



Delayed Transfers of Care



A report from Overview & Scrutiny







Delayed Transfers of Care

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Delayed Transfers of Care

Preface

By Councillor Deirdre Alden

Chairman of the Health and Adults Overview and Scrutiny Committee



One of the prime aims for the Council and its NHS partners is to help the people of Birmingham to have long, healthy, fulfilling lives living in and actively taking part in the community for as long as possible. Many may need hospital inpatient treatment at some stage of their lives, and hospital medics do their utmost to make them clinically fit for discharge from hospital as early as possible. Inpatients with simple post-hospital needs can usually be discharged safely very soon after they are medically fit to go. Some, with complex post-hospital needs may also be discharged then, but if, and only if, the Council or one or more NHS trusts have put in place the services and facilities to enable them to be safe.

Sadly, this is not always achieved. All too often the patients with complex post-hospital needs are kept in hospital long after they are clinically fit to leave it. There can be many reasons for this: for example the organisations that should put safe arrangements in place may not have the resources to do so, or the services or facilities needed from the private or third sector markets are not yet available, or not available at an affordable price.

This creates financial costs to the hospital trust, and potentially costs to the council, which may have to reimburse £100 per day of delay per patient to the hospital trust. But more important any lengthy delay can damage the inpatient's chances of recovery. For instance someone with early stage dementia may be able to cope living at home, but if they have to go to hospital, the longer they are there the greater the risk that they will be unable to return home, because they have lost touch with the coping routines they were used to. So they lose their independence perhaps years earlier than they would otherwise have done. And the delay can be great inconvenience and worry to others, such as family or carers having to visit the hospital without knowing whether or when the patient can come home.

The Scrutiny Committee I chair cannot hope to completely eliminate delayed discharges simply with a review, because millions of pounds have been invested and hundreds of wise people have been trying to solve the problem for many years, so far without success. But what we can do and have done in this report is to make recommendations for improvement and to highlight policy gaps where efforts can be better focused. I hope this will go some way towards helping to solve the problem.

Councillor Deirdre Alden



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.



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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



	enables patients to be discharged on any day of the week, including weekend days, in accordance with Department of Health Best Practice Guidance.	for Adults & Communities Cabinet Member for Children Young People and Families	
R07	That the Council undertakes a review and creates a lessons learned log about the risks inherent in major organisational changes such as introducing the latest version of CareFirst 6, the electronic record, which led to a sharp increase in assessment delays, and makes it mandatory for all Council departments approaching a service change to risk assess against the impact on DToCs – and other service delivery – and prepare contingency plans for managing the risks.	Cabinet Member for Adults & Communities	31 March 2011
R08	That a review be undertaken to ensure that commissioning of existing beds and other relevant capacity in the City, but particularly in the south of the City, satisfies the current requirement for 'enhanced assessment beds' which allow assessments to be carried out away from an acute hospital environment.	Chief Executive of South Birmingham PCT	30 June 2011
R09	That, in the absence of a PCT wanting to use the facility, the Cabinet Member for Adults and Communities and representatives from University Hospital Birmingham continue to work collaboratively towards finding a way of bringing the capacity in the Kenrick Centre into use as soon as possible.	Cabinet Member for Adults and Communities University Hospital Birmingham NHS Trust	31 March 2011
R10	That the City Council work with the third sector to provide commissioned practical support in all areas of the City to patients recently discharged from hospital, to reduce the need for readmission.	Cabinet Member for Adults & Communities	30 June 2011
R11	That delayed transfers caused by 'Awaiting community equipment or adaptation' should, for internal purposes, be recorded and reported separately by the Housing and Adults & Communities Directorates, whilst still needing to be combined for reporting to the Department of Health.	Cabinet Member for Adults & Communities Cabinet Member for Housing	31 March 2011
R12	That progress towards achievement of these recommendations be reported to the Health and Adults Overview & Scrutiny Committee in July 2011. The Committee will schedule subsequent progress reports thereafter until all recommendations are implemented.	Cabinet Member for Adults and Communities	31 July 2011



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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 Commission for Social Care Inspection (CSCI). Most recently the issue was given a red flag in the Comprehensive Area Agreement (CAA) in December 2009.
- 1.1.3 Tackling Delayed Transfers of Care has been a high priority for Birmingham and considerable effort has been put into improving what happens during the discharge process but it remains an area where the health and social care systems need to be more proactive both in reducing the need for admissions and in supporting individuals to either return home or to transfer to another setting.

1.2 What is a Delayed Transfer of Care?

- 1.2.1 A Delayed Transfer of Care (DToC), also known as a delayed discharge, is defined by the Department of Health as "occurring when a patient is ready for transfer from a general and acute hospital bed, but is still occupying such a bed. A patient is ready for transfer when:
 - A clinical decision has been made that the patient is ready for transfer;
 - A multidisciplinary team decision has been made that the patient is ready for transfer: and
 - The patient is safe to discharge/transfer" (*source Services for Older People – 2002-3 data definitions. Department of Health; 2002.*)

1.3 Why is this an issue for Birmingham?

- 1.3.1 Birmingham is not performing well in its own terms and the City's collective approach was highlighted in the December 2009 Comprehensive Area Assessment (CAA) which gave



Birmingham a 'red flag' because of its performance on delayed transfers of care. This highlighted it as an area in need of significant improvement.

