Delayed Transfer of Care: One Year On.

In February 2017, the Health, Adult Social Care and Communities Overview and Scrutiny Committee undertook a spotlight review to evaluate the subject of Delayed Transfers of Care (DToC) across Cheshire East.
The Committee took a full day and used a Parliamentary style select committee approach, in public, to consult with and question key partners as stakeholders. This enabled the gathering of evidence about how the system currently worked, whether it is effective, and made recommendations as to how improvements might be made across the whole system.

Following the review the Committee produced its findings, conclusions and recommendations in a formal report which was approved by Cabinet and sent to commissioners and providers for them to consider and agree to the recommendations.

Below are all of the recommendations in full, together with the current position statement from the relevant organisation to highlight the work that has taken place, over the last year, since the review.

Cheshire East Council:

Key Recommendation On:	Key Recommendation:	Response:
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review.	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 (e.g. Hospital-based provision, provisions in Care Homes) • Intermediate Care at Home	(South & Eastern Cheshire CCG) **This has been actioned NHS South Cheshire CCG and NHS Eastern Cheshire CCG/East Cheshire NHS Trust have recommissioned the step up and step down provision and worked with all partners including the Local Authority. Further work is underway across Cheshire East to improve the intermediate care and reablement offer going forward.** (Cheshire East Council) **A 'Home First' model has been agreed. The scope of this model and the outcomes required are being finalised by commissioners. The model will**

		include all short term provision (from health and social care) which is focussed on enabling people to be as independent as possible and will include bed-based and home-based provision. The principles on which this model will be based are as follows: • **Alignment to Home First** – To ensure that our care philosophy is based on a guiding principle that patients should expect to be discharged to the place they call home as soon as possible • **Timely response** – Which includes the facility to provide rapid response for 'stepping up' from the community in order to prevent people attending or going in to hospital unnecessarily. This also incorporates the need to facilitate more rapid discharge from acute care • **Simplification of 'categories' of intermediate care** – To provide the basis against which all intermediate care is viewed in order to streamline the pathways into the services within • **Transfer to Assess** – To transfer people to the most appropriate intermediate care setting based on a proportional assessment which allows for a full assessment of need to take place outside of an acute setting • **Trusted Assessor** – To provide the necessary dependency rating tool(s) to ensure that the initial assessment of a person's needs is trusted, regardless of which professional undertakes it. This is fundamental in the delivery of effective intermediate care pathways • **Integrated Support** – To develop multi-disciplinary teams of staff to support people at home or in community beds, regardless of existing team 'titles' and service names. This multi-disciplinary approach should join-up intermediate care once an individual is supported within in order to facilitate movement between care 'categories'

		• **Coordination and wider access** – To ensure that the model has a single coordination point to ensure that oversight of all available provision is maintained and duplication of effort is minimised. This should also ensure that those individuals within intermediate care are supported to access ongoing support, including long-term care, support in the community, mental health services or signposting to wider provision **It is envisaged that implementation of the Home First model will be from June 2018.**
Multi Working and hospital discharge process for patients and the Trusted Assessor Model.	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.	<u>(Eastern Cheshire CCG)</u> **Partners have worked together to implement the new ways of working with assessment staff working at the EDFD as well as introduction of the frailty pathway.** <u>(Cheshire East Council)</u> **Cheshire East Council play a key role in the Integrated Discharge Teams in each of the hospitals. These are multi-disciplinary teams in which information is routinely shared in order to make appropriate and timely discharge arrangements for patients. This includes, where appropriate, sharing patient records. The Cheshire Care Record can be accessed by all members of the team. This record contains health and social care information about the individual.**
Multi Working and hospital discharge process for patients and the Trusted	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.	<u>(South & Eastern Cheshire CCG)</u> **Partners have worked together to implement the new ways of working with assessment staff working at the Emergency Department Front Door as**

