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DATE: 13 June 2017 OUR REF: YOUR REF:

Dear Councillor

HEALTH AND ADULT SOCIAL CARE AND COMMUNITIES OVERVIEW AND SCRUTINY COMMITTEE - THURSDAY, 15TH JUNE, 2017

I am now able to enclose, for consideration at next Thursday, 15th June, 2017 meeting of the Health and Adult Social Care and Communities Overview and Scrutiny Committee, the following report that was unavailable when the agenda was printed.

Delayed Transfer of Care- Final Report (Pages 3 - 36)

Final report.

Yours sincerely

Democratic Services Officer

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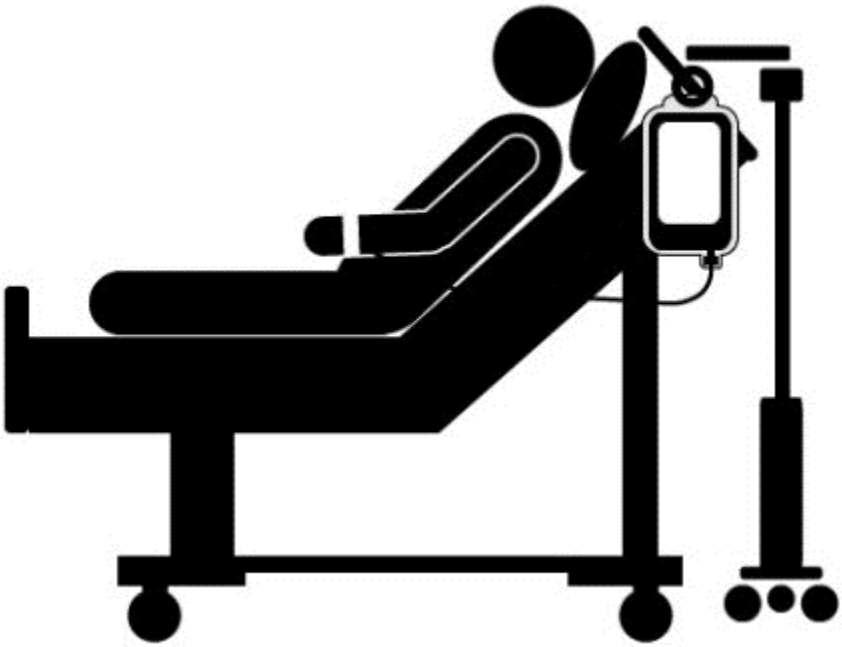
Cheshire East Council

Health and Adult Social Care and Communities Overview and Scrutiny Committee



Delayed Transfer of Care Review

Final Report

June 2017

Contents

1. Chairman's Foreword

1.1 Delayed Transfer of Care is an area of concern that is affecting large areas of the United Kingdom and Cheshire East is no exception.

1.2 The consequences of the delays not only have a negative impact on the Health and Wellbeing of the person concerned, but also affect our NHS and other partners, diverting resources and causing delays for those who also need treatment.

1.3 This is why this Committee decided that more needs to be done to address and understand the issues causing the problem, with the belief that recommendations could be made which could help mitigate the problems.

1.4 It is clear from the evidence that was taken that there needs to be changes to working patterns in order to achieve 7 day working, but this is not the only area that needs to change. There are huge pressures in Emergency Departments which are not assisted by the difficulty in recruiting Medical Staff to these posts. Therefore again, different ways of working and delivering care needs to be addressed.

1.5 There also needs to be collaboration between all partners to achieve a delivery model for Health and Social Care that meets the needs of all of our residents, the market needs to become broader and be able to react quickly to any excess or shortage in provision. Our residents are also living longer, which should be viewed positively, but they often need far more complex care packages than they did in the past and this is a problem that will only grow. Again, measures to address this need to be introduced quickly.

1.6 In formulating our recommendations the Committee was mindful that they needed not only to be achievable but also to be financially robust. We believe we have achieved this.

1.7 I would like to thank all of the Stakeholders who have contributed to this valuable report. We hope that all of our recommendations are taken into account when planning future services and care for our residents.

1.8 I would finally like to thank Helen Davies, who facilitated this whole process and contributed enormously to this report.

Councillor Jos Saunders
Chairman of the Health and Adult Social Care and Communities Overview and Scrutiny Committee

Committee Membership

LTR: Councillors Beverley Dooley (Vice Chair), Rhoda Bailey, Gordon Baxendale, Suzanne Brookfield, Ellie Brooks

Councillors Clair Chapman, Steven Edgar, Laura Jeuda, Gill Merry

Councillors Arthur Moran, Sarah Pochin, Jill Rhodes, Lesley Smethem, Mick Warren

Substitutes

Councillors Barry Burkhill, Alift Harewood, Brian Robers

Portfolio Holders

Councillors Janet Clowes (Adult Social

Care & Integration, Paul Bates
(Communities & Health)

What is delayed transfer of care (DToC)?

NHS England defines patients as ready for transfer when:

a. A clinical decision has been made that the patient is ready for transfer AND
b. A multidisciplinary team decision has been made that the patient is ready for transfer AND
c. The patient is safe to discharge/transfer.

DToC figures are officially recorded by NHS England in two ways: a snapshot of the actual number of patients delayed at midnight on the last Thursday of every month, and the total number of bed days during which discharge was delayed. This data is collected monthly and has been available from 2010.

Acute delays relate to patients in hospital beds and non Acute delays relate to intermediate care beds. Information about delayed transfers of care is collected for acute and non-acute patients (including mental health and community patients) on the Monthly Delayed Transfers Situation Report (SitRep) return.

The focus of the Sitrep is to identify patients who are in the wrong care setting for their current level of need and includes patients in all NHS settings, irrespective of who is responsible for the delay, statistics for Emergency Department closures, diverts and bed delays. Sitreps are collected all year round, each weekday and since June 2016 non-Acute delays have been included in the Sitrep.

Why is the Scrutiny Committee at Cheshire East Council scrutinising DToC?

It has been reported that DToC figures have increased and are causing additional financial pressures particularly to NHS partners and frontline staff. DToC is a serious delay for both the patient in the bed and for those who are in need of the bed, not only this but it diverts hospital resources in time and money unnecessarily. The priority is always the welfare of patients with the greatest need.

Typically frail Older People over 85 are most likely to experience DToC. According to British Geriatrics:

"Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years 3."

Typically frail people are housebound or only able to leave their homes with help.