- 1.3.2 Although Comprehensive Area Assessments ceased in June 2010, its targets remain essential commitments for the city and reducing the number and duration of delayed discharges remains a priority for the City.
- 1.3.3 This is an important partnership issue. The Government's National Indicator NI 131 that measures the number of delayed transfers of care from all hospitals per 100,000 population aged 18+ is shared between Adults and Communities and Health and is a cumulative target throughout the year.
- 1.3.4 The indicator measures the impact of hospital services and community based care in enabling timely and appropriate discharge from all hospitals for all Birmingham adults. As such it is an indicator of the effectiveness of joint working and integration between health and social care.
- 1.3.5 The Department of Health did not directly set national targets for this Indicator. Instead targets were set in Local Area Agreements ('LAA') established through liaison between the regional Government Office, local NHS bodies and local authorities. The target for Birmingham was 12.7 for 2010/11 and 10.2 for 2011/12. However the City's predicted outcome for 2010/2011 is 18.7 which is far higher than either target. The City clearly needs to raise its performance on this measure.
- 1.3.6 Birmingham also performs poorly relative to other local authorities in avoiding emergency re-admissions for patients of 75 or older. This measure reflects the Government's concern that some initial discharges might be done too early or some patients may get inadequate care and support after discharge.
- 1.3.7 In 2006/07 the best-performing local authority was Milton Keynes, which had 496 occupied bed days per 1000 population for patients aged 75 or older associated with two or more emergency admissions. The average figure of all local authorities was 1,984. Birmingham had 2,640. The worst performer had 3,879.
- 1.3.8 The corresponding figures expressed as numbers of patients instead of the number of days spent in hospital after the first inpatient stay shows a broadly similar picture: Milton Keynes had 24, the average was 66, Birmingham had 75, and the worst performing authority had 100.
- 1.3.9 The figures indicate there is scope to reduce the need for admission of older patients, and scope to provide timely and adequate care after discharge to help minimise the need for readmission.



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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 In 2008/09 the overall average number of delayed discharge patients in the acute hospitals (University, City, Heartlands, and Good Hope plus other much smaller hospitals) was 78.4. In the following year, 2009/10, the figure had grown slightly to 79.2. And in the first four months of 2010/11 it had edged up further to 79.6.

2.3 Delays are becoming slightly shorter

- 2.3.1 Although the numbers of patients experiencing delays has grown, the average length of delay has reduced, at least so far this year. In 2009/10 the overall monthly average number of days Birmingham residents were waiting for discharge was 32.6. For the first five months of 2010/11 the overall average has been 29.3.
- 2.3.2 We recognise that averages can screen wide variations and that "...the number of people waiting to leave hospital is less important than the time for which a patient has waited. In other words, it is much worse for one person to have waited for two months than for 50 patients to have waited one day". [*They Deserve Better*" Independent Commission of Inquiry into Social Care for Older People in Birmingham: Report of the Commission, December 2001].

2.4 Causes of delayed discharges by percentage

- 2.4.1 The Department of Health requires NHS Trusts and Councils to record and report reasons for delayed discharges under ten headings, shown in the left column of the following table. The central column shows the average percentage of delayed transfers caused by each, calculated over the 28 months up to the end of July 2010 and ranked from highest to lowest. The right



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
Awaiting nursing home placement	19%	SC or NHS or both
Awaiting a care package in their own home	17%	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
Patient or family choice	7%	SC or NHS but not both
Awaiting housing – patients not covered by the NHS and Community Care Act	5%	Only NHS
Awaiting community equipment or adaptations	3%	SC or NHS or both
Disputes	1%	SC or NHS but not both
Total	100%	

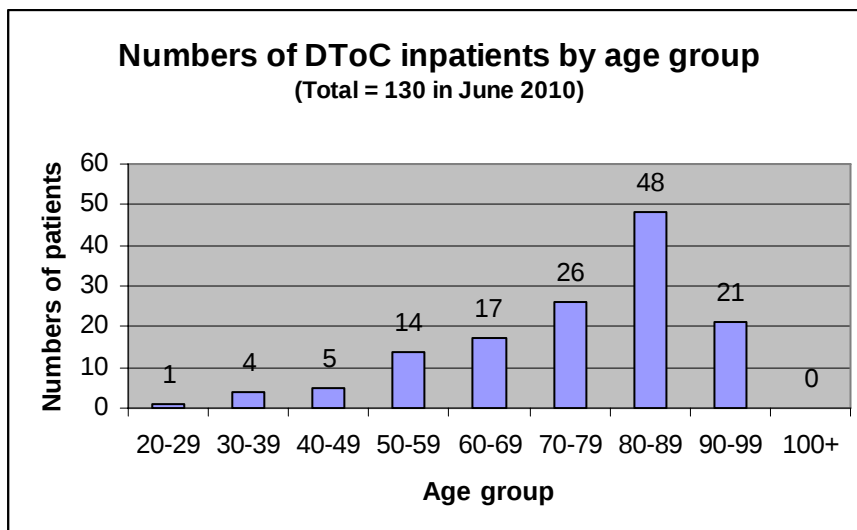
It can be seen from the table that the top three categories, namely awaiting a nursing home or residential care home placement or problems in securing a care package in their own home account for more than half of all delayed discharges with awaiting assessment the next largest category contributing to delays.

