularly review prescribing and report back to the GP with suggested changes. The PCT Medicines Management Teams focus on reviewing the



increasing numbers with the biggest rise being in the very old who often present with clinical frailty conditions such as falls, poor mobility, confusional states and inability to cope.

4.10.2 Patients in a confusional state tend to stay in hospital on average ten days longer, and are more likely to have an adverse event while in hospital and poorer outcomes in terms of mortality. This was placing considerable pressure on A&E Departments. He gave evidence that crisis referral to

6 PART 4: Reducing Discharge Delays

Main causes of discharge delays

The Department of Health requires councils and health trusts to classify the causes for delayed transfers of care into the following ten categories.

6.1 Awaiting assessment

6.1.1

of social care packages but not to NHS care, so the dispute outcomes can be very important to the patient and their family.

6.2.2 A small proportion of delayed transfers in this category are of patients whose immigration status is undetermined, and who have been given leave to stay legally but with no recourse to public funds. Under para. 6 of the Immigration Rules public funds cover:

Housing from a local authority directly or indirectly;

Health in pregnancy grant, attendance allowance, severe disablement allowance, carers allowance and disability living allowance;

Housing benefit, council tax benefit, income support, contribution-based employment and support allowance, state pension credit or child tax credit and working tax credit, and any social fund payment.

6.2.3 However a UK border agency policy enables those on family visas to claim child benefit and working tax credit without breaching the public funds condition.

6.2.4 The legal definition of 'public funds' for this purpose does not include benefits based in National Insurance Contributions, namely;

Access to emergency services;

NHS treatment;

Education funded by a local educational authority;

created by converting and redesignating some community respite beds for use as intermediate enhanced assessment beds.

6.3.7 Members noted that the evidence presented by South Birmingham Primary Care Trust in relation to the availability of interim beds appeared to be at variance with the evidence but forward by the University Hospitals Birmingham NHS Trust ('UHB') regarding the availability of community beds in South Birmingham PCT's area and the potential to use them differently. It is in patients' interests for this difference to be resolved quickly and replaced by an objective evaluation of the relative merits and defects of alternative ways of using beds. Funding of new initiatives either needs new money or the use of existing funds differently. So the possibility should be explored of decommissioning some community beds in order to provide more enhanced assessment beds. *Reference recommendation **R08***

6.3.8 Ideally intermediate accommodation is away from an acute hospital setting so the patient can re-learn and increasingly practice coping skills in preparation to return to living independently whilst their health is improving. This takes the delayed transfer away from the acute hospital. Ideally every patient who is likely to need a care package should have a pathway through enhanced assessment so that the care package can be purpose-designed. However UHB gave evidence

6.4 Awaiting a residential or nursing home placement or domiciliary services

6.4.1 About 17% of delayed discharges are caused by patients having to await a residential home placement, 19% are caused by awaiting a nursing home placement, and 17% are caused by awaiting domiciliary services, so these together account for over half (53%) of all delayed discharges.

6.4.2 However Members have heard that many, perhaps most, delayed discharges recorded as being attributable to these three causes should more accurately be attributed to waiting for assessment. That cause in turn may be because of a lack of social workers or health staff to do the assessments, or a lack of budgets, or – and this currently appears most likely - a shortage of suitable affordable places at private care homes or nursing homes, and at best a patchy availability of domiciliary providers. We do not have hard evidence to verify this but suggest the commissioners should explore the availability of affordable care home and nursing home places, and domiciliary care services in the market. If that shows a need to stimulate greater supply, they should apply market development techniques, perhaps using the expertise available from staff of the former market development team in Business Transformation, to bring supply closer to matching demand.

6.4.3 At present in parts of the City the Council partly funds a service where unpaid volunteers provide a variety of support to patients recently discharged from hospital for the first four weeks after discharge. A charity provides a similar but more limited service in another part of the City. The volunteers provide a parcel of shopping for people on their arrival home. Depending on need the volunteers can also:

- Reposition furniture, including where necessary moving it up or down stairs;
- Find and provide information about nearby day centres or luncheon clubs to assist the ex-patient to maintain engagement with others and to minimise loneliness;
- Do a benefits check to ensure the ex-patient receives all the benefits to which she or he is entitled;
- Accompany the ex-patient to the shops, pharmacy or GP; or
- Provide the ex-patient with information about handyman services.