The National Audit Office wrote a paper in May 2016 that stated:

"Unnecessary delay in discharging older patients (those aged 65 and over) from hospital is a known and long-standing issue. For older people in particular, longer stays in hospital can lead to worse health outcomes and can increase their long-term

care needs. Older people can quickly lose mobility and the ability to do everyday tasks such as bathing and dressing. Keeping older people in hospital longer than necessary is also an additional and avoidable pressure on the financial sustainability of the National Health Service (NHS) and local government."

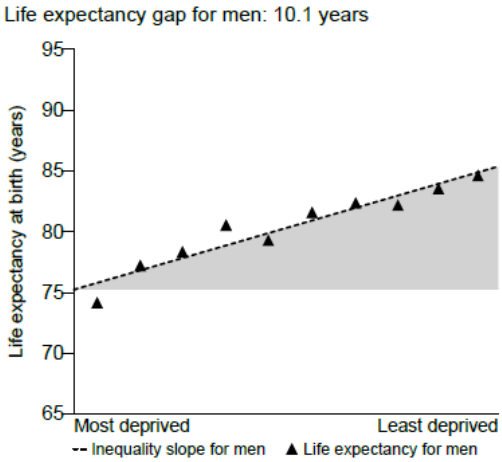
Frail Older People can become more frail if they are inactive for a long time, particularly in a hospital bed. This can increase the chances of the person needing to go into residential or nursing home care after they come out of hospital.
The National Audit of Intermediate Care shows that, for older patients, 'a wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength'.

A key outcome for Cheshire East Council (CEC) is that People live well and for longer. In September 2016, the Cheshire East Health and Adult Social Care and Communities Overview and Scrutiny Committee added DToC to the Work Programme to undertake a spotlight review to better understand the effect of delayed discharges in Cheshire East.

Cheshire East Demographic

Overall, life expectancy for both men and women residents is higher than the national average.

The charts below show life expectancy for men and women in Cheshire East for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in Cheshire East. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.



Cheshire East has a high elderly population compared to the national average, with a high percentage of people aged over 65 and over 85 years. This is expected to increase into the future, which will result in rising demands on financial budgets and the services provided by the NHS in the local area.

Types of beds available throughout Cheshire East

Care Homes
A place that people live in a group setting, this is alternative provision to living in own home. Care Homes are either Nursing or Residential (see below).

Nursing Home
A Care Home with nursing staff input.

Residential Home
A Care Home with no nursing staff input.

Domiciliary Care
Care in a person's own home to help people with daily living tasks.

Intermediate Care
A short term health care intervention, when someone still requires health input and support to recover greater independence. This can be in a care home or a hospital bed or in your own home.

Long Term Care Home Beds
These are beds that are for long-term living arrangements as an alternative to living at home.

Intermediate Care Beds
These can be located in various settings.

Hospital Beds (also known as Acute beds)
Located in hospitals.

Beds are paid for in several ways, Intermediate Care is NHS funded whereas Long-**term** care in residential, nursing and in someone's own home can be Council Funded, Privately funded (self-funders) or Continuing Health Care (CHC) NHS funded.

The rest of Cheshire

For the purposes of this report, the neighbouring Authority was asked about the experiences of DToC in the west of the county. At the time of writing, Cheshire West and Chester (CWaC) Council were due to submit their own report to Overview and Scrutiny. However, Cheshire East Council were advised that the content of the report covered the following key themes; 2016/17 performance, key interventions put in place in 16/17 and their impact, local and national best practice, what key interventions will be put in place for 17/18 and what is the 17/18 performance target.

The report also touched upon the work being conducted via the local Accident & Emergency Delivery Boards that have oversight of DTOC action plans and the work towards (to national condition in the Better Care Fund) managing transfers of care.

CWAC were looking to conduct an updated self-assessment against the 8 key themes of the high impact change model as part of the BCF plans to be signed off by the Health and Wellbeing Board prior to publication.

Most, if not all of the themes outlined by Cheshire West, were touched upon and expanded in this Cheshire East report. It is expected that following publication the two reports will hold key data into the current position with DToC pan Cheshire.

How was the review conducted?

In January 2017 the Cheshire East Health Committee invited key health partners from across Cheshire East to take part in a public meeting. A Parliamentary style select committee approach was used to enable the Committee to gather evidence and essentially fact-find to understand how the system currently worked and how effective current measures were. Also, the future challenges to services, and what initiatives might contribute towards making improvements to performance and provide better outcomes for patients in Cheshire East.

The Committee conducted the review by exploring how organisations had responded to the Eight Step High Impact Change Model of Managing Transfer 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 setwithin 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 areal help to patients in considering their choices and reaching decisions about their future care.

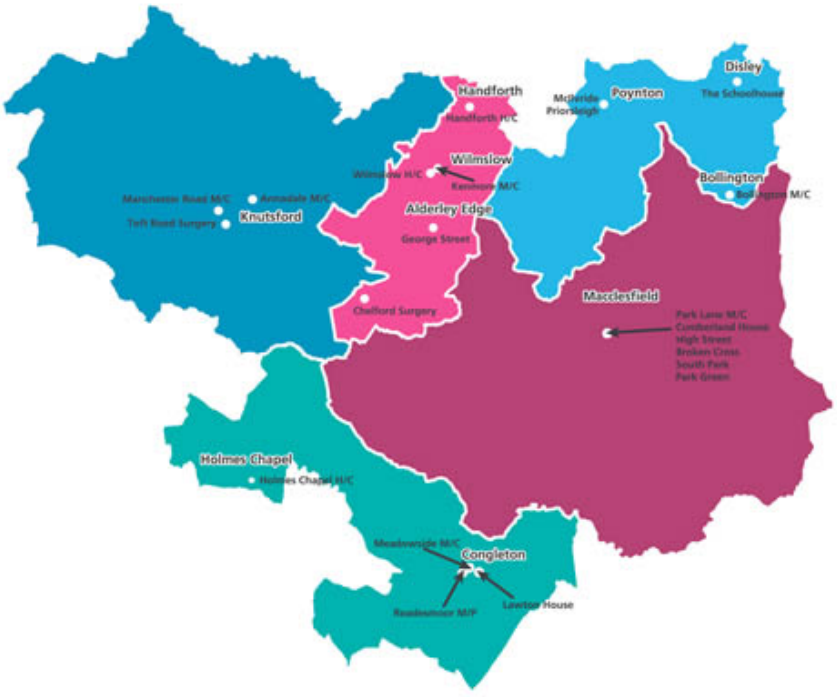
Change 8: Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Following the full day review, the meeting was adjourned for a further half day session in February where the Committee discussed its findings, conclusions and recommendations ahead of a formal report which will be sent to commissioners and providers for consideration.