2.5 Elderly residents experience majority of delays

- 2.5.1 Delayed discharges can affect inpatients of any age, including children. But the majority of patients experiencing delayed discharges are elderly. Analysis of BIU information for June 2010 revealed that 70% of the patients experiencing delayed discharges were aged 70 or above, and 51% were aged 80 or above.
- 2.5.2 The following bar chart shows how the full numbers in each successive ten-year age band increase with age to a peak in those aged 80-89, then tails off sharply.



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2.6 Birmingham children are also affected

- 2.6.1 Children are often forgotten in discussions of delayed discharges. This may be because they are a very small proportion of the patients who experience delayed transfers and because reimbursement is not payable for delayed transfers of patients aged under 18.
- 2.6.2 However evidence from Birmingham Children's Hospital showed that some children's delays have a serious impact on other patients and potential patients. 5% of patients are delayed for more than 23 days and use 47% - nearly half – of available bed days, meaning that the other 95% of patients have to use the remaining 53% of the beds. In October 2010 35 patients had stayed for more than 30 days.
- 2.6.3 As at October 2010 two patients had had to stay for a combined period of 1800 days beyond being medically fit for discharge, accounting for 3579 lost bed days, or the equivalent of losing 778 potential other patient admissions.
- 2.6.4 Delayed discharge can be particularly distressing for children, whose emotional and social development needs are very different from adults'. Children who are ready to go home and awake and alert, but require intensive nursing, can sometimes witness and hear potentially distressing and traumatic events. Despite having schooling facilities on site, education and schooling can be disrupted. Children are isolated for long periods from their usual friends and social networks. And most children would prefer going home to their family rather than staying in hospital.
- 2.6.5 There can be several possible causes for children's delayed discharges. The equipment and bed for a child or young person with complex needs can mean an existing home is too small for them, and there is a delay whilst waiting for suitable alternative accommodation. There may be pre-existing or new safeguarding concerns that need to be addressed by social care. The impact



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 Executive of Birmingham Children's Hospital told us that some agencies see Discharge Planning Meetings as low priority and that there is "sometimes low attendance of key individuals, notably social care, housing and sometimes GPs".

- 2.6.6 At present the Children's Hospital provides what should be a community care responsibility: employing staff to take a child home when discharged and to take care of them at the child's home until they can safely pass the responsibility for care to the family.

2.6.7 James' Story

James is a 7-year-old boy with a progressive neuro-muscular development disorder for which he was admitted for further investigations. His condition worsened after admission and he was transferred to the Paediatric Intensive Care Unit for help with his breathing and despite efforts to wean him off the ventilation, he was unable to breathe unaided. He was going to require long term support.

Consent was sought from his mum to perform a tracheostomy, but despite repeated attempts by hospital staff to engage with mum, both directly and through a named social worker, it took some days before consent was forthcoming. Legal proceedings had been considered at this stage to ask the court to appoint a legal guardian.

James' tracheostomy went well and this procedure allowed him to interact better and he had started to try to sign a little too: his improvement meant that two months later he was medically fit for discharge.

His social worker was notified but was not hopeful of his mum or grandma being able to look after him as she felt that their accommodation wasn't suitable and she was worried about continuity of care. She was reluctant to seek a care order as she felt it would be very difficult to place him in foster care, although she also didn't want him to remain in hospital.

After a discharge planning meeting, James' consultant engaged the PCT and social care about arranging a package of care for him, but James wasn't considered to be an urgent priority as he was in a 'place of safety': Birmingham Children's Hospital.

There then followed several months of discussion between all the agencies involved, including social care, staff from the Hospital, the complex care team, community nurses and the PCT.

Eventually James was discharged and is now being cared for in a long-term care home.



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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 hips¹. Some of these delays may be awaiting suitably skilled clinical staff such as consultants, but others may be waiting for a hospital bed.

¹ www.statistics.gov.uk, 'Hospital Episode Statistics: Headline figures 2008-09' accessed in June 2010.



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- 3.1.4 Thirdly the **patient's family or carer** can be harmed because they cannot plan ahead for the discharge date, and also they may have to spend time and money on regular and frequent visits to the hospital to see the patient, for an unknowable period.
- 3.1.5 Subtle harm may be caused to **other patients already in the hospital** because some of the staff and resources that could improve their care are being used instead on someone who no longer clinically needs to be there.