Assessor Model.		**well as introduction of the frailty pathway.** Cheshire East Council **Health and social care staff work together at all stages of the individuals' journey through hospital. This includes: diversion of people in A&E who do not need to be admitted to hospital; improving processes within hospitals to ensure interventions happen in a timely way; and arrangements for timely discharges when medically fit to leave hospital. There are work streams in place for each stage of the hospital journey and progress in each of these work streams is considered, and further action required agreed, at regular meetings of health and social care managers.**
Sitrep data.	Cheshire East Council to explore the possibility of a 'Named Social Worker' for each Nursing Home or small group of homes.	(Cheshire East Council) **All care homes have a nominated member of the locality Adult Social Care team allocated to them.**
The Care Career Pathway.	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.	(Eastern Cheshire CCG) **Mid Cheshire Hospital NHS Foundation Trust and the CCG have worked together and have put rotas in place further work is ongoing through workforce redesign** (Cheshire East Council) **We are working with Skills for Care and the Cheshire Career Hub, one of 5 Career and Engagement Hubs in the North funded via Health Education England to develop and link these initiatives across a Cheshire footprint. www.cheshirecareerhub.net**
Domiciliary care packages, safe	Cheshire East Council introduce Seven-Day working within the domiciliary care industry and the multi-disciplinary hospital	(Eastern Cheshire CCG)

transfer of care on weekends and bank holidays and Seven Day working.	discharge team at weekends and Bank Holidays at both Leighton and Macclesfield Hospitals.	**Home care packages are retained for up to 7 days and this was extended to 14 days over the winter period.** (Cheshire East Council) **There are social workers on duty at both hospitals over the weekend and on bank Holidays. This is currently on a voluntary basis and further work is required to consolidate this arrangement. This is currently funded from iBCF.** **The CEC Care Sourcing team is moving to a seven day 8-8 model from April 2018.** **The new care at home contract will reinforce the need to work over seven days- this will be implemented in October 2018.**
Sitrep data.	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 **Portfolio holders are regularly briefed and provided with the data.**
The Care Career Pathway.	To develop training for staff working in Care Homes dealing with mental health patients to enable the patient to stay in the area.	(Eastern Cheshire CCG) **The CCG's have commissioned a project "Care Home improving quality care project". The facilitators are focusing on supporting nursing home staff with; advance care planning, caring for residents with dementia, best interest decision making, symptom management, appropriate and non-appropriate admissions, liaising with discharge teams, end of life care and bereavement.** (Cheshire East Council) **We are working with Care Quality Commission, Skills for Care and across Health and Care to look at how we could upskill all levels of staff within**

		the independent sector, in particular registered managers.
Continuing Health Care.	The Committee have a standing item on the Work Programme to review delays in accessing CHC packages.	(South & Eastern Cheshire CCG) **These are reviewed regularly as part of the Discharge to Assess process.** (Cheshire East Council) **See Continuing health care (A process is in place to reduce the delays, however more work is required).**
The Better Care Fund.	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.	(South & Eastern Cheshire CCG) **The BCF planning for 17-19 has been completed.** (Cheshire East Council) **The Better Care Plan 2018-20 was agreed at the Health and Wellbeing Board on 26th September 2017 and clearly sets out the schemes of work, financial commitments and metrics. This plan now has robust governance around it and a monthly highlight report is produced to monitor progress. The plan is attached as an appendix to this report.**
The Better Care Fund.	The BCF outcomes evaluation be presented to the Committee including future BCF planning.	(South & Eastern Cheshire CCG) **Schemes were evaluated in 16/17 and new schemes put in place to support the 4 BCF measures.** (Cheshire East Council) **See: above information on Better Care Fund.**

Continuing Health Care.	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.	(South & Eastern Cheshire CCG) **A monthly report is completed and shared at A/E delivery board that covers CHC and DTOC.** (Cheshire East Council) **A process is n place to reduce the delays, however more work is required.**

Cheshire East Portfolio Holders:

Key Recommendation On:	Key Recommendation:	Response:
The Funding Formula in respect of CCGs.	The Cheshire East Portfolio Holders continue to lobby MP's about changing the national formula in respect of CCG's.	