Who are the partners involved?

There are a number of health providers that work to deliver Healthcare across Cheshire East. These organisations were invited to the review and presented on the day.

NHS Eastern Cheshire CCG (ECCCG)



Neil Evans CCG Turnaround Director

Karen Burton Clinical Project Manager for Urgent & Emergency Care
Jo Williams Service Delivery Manager.

NHS Eastern Cheshire Clinical Commissioning Group is made up of 23 Eastern Cheshire based GP practices. Their top priority is to ensure a high quality of health care by commissioning appropriate health care services, for over 201,000 residents in the main areas of Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow.

In Eastern Cheshire there is one District General Hospital in Macclesfield and two community hospitals (Congleton and Knutsford). The hospitals and community health services (e.g. district nurses who visit patients in their homes) are managed by East Cheshire NHS Trust. Mental health services are managed by the Cheshire and Wirral Partnership NHS Foundation Trust. ECCCG work in conjunction with these bodies, CEC and other health organisations to provide health services across Eastern Cheshire

NHS South Cheshire CCG & NHS Vale Royal CCG

Jamaila Tausif, Associate Director of Commissioning
Tracy Parker-Priest, Director of Transformation

NHS South Cheshire Clinical Commissioning Group (CCG) and has a budget of £203.4 million for a population of 173,000 people. The CCG is made up of 18 GP Practice with registered list sizes ranging from 2,500 to 21,242 from Nantwich to Middlewich.

The major acute hospital services are provided by Mid Cheshire Hospitals NHS Foundation Trust (Leighton Hospital), and practices on the edges of the patch have established relationships with other hospitals.

Their top priority is to use the local knowledge of our GPs and their practice teams to change the way that health services are currently delivered and help our patients to make full use of the services that are available.

East Cheshire NHS Trust

Steven Redfern, Deputy Director of Operations
Debbie Burgess Operational Manager
Jacqui Williams Associate Director of Service Transformation
Katrina Oliver Assistant Team Manager

East Cheshire NHS Trust was established in 2002. It consists of three hospitals at Macclesfield, Knutsford and Congleton. Macclesfield District General Hospital was purpose-built in the early 1980s, replacing a much older traditional infirmary.

Since 1 April 2011 East Cheshire NHS Trust has been an integrated community and acute trust providing healthcare across central and eastern Cheshire and surrounding areas, in hospital, at home and in community settings. With over 3,400 dedicated staff East Cheshire NHS Trust serves a population catchment area of approximately 450,000.

By bringing acute hospital services and community services more closely together their aim is to ensure that patients receive the best care in the right place.

The trust provides a comprehensive range of acute and community-based services, including Emergency Department emergency care and emergency surgery; elective surgery in many specialties; maternity and cancer services. Their community health services include; district nursing, health visiting, intermediate care, occupational and physiotherapy, community dental services, speech and language therapy and palliative care. The Trust provides a number of hospital services in partnership with other local trusts and private providers, including pathology, urology and renal dialysis services.

Inpatient services are provided from two hospital sites – Macclesfield District General Hospital (main site) and Congleton War Memorial Hospital. Outpatient services are provided in Macclesfield District General Hospital and community bases in Congleton, Handforth, Knutsford, Wilmslow and Poynton.

The trust holds a state-of-the-art Antenatal Department, Cancer Resource Centre, Discharge Lounge and a newly-built Renal Dialysis Unit.

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT)

Julie Weir, Divisional General Manager (Division of Diagnostics and Clinical Support Services)
Sarah Vaneeathen, Integrated Discharge Team Matron- DToC Reporting.

Mid Cheshire Hospitals NHS Foundation Trust manages Leighton Hospital, Crewe; the Victoria Infirmary, Northwich and Elmhurst Intermediate care Centre, Winsford. The Trust was originally established as an NHS trust in April 1991 and became a Foundation Trust in April 2008.

It employs approximately 3,200 members of staff and has around 540 hospital beds.

A range of services, including Emergency Department, maternity, outpatients, therapies and children's health are provided for people predominantly from the Crewe, Nantwich, Congleton, Middlewich and Northwich areas, although patients from other areas are also cared for.

In October 2005 the Trust opened a purpose-built NHS Treatment Centre, specialising in day surgery and diagnostics for a range of conditions. In 2008, the Trust supported the opening of a Macmillan Cancer Unit, one of the most modern in the country, which provides a range of cancer treatments and services for patients across Cheshire.

Cheshire & Wirral Partnership (CWP)

Roisin Reynolds, Interim General Manager
Kate Chapman, Modern Matron

CWP provide mental health, substance misuse, learning disability and community physical health services to a population of over a million people. These services are provided in partnership with commissioners, local authorities, voluntary and independent organisations, people who use our services and their carers. It also provides specialist services within Liverpool, Sefton, Bolton, Warrington, Halton and Trafford.

Cheshire East Council Health and Adult Social Care

Peter Gosling, Principal Manager, Adult Social Care
Mark Palethorpe, Strategic Director of Adult Social Care and Health
Ann Riley, Corporate Commissioning Manager
Lorraine Goude, Interim Director of Commissioning Adult Social Care and Health
Linda Couchman, Director of Operations

CEC employs Adult Social Care staff in the hospital and in intermediate Care services in both CCG areas. These staff work alongside health colleagues in assessing individuals' needs and making arrangements for their support either at home or in a care home environment. In order to do this, they have access to a range of services, including services provided internally and those commissioned by the local authority. The local authority is an active partner in both of the Emergency Department Boards and in both integration programmes in the locality.

What did the Committee hear?

On the 18 January 2017, each health partner was invited to give a 30 minute presentation with time at the end for the Committee to ask questions. Where the partner provided care in both Acute and Community Services they provided information for both areas. Each partner gave an account of their own service, with reflection on where improvements had been made and how their organisation planned to address DToC moving forward.
The key messages from the day were:

NHS Eastern Cheshire CCG

- In order to support recovery of Emergency Department performance NHS England and NHS Improvement were focused on ensuring that all health systems adopt a standard approach to urgent and emergency care best practice as set out in the NHS England report on transforming urgent and emergency care services: Safer, Faster, Better. At a local level, all systems were asked to implement five mandated initiatives, developed by :

- **Streaming at the front door**
  Efficiently streaming patients that presented at emergency departments through introduced primary and ambulatory care screening led by East Cheshire NHS Trust;

- **NHS 111**
  Increased proportions of NHS 111 calls handled by clinicians led by CCG and North West Ambulance Service (NWAS);

- **Ambulances**
  Implementation of the Ambulance Response Programme (ARP) that aimed to improve response times to critically ill patients, providing the, most appropriate response for each patient first time.