3.1.6 Molly's Story

Molly was a normal child, thriving and achieving all her milestones. But at the age of two she suffered an acquired brain injury and multiple disabilities after contracting encephalitis, and is now fed by a gastronomy and dependent on around the clock care.

Before Molly was admitted to hospital she lived in a 3 bedroom house with her expectant mum, Susan, her grandmother and uncle. Susan's ex partner, Molly's father, had been violent towards Molly's mum. Her care needs meant that, sadly, Molly was unable to return to her former family home because it was unsuitable. Mum Susan was also fearful of her ex partner.

The ideal solution was that Molly, Susan (and ultimately her new sibling) move into a 2-3 bedroom house with enough room for all the equipment Molly requires, which includes a feeding pump, wheelchair and a standing frame. Susan submitted a change of circumstance form and a medical priority application whilst Molly was in hospital.

But, like many mums in Susan's situation, she needed essential support from her family to care for Molly, so the house needed to be near them. This was a cause of anxiety for Susan, and she didn't feel that it was acknowledged or recognised enough by the housing department. She also had great difficulty in engaging with social care, because Molly didn't meet the referral criteria of the in-house hospital team as there were no safeguarding issues. She was instead referred to the Children's Disability Team, but she didn't meet their criteria either, because Molly was an in-patient and a core assessment could not be undertaken as she didn't yet have a discharge address. Susan didn't receive any practical help in completion of forms and advice on housing and financial support from social care, which further delayed the process.

She felt she had very little support and did not know who to turn to at an already difficult time. Because Molly had to wait a full seven months after she was fit for discharge to be suitably housed, Susan gave birth to Molly's brother halfway through this wait and had to care for a newborn baby in the hospital. While the staff at the hospital were very fond of Molly and her family, her delayed discharge meant that over 200 bed days had to be provided for her unnecessarily, which could have been used to provide care for another 46 patients.



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 authorities were required to comply with the Act by putting into place information systems and protocols to record delayed transfers and to be able to account for their reimbursement transactions.

3.2.5 Historically in Birmingham a tripartite agreement has been in place which seeks to agree joint initiative spending to decrease delays, rather than levying fines. The agreement was with the three hospital trusts that had the largest number of acute beds, namely Heart of England Hospitals Foundation Trust, University Hospital Birmingham Trust, and Sandwell & West Birmingham Hospitals Trust, and indirectly with the three Birmingham primary care trusts. The aim of the partnership was to consult and seek consensus on how to spend the RIG-equivalent funding so that it had maximum effect in reducing the number and/or average duration of delayed transfers, and investment would replace the need for reimbursement.

3.2.6 RIG ended as a grant in 2008/9 and it was left to local discretion whether to continue to make such funds available. The City Council currently sets aside £2.1m of its base funding for either the development of services or the payment of fines.



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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, mainly on interim beds, but also including £50,000 on specialist discharge staff and £84,000 paying a previous year's refund to South Birmingham Primary Care Trust. £294,415 was spent in the Heart of Birmingham, of which half was on specialist discharge staff and half on interim beds.
- 3.2.8 In a speech on 8 June 2010 Andrew Lansley, Secretary of State for Health, announced that from April 2011 hospital trusts would take responsibilities for meeting peoples' care needs for the first 30 days after their discharge from hospital. The focus will be on re-enablement, preventing premature clinical decisions to discharge, and reducing the need for emergency readmissions.
- 3.2.9 On 5 October 2010 he also announced that a once-only fund of £70 million will become available to NHS hospital trusts from November 2010 to enable them to work together and with local authorities to ensure systems will be put in place so that the trusts can carry out this duty effectively. The £70 million is expected to help about 35,000 people, so the average fund available per person will be about £2,000.

4 PART 2: Reducing Admissions

4.1 Causes of admission

- 4.1.1 It is clear that tackling delayed transfers needs to begin with bringing about a reduction in the demand for admissions to hospital and the duration of hospital stays.
- 4.1.2 The main causes for admission of patients aged 70 or over are slips, trips and falls; a progressive worsening of a longstanding illness or disability, or new complications setting in; the onset or worsening of an age-related condition such as dementia; chronic obstructive pulmonary disease; cancer; and adverse drug reactions. As might be expected, the main causes of admission for younger adults tend to be more related to specific diseases or injuries.