Cheshire East Council and Eastern Cheshire CCG & South Cheshire CCG:

Key Recommendation On:	Key Recommendation:	Response:
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review.	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.	(Eastern Cheshire CCG) **the CCGs are working with the Local Authority to ensure a joint contract and specification for care homes and domiciliary care this will enable market management and a fair cost of care. This work may result in fewer people requiring 24 hour care.** (Cheshire East Council)

		See above on Home First Model.
Multi Working and hospital discharge process for patients and the Trusted Assessor Model.	CEC and CCG's lead on developing a clear pathway for patients presenting at the Emergency Department through to discharge.	(South & Eastern Cheshire CCG) **A clear pathway has been agreed by all partners through the Discharge to Assess process. As well as the introduction of a patient leaflets that informs patients about their stay and discharge options. Through existing services e.g. Frailty and the Improved Better Care Fund and Better Care Fund schemes we have increased the services supporting timely discharge.** Cheshire East Council **See: Multi Working and the discharge process for patients.**

Cheshire East Council and Eastern Cheshire NHS Trust and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT):

Key Recommendation On:	Key Recommendation:	Response:
Domiciliary care packages, safe transfer of care on weekends and bank holidays and Seven Day working.	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.	(South Cheshire CCG) **The CCG are working with the LA on a new combined domiciliary care contract that will ensure that appropriate quality measures are in place. The CCG are also working with partners to extend 7 day assessments.** (Cheshire East Council) **Social Care and Health are currently involved in the recommissioning of care home provision and new contracts will be in place by 1st October 2018. New contracts will include requirements of providers in relation to accepting residents at weekends and on Bank Holidays.**

		The Care Sourcing Team from April 2018 assists in this process.
Domiciliary care packages, safe transfer of care on weekends and bank holidays and Seven Day working.	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.	(Eastern Cheshire CCG) **The CCG'S are working with the Local Authority on a new combined domiciliary care contract that will ensure that appropriate quality measures are in place. The CCG's are also working with partners to extend 7 day assessments.**
The Care Career Pathway.	Cheshire East Council and NHS England develop a 'Care Career Pathway' for school leavers and older adults.	(Eastern Cheshire CCG) **Mid Cheshire Hospital NHS Foundation Trust and the CCG have worked together and have put rotas in place further work is ongoing through workforce redesign** (Cheshire East Council) **We are linked to the work of Skills for Care and Skills for Health in developing a 'Care Career Pathway' for school leavers and older adults and linked to the work of the NW ADASS Workforce Strategy workstream.**
Domiciliary care packages, safe transfer of care on weekends and bank holidays and Seven Day working.	Patients already receiving a domiciliary care packages when admitted to hospital must have their package retained.	(Eastern Cheshire CCG) **Home care packages are retained for up to 7 days and this was extended to 14 days over the winter period.** (Cheshire East Council) **For people who are in receipt of home care on admission to hospital, the local authority continues to pay for that support for upto seven days. (This has been extended to fourteen days for the winter period). As long as the individual's needs remain largely the same as on admission, people can**

		therefore be discharged to an existing home care arrangement with the provider they know within this period. This arrangement is currently being evaluated under the BCF programme.