  The Dispatch on Disposition (DoD) that allowed more time to triage to identify the clinical situation and take appropriate action

  Code Review changes all led regionally by NWAS (Code Review is when NWAS review the reasons people call an ambulance and whether the person can be treated in a way other than being transported to Hospital e.g. a GP goes to see them instead)

- **Improved flow**
  Each Trust should implement recognised initiatives to enhance patient flow led by East Cheshire NHS Trust; and

- **Discharge**
  Implementing best practice for discharged patients to reduce DToCs (Discharge to Assess, Trusted Assessor type models), led by East Cheshire Trust and CEC.

- The number of Acute DToCs for Eastern Cheshire CCG had reduced in 2016/17 (8040) compared to 2015/16 (9133). However the reduction in acute delays had been slightly negated by increased delays in Intermediate Care beds. Delays in intermediate care were higher and this in turn can lead to delays in acute beds as patients are waiting for a place there.

- The main reasons for DToCs from Acute beds and Community Intermediate Care beds are different:

  - Acute Beds (Care Home Placement/Availability)
  - Community Beds (Care Package in Own Home)

- Since August 2016 the most significant increase in DToC is due to waits for care packages in the patients own home.

- The majority of delays were short but there were a number of patients who faced very long delays. The longest delays were in non Acute community hospital beds.

- Seven day working is not fully in place meaning discharges drop significantly at the weekend.

- It was widely acknowledged that determining long term support for most patients in an acute hospital was not appropriate and that assessments in hospital should be focussed on safe and timely discharge.

- Patients who experience DToC in an acute bed were more likely to already live in a Care Home with a higher prevalence of dementia, requiring a significant care package, had safeguarding issues and could already live in a Care Home.

- In Eastern Cheshire the population of people over the age of 85 was expected to increase by 140% by 2035 (from 6,597 in 2015 to 15,818). This was in conjunction with an increased number of patients with frail and complex needs. Despite growing demands, nursing home admissions were the lowest recorded in the north-west. Overall the demand for acute and non acute beds was likely to increase.

- There was an issue about accessing Care Home beds at the agreed CEC rate. This issue was worse for Nursing Home Beds than Residential Beds. There was an undersupply of nursing home beds that catered for patients presenting complex medical needs, and an over supply of Residential care home beds. Care homes supported nursing needs but it was more difficult to find places for patients with more complex care needs. However, the issue was more complex than to commission more Care Home beds. If more beds were commissioned there would be a strong possibility these would be high-end Residential Homes and could easily be filled with self funding patients, this would not solve the problem.

- The future priorities for Eastern Cheshire CCG would be, more seven day working in partnership with other stakeholders (including providers, nursing homes, better care packages for patients in their own homes especially those with complex needs). Better prevention measures which would enable patients to be better looked after. Therefore increasing their resilience to avoid inappropriate hospital admission and better value for money from residential homes.

NHS South Cheshire CCG

- In South Cheshire whilst there had been a reduction in hospital attendances, there had been an increase of DToC patients. Excess bed days and an increase in the number of patients over 80.

- The aims of South Cheshire CCG are:

  - to ensure early discharge planning at the Emergency Department's Front Door (EDFD);
  - to design flexible pathways for patients to maintain the flow of patients through the hospital;

- to promote access to responsive health and care services in the community; and
- to reduce inappropriate admissions though integrated community support. Last year the overall stay for patients was 57 days.

  Part of the new contract was to open up Step Up Beds for Community Nurses and Matrons, which offered an alternative to hospital admission or early supported discharge when the patient could not be supported at home.

- Early discharge planning (EDP) had been a way of managing DToC patients however; Multi disciplinary teams (MDT) in partnership with the Third Sector (Age UK and The Red Cross) now reviewed patients daily. EDP now happened with both patients and families and also at the first point of entry with patients referred to hospital by their GP or from the Emergency Department (ED).

- As part of the winter provision 2015/16, the Red Cross had provided additional support to patients in the hospital. The success of this initiative meant they were invited to provide the same service for the winter of 2016/17. The Trust took the decision to maintain the services provided by the Third Sector, and they now offered early intervention with patients all year round, not just for winter care.

- There was a proposal to move discharge planning from taking place on the ward to taking place on the emergency department front door. Choice protocols were in place, (the recognition that patients need to receive care in the setting most appropriate for their assessed needs) and further awareness training would be delivered.

- South Cheshire CCG completed a patient analysis that tracked flows, lows and demands. The CCG identified bottlenecks resulting in the design of more effective work patterns for employees and joint working.

- South Cheshire CCG introduced a clinical streaming service with North West Ambulance Service (NWAS) within the Emergency Department that will launch in March 2017.

- South Cheshire CCG was developing a Discharge to Access model. This included redesign of the current capacity in partnership with CEC to determine what combination of home based services are required.

- Supported seven-day discharges was in place and seven-day palliative care services and Community District Nurse provision were in development.

- The Trust had developed a nationally recognised piece of work for the Trusted Assessor role. A Trusted Assessor is a person who, when trained, will be able to assess for and prescribe a simple solution or basic piece of equipment to meet the needs of an individual. South Cheshire CCG plan to roll out their Trusted Assessor in two phases; one this year to patients in hospital, and phase two for patients in a community environment. The role would extend to Third Sector

engagement and further training provision within community settings including step-up and step-down beds.

- Increasing numbers of people presenting with complex needs leads to more extensive care packages. Future planning would require much more commissioning of care and flexibility in terms of contract.

- Primary care was at a point of crisis, there were not enough GPs being recruited.

- DToC plus moving Older People to different locations could have a detrimental affect on their well-being.

- The focus for South Cheshire CCG was on supporting patients to remain in their own homes, and enhancing community services and support to enable seven-day working.

East Cheshire NHS Trust

- The local pressures and challenges at East Cheshire Trust included:

    - not achieving the 95% ED standard, the Trust were increasingly an outlier (at the time of the presentation, it had achieved 66%);
    - delays accessing inpatient beds, this was one of the root causes of the breach of the four hour standard. (The national target expected at least 98% of patients presenting at emergency departments must be seen, treated, and admitted or discharged in under four hours);
    - emergency patients were currently placed in surgical and orthopaedic beds and that breached the elective capacity; and
    - in comparison to the region there were a higher level of DToC patients and there was not the ability across the whole system to accurately predict demand and capacity.