4.2 Public health programmes

- 4.2.1 Much of the work currently being co-ordinated though Birmingham Health & Wellbeing Partnership is addressing public health factors which should in time contribute to reducing the need for admissions to hospital. The work includes programmes on obesity, tobacco control, infant mortality and life expectancy, all of which will gradually tend to reduce the incidence of cancer and other major causes of admission to hospital such as Chronic Obstructive Pulmonary



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 number of hip fractures that occur during each winter season.
- 4.4.2 Members were told that last year, 88 hip fractures occurred in Birmingham during the three weeks of exceptional icy weather that occurred in the winter period, which cost an estimated £2.1 million to the NHS and Social Care, in addition to being shocking, painful, life-damaging and in some cases potentially fatal to the individuals. These costs do not include costs incurred for delayed discharges, which often occur following a hip fracture.
- 4.4.3 The proposal suggested that a significant proportion of these fractures could be prevented if gritting were considered for footways on hills and steep inclines, ramps and steps, footway areas



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outside public buildings and other facilities, rail, bus, coach stations, bus stops, decks and steps of footbridges, junctions and crossing points, footways on the eastern side of terraces or between tall mansion-block-type housing lying north-south (where the eastern side may not receive direct sunlight before midday and no thawing of ice would occur without treatment) and footways in essentially residential areas with a significant proportion of the population over the age of 50. Gritting in more of the areas where elderly people are most likely to need to walk should greatly reduce the numbers suffering hip fractures and save money for the public sector as a whole.

- 4.4.4 Members strongly supported in principle the need to grit pavements and footways but it was recognised that this issue needed to be tackled as soon as possible in order to make a difference during the coming winter months. Therefore, instead of waiting to make a recommendation, the Chairman of the Health & Adults Overview & Scrutiny Committee contacted the Cabinet Member for Regeneration & Transportation in early October. The Cabinet Member indicated that the Highways Department was in the process of agreeing the Highways Winter Maintenance Programme in which they were proposing to do more gritting of pavements at shopping centres this winter. As a result of the meeting he asked his Chief Highways Engineer and two other senior Highways staff to contact the Director of Public Health at NHS South Birmingham with a view to working together to facilitate the gritting of more pavements in shopping centres this winter.
- 4.4.5 The Council is currently piloting a falls prevention scheme in Hall Green and Yardley though it is too soon yet to gauge its effectiveness.

4.5 Primary filtering at Accident and Emergency

- 4.5.1 Members were told that in the last few years there has been a substantial growth in the proportion of urgent self-referrals for admission to accident and emergency ('A&E') centres because of patients calling for ambulances to take them to A&E. We were also told that once a patient goes into A&E in an acute hospital setting it becomes likely they will be admitted as an inpatient, because acute bed capacity creates its own demand. For example, in Heart of England Foundation Trust's main hospitals, namely Heartlands, Good Hope and Solihull hospitals, in 2009/10 out of 51,513 patients who came to Accident & Emergency Wards, 24,236 (47%) were admitted as inpatients.
- 4.5.2 Part of the problem is that many services – including many Council services - operate on an eight hours per day, five days per week basis so that, for example, community services cannot be 'switched on' at short notice out of hours. Also families and carers press for the patient to be admitted because they see that as the safest option.



- 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 about the efficacy of basing a GP in A&E. It was suggested that if one or more GPs were based in each A&E unit with the role of screening referrals it would reduce the numbers referred for admission, since other patients would be directed to a primary care service that can treat them effectively. But another witness warned of the risk that basing a GP in A&E could increase the number of patients, because it would increase the numbers of patients coming in solely to see the GP, if their own GP is less accessible.
- 4.5.7 So a solution may lie in telling patients who come to A&E that they will be assessed by a primary care health professional with knowledge of the scope of primary care services – who may or may not be a GP themselves - and if there is reason to think the patient can be treated effectively by a GP they will be directed to their own GP or to a walk-in GP centre. But if the patient needs immediate treatment that will be provided by acute medical staff, not by the primary health professional, whose role at A&E is confined to assessment and signposting. This needs to be explored to establish an effective screening process at A&E. *Reference Recommendation R01*

4.6 Referrals from General Practitioners to Accident and Emergency

- 4.6.1 Most A&E referrals are self-referrals, but others are by GPs. The Chief Executive of NHS South Birmingham told Members that GP urgent referrals to A&E departments were fairly static in total but there are very wide variations in the numbers of hospital referrals by GPs irrespective of the characteristics of their patient population or the practice's resources. Generally experienced GPs made fewer referrals than inexperienced GPs. A BEN PCT witness said in her feedback that there is a "need to look at the rate of sending to A&E by Out of Hours GP services": this suggests they refer too many of their patients to A&E.
- 4.6.2 The creation of strong GP commissioning consortia should help to identify and standardise best practice.



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4.7 Senior responsible officers to resolve budgetary disputes

- 4.7.1 In the 9% of delayed transfers in the 'waiting for public funds' category Members were told that many delayed transfers are caused by waiting for the resolution of 'which budget should pay' negotiations. In some cases the negotiation is done by staff or managers who do not feel they are senior enough to offer and deliver any compromise, so the standoff persists, because neither negotiator can adjust their stance. Sometimes the issue is between Council budget holders, and in other cases the issue is between whether a Council budget or a health budget should pay. Whichever negotiator 'wins' in the end, the patient is harmed by the delay.
- 4.7.2 Witnesses told Members that the bulk of these disputes could be resolved if a senior manager is identified in the Council and another in the NHS, each of whom would have authority and agreed remit to decide cross-boundary or cross-budget matters quickly to minimise any further delay.
Reference Recommendation R02
- 4.7.3 On an exceptional basis, where large amounts of funding are involved and there is little or no precedent to guide decision-making, the problem could be referred to the Birmingham Health & Wellbeing Board which is likely to include Council strategic directors and NHS trust chief executives.
- 4.7.4 The above recommendation will be necessary except where high level decisions are made leading to the pooling of Council and health budgets under section 2 agreements, after which unified management decision-making on spending will eliminate some of these delayed transfers.