6.4.4 Since volunteer-staffed schemes are relatively inexpensive, Adults and Communities is considering changing the specification for which they commission. Seven matters are being considered:

- extending the period the service covers from the first four weeks after discharge up to three months;
- asking the enterprise about its capacity to expand to cover other areas of the City;
- exploring whether other volunteer-staffed enterprises could set up to cover other parts of the City;
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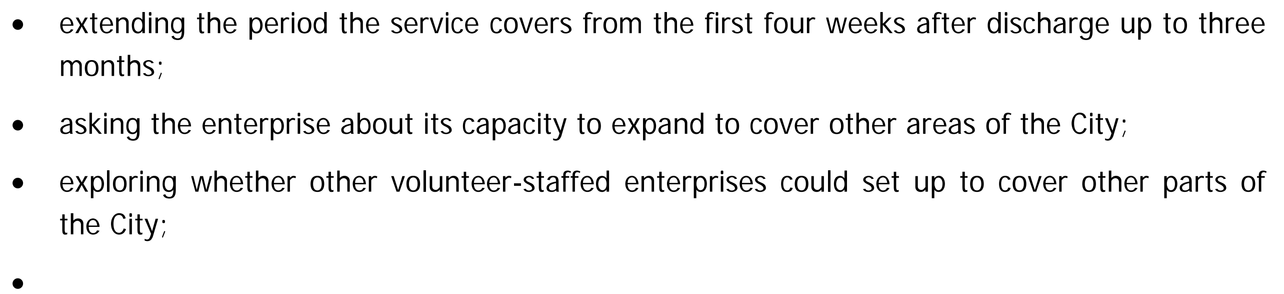

6.5.2

7

Appendix

The Review Group members wish to thank the following witnesses for taking the time and hard work to provide evidence, either by attending and giving evidence in person or by providing reports or both.

Link Officers:

Alan Lotinga, Director, Birmingham Health & Wellbeing Partnership

Richard Miles, Independent Health Consultant (Health Link Officer until the end of October 2010)

Steve Wise, Project Director Transformation, Adults & Communities Directorate

Others from Adults and Communities Directorate:

Osaf Ahmed, Commissioning Project Manager, Third Sector Partnership Scheme

Charles Ashton-Gray, Head of Commissioning for Older People

Jules Gregory, Head of Service - Integrated Community Equipment

Debbie Howell, Team Manager Older Adults, Hospital Social Work Team West Birmingham

Sally Jellis, Operational Manager Hospitals – HoB/BEN Intermediate Care

Ashok Khandelwal, Head of Service – Rehabilitation & Enablement

Dawn Lowe, Chair of the City-wide Delayed Transfers of Care Group

Pauline Mugridge, Operational Manager Hospitals – South Intermediate Care

Jon Tomlinson, Director of Joint Commissioning, Learning Disabilities & Mental Health

From Housing Directorate:

Louise Collett, Assistant Director of Housing Strategy

Kalvinder Kohli, Lead Officer, Supporting People

John Jamieson, Senior Partnership Manager – Private Sector

Colette McCann, Service Improvement Manager

From NHS Trusts

Margaret Barnaby, Group Operations Director, Heart of England Foundation Trust

Kevin Bolger, Chief Operating Officer, University Hospitals Birmingham

Heather Butler, Head of Intermediate Care, Heart of Birmingham teaching Primary Care Trust

Rob Checketts, Director of Communications, Birmingham Children's Hospital

Maureen Clark, Head of Intermediate Care, NHS Birmingham East & North

John Denley, Assistant Director of Public Health, NHS South Birmingham

Vanessa Devlin, Senior Strategic Commissioning Manager, NHS Birmingham East & North

Ian Donnelly, Head of Logistics & Capacity, Heart of England Foundation Trust

Moira Dumma, Director of Commissioning, West Midlands Strategic Health Authority (formerly Chief Executive, NHS South Birmingham)

David Eltringham, Chief Operating Officer, Birmingham Children's Hospital

Elaine Giles, Safeguarding Lead, Birmingham Women's Hospital

Tasnim Kiddy, Head of Performance, Birmingham & Solihull Mental Health Foundation Trust

Richard Kirby, Chief Operating Officer, Sandwell & West Birmingham Hospitals Trust

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