- East Cheshire Trust are delivering three large scale improvement programmes, SAFER Patient Flow, a joint approach to reduced DToC and Emergency Department System Improvement. They all reported to the Accident & Emergency Delivery Board.

- Due to a rise in DToC figures, the Trust was approached by NHS England to discuss improvement measures and one of the outcomes of this was a large scale whole systems event in April 2016.

- East Cheshire Trust has taken a number of steps towards decreasing its number of DToC. These included:

    - the development of a facility (Hub) for carers and relatives;
    - the introduction of The Red Cross to supporting patients on discharge;
    - tested Trusted Assessor process;
    - Community Matrons were linked to Intermediate Care increasing patient assessment capacity; and

- Frailty functions were relocated to the front door.

- The Trust was now building on these initiatives and further work was underway. It was explained that the Joint Working part of the programme had been the biggest success and the next steps would be to develop a seven-day working model, assessments outside of the hospital and domiciliary care provision.

- One of the key barriers to delivery was the geography of Cheshire East that included principal towns within a rural borough. At present there had been no correlation between DToC and Emergency Department Performance but the proportion of patients experiencing DToC had increased. During the recent winter months, there had been an increase in patients needing hospital care which then increased the need for individual investigation and assessments.

- The Committee questioned East Cheshire NHS Trust about the capacity to support seven-day working. At present, a physician/consultant would be on duty seven days a week, 12 hours a day. The Trust continued to work with NHS England towards improvements in delivery. It was recognised that being able to facilitate peaks and troughs in service must include provision of appropriate medical staff and there had been issues in being able to recruit in this area.

Mid Cheshire Hospitals NHS Foundation Trust

- Mid Cheshire Hospital Foundation Trust (MCHFT) presented the Committee with statistics that outlined the top ten delays and bed days within the hospital for 2016. The Trust stated that, “the highest number of bed days were associated to social worker assessments. During 2016 there were 5,271 hospital bed days that were attributed to patients waiting for a particular service from CEC. This equated to 14 beds per day”.

- Current progress to date for MCHFT included strong partnership working over a two year period, a shift in the working culture and an integration of social care posts. Ambulatory Care Pathways had been developed, patients were reviewed daily with partners and there were improved informatics (getting this information to the right person at the right time) which had enabled electronic patient flow.

- In order to address the increase in demand over the winter period, MCHFT had responded through the use of the Third Sector (The Red Cross), the REACT (Rapid Elderly Assessment Care Team) service that were able to go wherever needed and the introduction of Discharge Coordinators.

- Next steps for MCHFT included: early intervention to address the increasing needs of residents in residential care homes, revised contract agreements for Care Homes and the development of the integrated community teams to manage regular attenders. There would be an emphasis in community working, faster assessments and management of choice, however this could be challenging in an acute environment.

- In response to the presentation, the Committee questioned MCHFT about the number of DToC patients who were self funding. They were advised that personal health budgets were scheduled. However often during the Multi Disciplinary Team (MDT) meetings, challenges had arisen between the patient and their families. Managing the best interests of the patient had resulted in a time consuming, lengthy process, for example when the health care professionals and the family would like the patient to go into a care home, but the patient disagreed.

Cheshire and Wirral Partnership

- Cheshire and Wirral Partnership (CWP) covered a geographical area that contained 35 nursing and residential homes plus 23 GP surgeries. The way in which DToC figures were calculated was different in a mental health capacity. The DToC percentage was calculated as the number of days of delay divided by the total number of occupied bed days excluding leave. The national target was 7.5%. CWP calculated their patient as a DToC once they had been to panel.

- Some of the reasons for mental health DToC included the lack of appropriate specialist placements, homelessness and family choice.

- A main area of concern for CWP was patients being moved out of the area and patients with complex needs such as Dementia. These patients could be on a ward for 100 days. CWP had completed extensive engagement with families of complex need patients and always tried to locate them in the closest appropriate placement.

- CWP had delays with functional Older People but not as many. They were supported by nursing home advisors.

- CWP had a lack of beds for patients with complex cases, if beds were not found in the area, then patients were relocated to Leek or Cheadle. There was a training need for staff in care homes to enable patients to stay in the area.

- The Committee engaged in a short discussion, on DToC within community services at MCHFT. The summary of this discussion was there was an emphasis on seven-day working, care packages and discharging patients in a timely way, and explore how the results were delivered. Any care after 10pm, care on Bank Holidays, or care at the weekend resulted in patients presenting at Emergency Department. There were very limited resources if a patient fell or was unwell after 4pm.

- The Committee then discussed community services in Eastern Cheshire. The summary of this discussion was that the majority of beds located at Congleton and Macclesfield hospital offered flexibility because of the location and the way in which the beds had been commissioned. Assessment of patients happened in an acute bed.

- There was no provision for an overnight service, DToC patients in care homes was encouraging dependency.

Cheshire East Adult Social Care

- Cheshire East Adult Social Care (CEASC) explained that the main reasons for DToC in the social care environment were Nursing Home placements and the availability of Home Care. Social Care had joint plans for tackling these issues using The High Impact Change Model as a guide for areas that could be improved.

- Discharge planning was a process to improve the coordination of services after discharge from hospital by considering the patient's needs in the community. In Cheshire East, Board rounds had proved to work effectively when used consistently but they had been more established in Macclesfield than in Leighton Hospital.

- There was more work to do in relation to patients with planned surgery.

- It had been recognised that overall, patients in the past had been over-assessed and hospitals were considered to be the wrong environment to make long term decisions about patients.

- The communication system for patient flow was good. An escalation process was in place to deal with patients who experienced DToC for extended lengths of time. The key message was that timely discharge was in the best interests of the patient. This would be improved by better understanding of the range of health and social care services required with clarity around funding arrangements.

- Multi-disciplinary/multi-agency Discharge teams included the voluntary and community sector. Social care recognised that having access to assessment services and provision seven days a week for both health and social care is helpful. For some services this will require significant changes to current work practices and there may be financial implications.

- Home First/Discharge to Assess focused on patients who were clinically optimised and did not require an acute hospital bed, but would continue to require care in the short term in their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs would then be undertaken in the most appropriate setting and at the right time for the patient. There were six Discharge to Access beds in South CCG.

- A number of short term services (both bed and home based), each had their own criteria which led to confusion and delay. The number and type of beds and funding arrangements needed to be clarified.

- Contractually, social care services in the hospital currently operated over five-days Monday-Friday. Social workers worked at the weekend and most providers

worked on a five-day basis for assessments for care homes. The option of weekend working needed to be more fully explored.