4.8 Capturing Good Practice – Optimal Care Initiative

- 4.8.1 It is acknowledged that cost pressures across the public sector can lead to a silo mentality which passes the demand onto another service rather than achieving the savings required across the care economy. Although health and social care are inextricably linked the processes and budget have not usually been considered together. The challenge is to equip the care economy to meet the needs of the population in the medium to longer term.
- 4.8.2 Responding to this challenge will require a new system-wide approach to the planning and delivery of services in order to focus on things that will make a sustainable reduction in demand pressures such as early intervention and prevention. Inter-agency work is underway both in health and social care on the Optimal Care Initiative. The work will focus initially on optimising the whole pattern of care for those who have suffered strokes, coronary disease, mental health disorders or dementia. The initiative aims to encourage partnership working, integration, remove duplication and to improve quality whilst simultaneously realising significant cost savings.



- 4.8.3 The outcomes from this initiative are likely to reduce the number and duration of hospital admissions and the numbers and durations of delayed discharges. A Department of Health report 'Quality outcomes for people with dementia: building on the work of the National Dementia Strategy' published on 8 September 2010 mentioned that it is estimated that 40% of patients in hospital have dementia; that people with dementia stay longer in hospital, and that the excess cost of this in the average General Hospital is £6m per year.
- 4.8.4 In feedback from BEN PCT we were told that 'excess costs' are charges for excess bed day costs incurred by the hospital trust if an inpatient stays beyond the 'Trimpoint', which is the nationally-set length of stay for each medical condition that is paid for by each tariff under the NHS Payment by Results scheme regardless of whether an inpatient leaves hospital sooner.
- 4.8.5 Some practical means – perhaps a forum with senior representatives from each organisation - is needed to do two things: firstly to identify and assess the relative merits of different practices, as far as possible on the basis of verifiable evidence; and secondly to scale up the best practice so it is used as standard by all the relevant organisations. Even where best practice is identified there is a risk that progress towards making them universal practice will be slow, patchy, disparate and easily deflected. It is difficult to spread best practice across different organisations as it can ask for decommissioning of well established and ingrained services as well as a complete change of culture. Accountability for implementation will be key: the optimal arrangements may need to be tied into joint contractual arrangements and in some cases jointly-funded as part of an agreed strategy. *Reference recommendation R03.*

4.9 Adverse drug reactions

- 4.9.1 Dr Sinead O'Mahony, a geriatric medicine consultant, estimates that adverse drug reactions cause up to 30% of over-70 hospital admissions, 80% of which are preventable.² As people age they become slower at metabolising and disposing of drugs; their body contains more fat so more fat-soluble drug accumulates; and they become more likely to have multiple conditions each requiring different drugs, which may interact adversely. Dr O'Mahony says that over 80% of adverse drug reactions in older people are predictable from the information on the drugs and could be avoided either by better drug choice or more appropriate dosing, and that doses commonly need to be reduced.
- 4.9.2 GP's are personally clinically, professionally and legally accountable for the prescribing decisions they make.

² Dr Sinead O'Mahony included these estimates in her article 'Therapeutics in older people – the challenges' published on 17 June 2010 in Pulse (a national printed journal for GPs and also a daily and weekly email update service to GPs and others who register to receive them). Six GPs added comments electronically to her article, each comment being very positive. Her study findings were supported by the findings of similar studies done in Australia and elsewhere.



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- 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 quality of prescribing by practices and also on areas such as antibiotic prescribing and stepping down treatments. This involves audits and meetings between practices and PCT pharmacists. PCTs employ Assertive Case Managers (specialist Nurses) with a specific remit to assertively manage the frail and those at higher risk of admission. Medication reviews and support to regular medication administration is a key part of their role.
- 4.9.4 The GP Chair of the Professional Executive Committee at Birmingham East & North Primary Care Trust agreed that adverse drug reactions can be reduced, but that some will remain unavoidable. This is either because the information on each drug gives no clue that an adverse drug reaction may occur, or because patients' health may worsen if their drug dosages are reduced or altered.
- 4.9.5 The Clinical Director for Elderly Care at Heartlands Hospital told us via the Chief Executive of Heart of England Hospitals Foundation Trust that:
- "The figure given by Mahoney.....applies to those where the reaction was contributory rather than mainly or wholly to blame.....I would say that drug interactions/adverse events are a contributory factor in about 1 in 4 of our frail elderly admissions. However to view the interaction as preventable or indeed causative of the admission is too simplistic. In many situations the drug was indicated until such time as another inter-current event occurred and then destabilised the situation."
- 4.9.6 However he thought there is still scope for improvement:
- "...medication reviews should occur regularly in primary care and particularly in care homes, especially when inter-current illness supervenes. More could be done in the care home sector and this would make some difference. Secondary care is not blame-free in this respect either, with patients usually being discharged on more medications than when admitted. Arrangements for review are often not made."