Eastern Cheshire CCG:

Key Recommendation On:	Key Recommendation:	Response:
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review.	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.	(Eastern Cheshire CCG) **NHS Eastern Cheshire CCG have developed and implemented a model for Discharge to Assess beds (Assessment Outside of Hospital). This was implemented in August 2017.** Cheshire East Council **See: Home First Model**

Mid Cheshire NHS Foundation Trust:

Key Recommendation On:	Key Recommendation:	Response:
Seven Day Therapies.	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.	(South & Eastern Cheshire CCG) **Happy to do this if we have a date**

All partners:

Key Recommendation	Key Recommendation:	Response:

On:		
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review.	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.	(South & Eastern Cheshire CCG) **The CCGs are working with the Local Authority to ensure a joint contract and specification for care homes and domiciliary care this will enable market management and a fair cost of care. This work may result in fewer people requiring 24 hour care.** Cheshire East Council **Social Care and Health are currently involved in the recommissioning of care home provision and new contracts will be in place by 1st October 2018. Alongside the recommission there is also a review of fees being undertaken by an external company call C.co, a subsidiary of CIPFA (Chartered Institute of Public Finance and Accountancy) C.co have undertaken a review, the results of which will be given to Cheshire East on the 19th February for analysis. If approved by Cabinet, it is anticipated that the fee levels produced by this exercise will be incorporated into the new contract.**

Eastern Cheshire NHS Trust and MCHFT:

Key Recommendation On:	Key Recommendation:	Response:
Domiciliary care packages, safe transfer of care on weekends and bank holidays and Seven Day working.	Alternatives to Emergency Department Doctors are to be considered e.g. Emergency Department Nurse Specialists.	(South & Eastern Cheshire CCG) **This has been considered and primary care streaming is now in place.**

The Care Career Pathway.	To develop means of mitigating the difficulties in recruiting Emergency Department medical staff including the training of Nurse Specialists.	(South & Eastern Cheshire CCG) **Mid Cheshire Hospital NHS Foundation Trust and the CCG have worked together and have put rotas in place further work is ongoing through workforce redesign**

Cheshire and Wirral Partnership:

Key Recommendation On:	Key Recommendation:	Response:
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review.	Improvements to access and care provision for patients with late stage Dementia.	(South & Eastern Cheshire CCG) **Improved Better Care Fund - funding has been used to have Community Psychiatric Nurse input in the initial hospital triage process as well as input into the step down beds to ensure patients with dementia are support through appropriate care plans that will enable early discharge. Further work is ongoing with Cheshire & Wirral Partnership FT to ensure the right community support is available for patients with dementia to be supported in their own home.** Cheshire East Council **CEC are moving community development officers and Local Area Co-ordinators into the operational teams to ensure that patients with late stage dementia have access not only to care and support services but services within heir local communities. A plan to build on the CEC connected community centres to make then 'dementia friendly' and within the recommission of Care at home and accommodation with care we will ensure improvements as part of the new contracts.** Cheshire & Wirral Partnership

		Cheshire & Wirral Partnership FT do not have any step down beds for Dementia, when we have approached people to access these beds they have confirmed that they can only be used for Physical Problems or discharge from the Medical wards not for patients with Dementia. **Community support- referrals can take weeks to be picked up by Smart teams and no support at all if people are self-funders.** **Currently the dementia beds on Croft are gate kept by a consultant to consultant referral or in the absence of the consultant the referral is forwarded to the matron and ward manager.** **We are currently piloting a discharge co-ordinator who his liaising with the families/nursing homes/CCG/Social care and the community teams this pilot is running for 6 months to ensure a timely discharge.**

Eastern Cheshire CCG & South Cheshire CCG:

Key Recommendation On:	Key Recommendation:	Response:
Intermediate Care Packages, Step up and Step down beds and the Bed Based Review and on the subject of Continuing Health Care.	Access to Continuing Health Care for patients with complex care needs, be investigated and reviewed as a matter of priority.	<u>(South & Eastern Cheshire CCG)</u> **This has been completed and a report is produced that is shared at A&E Delivery Board and the Continuing Health Care Board. The CCGs are continuing to work with NHS England Strategic Improvement Programme.** <u>Cheshire East Council</u> **A number of Discharge to Assess beds have been commissioned in order that assessments in relation to eligibility for CHC funding can take place in a more appropriate setting than hospital. There are**

		ongoing discussions about the processes to support CHC eligibility decisions.