- It was acknowledged that access to assessment services and provision seven-days a week for health and social care was helpful. However it is understood this would require practical shifts in ways of working and there could be financial implications of seven-day working.

- There were examples of trusted assessor processes in Intermediate Care where the assessment was done either by health or social care staff in the integrated teams. Care providers assessed for Residential and Nursing Homes. In Macclesfield and Leighton Hospital there was an identified individual as the care home link and work was ongoing to build relationships and trust towards establishing trusted assessor roles and agreed processes to facilitate appropriate discharge to Care Homes.

- Age UK was in place as part of the Integrated Discharge Team in Macclesfield. There were choice protocols in place and these formed the basis of discussions with families when the first choice was not an option.

- The Committee heard examples of how health had been enhanced in Care Homes. One of the community social work teams had identified social workers for each care home in their locality and this had worked well. The Frailty service at Macclesfield Hospital provided expert support, additionally there was now a single number for GP's that provided access to a range of short term provision.

- The Social Care team understood their role in needing to monitor, understand and try to resolve delays. However it was important to keep the patient at the centre and not focus solely on patient discharges but also with the offer of appropriate care alternatives for patients not requiring hospital care to avoid inappropriate hospital admissions.

- The Committee discussed some of the points brought out of the presentation. The percentage of DToC patients at Leighton hospital was high as a result of over-assessment. It would be safer to redesign the assessment of patients, to prevent patients going into hospital who did not need to be there.

- Domiciliary care in West Cheshire was commissioned in a different way to East Cheshire, (care packages in the west were kept open when a patient went into hospital). This approach would be built into re-commission in Cheshire East.

What did the Committee recommend?

Following the day of DToC presentations, the Committee established that by the end of the second meeting, the Committee would have a compiled list of key recommendations that were realistic, credible, outcome based, fiscally robust, did not breach legal regulations and had clearly defined lines of responsibility.

The Committee reconvened on the 22 February to reflect on the presentations and discussions, this in turn led to a number of cross cutting themes being identified, these were then discussed further by the Committee and some of the previous health partners. These have been clustered together with the appropriate recommendation from the Committee.

- **Intermediate Care Packages**
- **Step up and Step down beds**
- **The Bed Based Review**

The Committee noted that the demand for Intermediate Care was a subject that needed to return to the Health and Adult Social Care and Communities Overview and Scrutiny Committee and could include the bed based review and GP referrals.

It was explained that there are a number of Intermediate Care Models in operation across the Cheshire East health and care economy, using different terminologies and catering to patients with different levels of care need.

Linda Couchman, Director of Operations at CEC gave the Committee a successful example of better flow within the hospital attained with Step-Down beds. The Clinical Commissioning Group (CCG) had purchased 2-3 Step-Down beds, in Winsford Grange care home, Winsford, alongside implementing a package of care, funded through Continuing Health Care (CHC), which included a nurse who assisted with the discharge of patients.

Tracy Parker-Priest added that this model helped to build confidence in the care home and the increase in hospital flow distributed the costs thereby not incurring new costs. The Winsford Grange model was an intermediate trial but the Committee noted this was something that would feed into their recommendations and that it was important for patients with existing domiciliary care packages to continue to receive care in an Acute setting. The Committee heard that patients with complex needs experienced difficulties accessing available CHC packages from providers.

The Committee noted that across Cheshire East there was sufficient capacity in the residential care sector but an acute shortage of Nursing Home capacity. There was a shortage in some parts of the area of specialist provision to meet higher, more complex healthcare needs such as late stage of dementia care.

Recommendation:

Intermediate Care provision across Cheshire East is clearly defined and identified.
This to include:

- **'Step up Beds', 'Step down Beds',**
- **Intermediate Care residential bed provision (eg Hospital-based provision, provisions in Care Homes)**
- **Intermediate Care at Home**

Collaboration between CEC, CCG's and GP's work to change the delivery

model for the Cheshire East heath and social care market in order for it to become broader and to include more step-up and step-down beds.

Social Care and health partners engage with both Residential Care Home and Nursing Home providers to remove excess provision of residential care to better utilise the needs of the wider health care economy.

Access to Continuing Health Care for patients with complex care needs, be investigated and reviewed as a matter of priority.

Improvements to access and care provision for patients with late stage Dementia.

Eastern Cheshire CCG to develop a model of Discharge to Assess beds in line with the arrangements between South Cheshire CCG and Cheshire East Council.

- **Multi Working and hospital discharge process for patients**
- **Trusted Assessor Model**

Tracy Parker-Priest advised the Committee that the new GP contract had recently been released, as part of that, GP input into care homes had been mainstreamed. Currently there was no discharge plan for patients and it was recognised that an acute setting was not optimum for the assessment of patients. Patients in an acute setting were being over assessed which caused further delays. The Committee acknowledged there were a number of intermediate care models that catered for patients with a variety of health care needs but that there was a need to streamline the assessment process. Streamlining linked back to the Cheshire Record in terms of electronic collation of multiple patient records.

Partners described how preparation for discharge was relatively straightforward for patients admitted for elective procedures and was usually discussed at pre-surgical assessment meetings. However patients entering hospital as non-elective admissions (usually through the Emergency Department (ED)) were often more complex, had multiple long-term conditions and increased frailty.

The Trusted Assessor role was mentioned by a couple of the health providers during the last meeting. The Committee requested clarification of the role. Karen Burton confirmed that the Trusted Assessor Role was a model of working, whereby a patient was assessed at the beginning of their health journey and the follow on care providers trusted the initial assessment rather than spend time duplicating tests, this model also had links with the Cheshire Record.

Recommendation:

Cheshire East Council lead on further developing a 'Trusted Assessor Model' of assessment whereby all relevant members of the multi-disciplinary team

can access and input to a patient's shared medical/care records.

Cheshire East Council and CCG's explore multi working the discharge process for patients must be started upon admission and models of discharge planning must be introduced which are appropriate to non-elective admission patients.

CEC and CCG's lead on developing a clear pathway for patients presenting at the Emergency Department through to discharge.

- **Domiciliary care packages**
- **Safe transfer of care on weekends and bank holidays**
- **Seven Day Working**

CEC followed national guidelines and worked with care and domiciliary providers to agree on a set rate that included a margin of profit. Negotiation happened for specific care packages or individuals with more complex social care needs. It was accepted that some care providers in Cheshire East were charging more than the set rate. There was wide acknowledgement that there was an excess of residential care beds but an undersupply of nursing home beds although the Committee appreciated the situation with beds was more nuanced when dealing with patients with complex and enhanced needs (e.g. Dementia care).