4.10 Frail elderly care

- 4.10.1 The Clinical Director for Elderly Care at Heart of England Foundation Trust (HEFT) gave evidence that the number of older people is steadily rising, and older patients are presenting to A&E in



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 A&E is a blunt tool with which to manage clinical frailty conditions and that it is necessary to work in a different way to tackle the problem.
- 4.10.3 He said people need to be assessed prior to admission by a multidisciplinary team comprising a range of professionals including social care staff, clinicians, therapists and voluntary services all being part of the elderly front door assessment teams.
- 4.10.4 In terms of health services for frail older patients, there would be fewer admissions and emergency readmissions of frail elderly patients – who are the group most likely to experience delayed transfers of care – and improved outcomes for patients if new arrangements were made at hospitals and in the community.
- 4.10.5 He said that at hospitals there is a need for:
- Rapid access to 'Front door' elderly care multidisciplinary specialist teams; *Reference recommendation R01*
 - Integration with community facilities;
 - Rapid access day hospital reviews;
 - Step down at the 'window of opportunity' – the often brief interval between the patient being clinically fit for discharge and them becoming institutionalised and losing the ability or confidence to cope in the community – to semi-independent living;
 - Transfer (of responsibility for a patient's care between services or organisations) on trust, letting the paperwork and financial aspects be sorted out afterwards, so the patient's needs are given primacy over the organisational needs; and
 - No toleration of delays.
- 4.10.6 In the community there is a need for:
- A Rapid Response Elderly Multi-Disciplinary Team that can be convened quickly where and when needed;
 - Access to a range of resources according to need;
 - An emphasis on care at home wherever possible; and
 - A comprehensive geriatric assessment ('CGA') – a multidisciplinary assessment of need contributed to as necessary by an elderly care physician, social worker, nurse, therapist, old



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age mental health expert (nurse and/or psychiatrist), dietician, speech therapist etc. – before final decisions are made on long term care.

- 4.10.7 There was also evidence from other witnesses from HEFT that the number of elderly mentally infirm (EMI) patients was increasing and there was a shortage of appropriate placements.
- 4.10.8 The Cabinet Member for Adults & Communities said the problem seems to arise where EMI beds are not available at a given location or without top-up payments. Empty EMI beds are those that do not meet the market need. The normal market pressures towards equating supply and demand cannot operate as there is no incentive or premium in Birmingham for providers to enter the EMI market, which does not recognise the higher resource needed to care for EMI service users. Acute beds are not appropriate for dementia cases. *Reference Recommendation R05*
- 4.10.9 It will be helpful if a review would explore what support care homes need in order to avoid admissions.

5 PART 3: Hospital Stay

5.1 When discharge planning and preparation is started

- 5.1.1 Discharge or care transfer is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another setting. It also ensures that resources are being used efficiently.
- 5.1.2 Although Members heard conflicting evidence from witnesses in relation to discharge planning, it is clear from Department of Health Best Practice Guidance that discharge planning should be initiated as soon as – or even before – the patient is admitted. Discharge or transfer planning needs to start early to anticipate problems, put appropriate support in place and agree an expected discharge date. It is crucially important to identify any factors that would make a patient's discharge problematic so that action can be taken early to plan care. Failure to do this will have consequences for the patient's transfer later in the care planning process. Ideally an expected date for discharge should be set within 24-48 hours of admission, and discussed with the patient and carer.
- 5.1.3 There is anecdotal evidence that at least in some cases discharge planning starts long after this, and sometimes is only begun just before the expected discharge date, which brings a high risk of a delayed discharge. *Reference Recommendation R06*