Lorraine Goude (Interim Director of Commissioning) had experience of managing multiple numbers of care homes. She explained to the Committee that diversification in residential services was complex, ultimately the delivery model needed to be changed because the perception from the general public was that care home contact care was 24 hour. The actual amount of contact per week was more aligned to 10-12 hours. A better approach would be a broader commissioning strategy. The Committee noted this for their recommendations.

Throughout the two-day review, the Committee registered concerns that significant 'blocks' to efficient discharge occurred at weekends and bank holidays.
These reductions in staff availability (and resultant delay in discharge processes) occurred in many different areas and so need further investigation.

Whilst some providers did assess patients Monday-Sunday, care homes currently did not accept patients after 13:00 on a Friday due to a lack of resources over the weekend. Ideally there should be discharge on admission and a clear plan for patients that operated over seven-days.

The Committee recognised that several of the health partners had expressed difficulties in recruitment of staff, particularly outlined by East Cheshire Trust in relation to appropriate medical staff in the Emergency Department.

Recommendations:

Cheshire East Council introduce Seven-Day working within the domiciliary care industry and the multi-disciplinary hospital discharge team at weekends and Bank Holidays at both Leighton and Macclesfield Hospitals.

Patients already receiving a domiciliary care packages when admitted to hospital must have their package retained.

Cheshire East Council and the NHS work with care providers (domiciliary, residential and nursing) to implement how the NHS and Local Authority with (advice, training, support) will facilitate better 'Safe Transfer of Care' out of hospital over the weekends and Bank Holidays.

Cheshire East Council, and the NHS are to work with care providers (domiciliary, residential and nursing) and those in an Acute setting to achieve adequate appropriate medical staff cover to facilitate the peaks and troughs working towards a 7-Day service.

Alternatives to Emergency Department Doctors are to be considered e.g. Emergency Department Nurse Specialists.

- **Sitrep data**

The Sitrep return data was used daily by Cheshire East Commissioners, and published nationally quarterly and managed by the Emergency Department Board. The Committee agreed that it was important for partners and Cabinet members to analysis the data on a monthly basis. They requested Cabinet members reported back to the Committee on a quarterly basis.

It was noted that during the presentations on the 18th January, there were some discrepancies in data collation and interpretation (identifying the potential time lapse between patients declared medically fit for discharge / medically optimised / and the 48 hours permitted for Social Care Assessments and packages to be identified and put in place.

Mid Cheshire Hospitals NHS Foundation Trust reported from data that related to patients who were in a clinically optimised position. Clinically (or medically) optimised patients were when care and assessment could safely be continued in a non-acute setting. Whereas East Cheshire NHS Trust reported from the Situation Report (Sitrep) return. The Sitrep included delayed transfers of care (DToC) for acute and non acute patients, that included mental health and community patients. The focus of the Sitrep was the identification of patients who were in the wrong care setting for their current level of need and included patients waiting for external transfer in all NHS settings, irrespective of who was responsible for the delay. The

Committee acknowledged that although both sets of data were accurate the way that they had been presented were not necessarily comparative.

The monthly DToC Sitrep return collected data on the number of patients delayed on the last Thursday of each month and the total delayed days during the month for all patients delayed throughout the month.
Data was shown at provider organisation level, from NHS Trusts, NHS Foundation Trusts and Primary Care Trusts and by Local Authority when responsible for delayed patients.

The Committee noted that during the Committee meeting on the 12th January and the subsequent DToC meeting, the problems associated with paper records had been highlighted. Despite the progress made in digitising many of the existing paper records (as part of Cheshire Care Record) the way that health professionals are clustered was confusing to those outside of the health industry. The Committee recognised the importance of good practice but also the need to communicate processes from the perspective of the residents and patients, the importance of having a named Social Worker or named GP was noted.

Recommendation:

Sitrep data to be sent to the Portfolio Holders (Adult Social Care & Integration and Health & Communities)on a monthly basis and that the Portfolio Holders report back to the Committee on a quarterly basis.

Cheshire East Council to explore the possibility of a 'Named Social Worker' for each Nursing Home or small group of homes.

- **The care career pathway**

There is a greater awareness that maintaining a sustainable workforce in the health and care sector is a National Issue. However it is particularly problematic in the North-West.
The Committee discussed problems experienced across the health sector of recruitment, selection and retention of staff. In Cheshire East the trend was for care workers to travel into the borough to work rather than live and work within the borough. The CCGs had considered the long-term plan for the workforce as part of the Sustainability and Transformation Plan (STP). Individuals who worked in care homes were offered a care skills certificate however most individuals then left domiciliary care to pursue a career in nursing. The Committee agreed that a clear career pathway needed to be explored that included support for school leavers, yet it was acknowledged that for certain jobs, a younger person might not necessarily be the best fit for the role. It was noted that some work was already underway through the Cheshire East Skills and Growth ASDV.

Recommendation:

Cheshire East Council (through the CE Skills and Training Arm) and NHS England introduce/develop a clear career pathway which includes support for school leavers, apprenticeships, return to work opportunities and Skills for Care Training.

Cheshire East Council and NHS England develop a 'Care Career Pathway' for school leavers and older adults.

To develop means of mitigating the difficulties in recruiting Emergency Department medical staff including the training of Nurse Specialists.

To develop training for staff working in Care Homes dealing with mental health patients to enable the patient to stay in the area.

- **Seven Day Therapy Services**

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) had previously emphasised their priority towards seven-day working, care packages and discharging patients in a timely way. The Committee was advised that seven-day therapy services had been a pilot at Leighton Hospital and that now needed to be evaluated fully to inform any service design. The Committee requested more information about the pilot to assess the performance of seven-day therapy services.

Recommendation:

Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) are to be invited to bring the evaluation of their seven-day therapy services pilot for the Committee to scrutinise and evaluate the outcomes.

- **The funding formula in respect of CCG's**

The Chairman raised the subject of CCG funding formulas. Within Cheshire East, both CCGs experienced a significant distance from funding target (this related to historical underfunding of CCG-budgets calculated on a £ per head of population). This historic underfunding of the CCGs in Cheshire East (in comparison to like CCGs locally and nationally) means that both CCGs are challenged in terms of adequacy of resource to meet local population health need. Tracy Parker-Priest proposed that a further issue for consideration was a the speed at which both CCGs are "moved" towards receipt of the full allocated resource rather than a focus on year on year cuts to commissioned services. Councillor Paul Bates advised the Committee that this subject was a standing agenda item when the Portfolio Holders met with the Local MP. The Committee noted the point for recommendations.

Recommendation:

The Cheshire East Portfolio Holders continue to lobby MP's about changing the national formula in respect of CCG's.

- **The Better Care Fund**

Councillor Janet Clowes explained that much of the activity associated with tackling DToC is directly related to the activities, metrics and funding of the BCF. BCF Funding was not 'new money'; this system would continue for a further two years. The Committee discussed the changes in terminology of past and current projects for example STAIRRs / Rapid discharge responses; they agreed that a BCF briefing would be helpful. Currently there was an evaluation underway of the outcomes of the Better Care Fund (BCF). The Committee requested a presentation of the evaluation.

Recommendation:

The Better Care Fund Briefing note be produced for Members including: activities included in the BCF (including clarity regarding those activities specifically required by NHS England/Department of Health. (DoH), funding mechanisms for BCF (including the administration of S256 and S75 monies) and BCF metrics required by DoH/NHSE.

The BCF outcomes evaluation be presented to the Committee including future BCF planning.

- **Continuing Health Care**

The Chairman highlighted that throughout the presentations on the 18th January, the highest levels of DToC were attributed to care packages in the home. CHC was part of the NHS Framework model, currently Eastern Cheshire CCG had considered the Discharge to Assess model. Karen Burton advised this could be shared with the Committee. The aspiration was to have a safe, person centred approach that relied on one point of contact. The Committee agreed that contracts needed to reflect the focus on well being but also invited Tracy Parker-Priest and chief finance officers from the CCG to return to the Committee with data that outlined where assessments had been delayed and to discuss the ongoing difficulties of people getting CHC packages in their own homes with a view to designing a new approach.

Data and information provided through the DToC Review process suggests that CHC Assessment and CHC Care Packages are also a significant cause of delays in patient transfers both from hospital and Intermediate Care beds.
It is acknowledged that CHC is a significant financial pressure on the health system.

Recommendation:

A separate report be prepared for the Committee covering the statutory and legal position regarding CHC assessments, appeals and care provision, how CHC is administered in Cheshire East, how CHC Assessments and Social Care Assessments are integrated/synchronised to reduce DToC and what the financial pressures are associated with CHC.

The Committee have a standing item on the Work Programme to review delays in accessing CHC packages.

Access to CHC for patients with complex care needs, be investigated and reviewed as a matter of priority.

Glossary of Health Terms

Acute Care	Provision of short-term emergency services, general medical and surgical treatment for acute disorders, usually in a hospital, for patients with an acute illness or injury or recovering from surgery.
Advocacy	Any action or service which supports, encourages or helps to represent individuals; helps them to understand and communicate their views, needs or rights.
Assessment	A process whereby the needs of an individual are identified and their impact on daily living and quality of life is evaluated.
Bed Day	A 24 hour period that a patient remains in a bed.
Broker / Brokerage	An organisation or person that helps a customer to arrange the support they need. Brokerage can be done by the Council, a voluntary organisation/charity, a private company, or an individual such as a family member or friend.
Care Coordination	A process through which a particular professional assumes responsibility for ensuring that any referral made are acted upon appropriately assessments are completed in a timely fashion.
Care Management	A process where by an individual needs are assess and evaluate, eligibility for services determined , care plans are drafted and implemented ,and needs are monitored and reassessed
Care Package	A combination of services designed to meet an individual's assessed needs.
Care Pathway	An agreed and explicit route and individual takes through health and social services. Agreements between the various professionals involved will typically cover the type of support to meet those needs, and the objectives and potential outcomes that can be achieved.
Care Planning	Care planning is a process based on an assessment of an individuals assessed need that involves determining the level and type of support to meet those needs, and the objectives and potential outcome that can be achieved.
Care Programme Approach (CPA)	Providing people with serious mental health problems an individual agreed care plan.
Community Care	Services and support which help people to continue to live independently at home.
Continuing Health Care	Continuing health care is a package of care arranged and funded solely by the NHS. It is awarded depending on whether a person's primary need is a health need. It can be provided in a range of settings, including an NHS hospital, a care home or someone's own home.
Delayed Transfer of Care (DToC)	A delayed transfer of care occurs when an adult inpatient in hospital (children are excluded from this definition) is ready to go home or move to a less acute stage of care but

	is prevented from doing so.
Discretionary Services	These are services which local authorities are not required to provide by law. They are also sometimes referred to as Non-statutory services.
Domiciliary Care (also known as Home Care)	Personal, practical household domestic tasks, or nursing care provided for people at home rather than in an institution enabling them to stay at home and be as independent as possible.
Extra Care Housing (ECH)	Extra Care Housing offers people the opportunity to live independently in self-contained units but with access to a flexible and responsive 24-hour care support service on site. They are suitable for accommodating the use of Assistive Technology and offer facilities and services to the wider community.
Intermediate Care (IMC)	Intermediate Care is a generic term that covers a wide range of services that help prevent unnecessary admission to hospital, or help facilitate early discharge. The term refers to a very important range of services that can help reduce delayed discharges. These services will also improve the patient experience, either by assisting them to remain at home in situations that might previously have led to admission to hospital or care, or by enabling a supported transition back into the community following a stay in hospital. They are normally time limited services up to 6 weeks.
KPIs	Key Performance Indicators KPI Measures, usually statistical, which are used to assess performance against
Multidisciplinary Assessment	Multidisciplinary assessment is an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.
Non-Acute Care	Care in which the primary clinical purpose or treatment goal is support for a patient with impairment, activity limitation or participation restriction due to a health condition often over an indefinite period.
Primary Care	The first stage of treatment when you are ill and usually provided by your GP or at a community clinic - see also secondary care and tertiary care.
Review	This refers to re-assessment of people's problems and issues, and consideration of the extent to which services are meeting the stated objectives and helping to achieve the desirable outcomes.
Respite Services	These services are available for customers to give their partners or carers a break
Secondary Care	The second stage of treatment when you are ill and usually provided by a hospital. See also primary care and tertiary care.
Step Down Bed (also known as	A hospital bed in which the occupying inpatient is medically stable and needs less-intensive care than before (i.e., is

Intermediate Care bed)	"stepped down") and is able to leave hospital by moving to and being specially cared for in a residential care home bed. Step-Down beds allow patients additional time and rehabilitation to recover when they are unable to have this provided at home.
Step Down Bed (also known as Intermediate Care beds)	Step up beds are defined as those where people are admitted from home as an alternative to acute hospital admission.
Trusted Assessor	A person who is competent in performing to an agreed set of standards.

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