5.2 Responsibility for discharge planning and preparation

- 5.2.1 Once the legal requirement to eliminate eligibility for Continuing Health Care funding has been met the inpatient can be referred for social care assessment. Most patients admitted to hospital are allocated to the hospital-based social care team for their assessments. That team keeps responsibility for care co-ordination for seven days after discharge, when responsibility is formally transferred to the relevant community team.
- 5.2.2 City Hospital has Discharge Trackers who progress-chase delayed discharges. In Heartland and Solihull hospitals this job is done by Senior Discharge Co-ordinators. Both hospital trusts (Sandwell & West Birmingham and Heart of England) have multi-disciplinary meetings to keep on top of delays. The meetings at Heart of England Hospitals Trust are weekly, or daily when there are bed pressures, and those at City Hospital are held several times per week.
- 5.2.3 In exceptional circumstances such as a safeguarding case or a very complex situation the community social care team that had responsibility before admission will retain responsibility throughout the hospital stay. Similarly currently no mental health social workers are based in hospitals, so for a Mental Health service user who is hospitalised the original mental health social work team retains responsibility for care co-ordination throughout the hospital stay. In each case there needs to be close liaison with the discharge staff at the hospital.
- 5.2.4 Work is currently ongoing to develop a Mental Health referral for patients needing psychiatric support but who are otherwise fit for discharge from acute hospital. Social care mobilisation can be an issue.
- 5.2.5 Hospitals also need to ensure that discharges and transfers are planned to take place on any day of the week, including any weekend or bank holiday day, in order to minimise delay for the patient. For this to succeed fully other agencies and providers of home care need to be operating on a similar basis. *Reference recommendation R06*
- 5.2.6 Whilst a patient is still in an acute bed an assessment of likely support needs can be made, but this may need to be revised as the patient's health improves. Where there is doubt about the patient's ability to cope after discharge, the ideal would be to transfer the patient to another setting which enables enhanced assessment to take place. Feedback from Birmingham East & North Primary Care Trust suggested that "Trying to fund a care package too early before full recovery is known will push more (patients) onto Continuing Healthcare funding where they will have little choice on how their services are provided and will be (at) a higher risk of premature admission to care homes. Rather than making the decision on funding while someone is in hospital, we need more assessment step down outside the hospital to give more time for recovery so that appropriate decisions can be taken." In many complex cases enhanced assessment will be needed.



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 This accounts for 14% of delayed transfers. We were told that in most cases the waiting is because of shortages of skilled staff to do the assessment, shortages of budget, or shortages of the market availability of affordable services or facilities to which an assessment may be likely to point.
- 6.1.2 There was evidence from Heart of England Foundation Trust that delays in carrying out social care assessments had increased week on week throughout August and September 2010 resulting in the blocking of beds to the equivalent of two full wards across all hospitals. Those beds would otherwise have been available to new patients and patients' conditions could deteriorate while waiting for assessments.
- 6.1.3 We were told that the social care assessment delays had been caused partly as a result of the introduction of the latest version of CareFirst 6, the electronic social care record, which led to a sharp increase in assessment delays over the summer. Lessons need to be learned from this experience about the need for adequate planning and risk assessment when major organisational changes are taking place. It should be mandatory that all Council departments approaching a service change should risk assess against the impact on DToCs – and other service delivery – and prepare contingency plans for managing the risks. For example care home contract renewal might reduce some risks. *Reference Recommendation R07*

6.2 Awaiting public funding

- 6.2.1 This accounts for 9% of delayed transfers. It covers all patients whose assessment is complete but transfer has been delayed due to awaiting social care funding (e.g. for residential or home care), or NHS funding (e.g. for nursing care or continuing healthcare). It should also include cases where Social Services and NHS have failed to agree funding for a joint package or an individual is disputing a decision over fully funded NHS continuing care in the independent sector. It excludes delays due to arranging other NHS services (residential or community). The main delays are due to gaps between meetings of funding panels and disputes about whether social care or NHS funding should be used. Patients may be required to contribute to the costs



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;
- Certain community care services (although there are rules about accessing these);
- Incapacity benefit, contribution-based job seekers allowance, a retirement pension, widows benefit, bereavement benefit, guardians allowance, maternity allowance and statutory maternity pay.

6.2.5 Unfortunately neither the Council nor its health partners can reduce the numbers or durations of delayed discharges of inpatients in this circumstance, since it is only the courts that can determine their legal rights.

6.3 Awaiting further non-acute NHS care

6.3.1 This includes waiting for hospital-based therapies and community based intermediate care, and accounts for 8% of delayed transfers.

6.3.2 Annual programmes of funding for interim beds set up by the City-wide Delayed Transfers Group are considered and agreed by a Joint Group of Directors of Commissioning and Directors of Finance. The City-wide Delayed Transfers Group includes acute, social care and PCT staff.



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- 6.3.3 We asked PCT Information teams how many interim beds their PCT has as at October 2010 and the figures they provided are shown in the following table. The third column shows in brackets where PCTs temporarily use additional beds and in the fourth column the bracketed figures show the population served per bed if temporarily-used beds are counted in the total. The figures imply differences in usage of interim beds.

Primary Care Trust area	Approximate population	Number of interim beds	On average each bed serves a population of
South Birmingham	340,000	235	1,447
Heart of Birmingham	270,000	44 (plus right to spot purchase up to 10 others)	6,136 (5,000)
Birmingham East & North	400,000	64	6,250
Total	1,010,000	343 (plus up to 10 more)	2,945 (2861)

There is currently a shortage of interim beds suitable for patients with dementia and/or challenging behaviour, which require a higher than normal specification. Also there is need for a small number of intermediate step-down beds for children who no longer need acute services but need time to learn and adjust to use equipment for their care before they return to live at home. Some interim beds should be used to avoid the need for admissions.

- 6.3.4 A research paper from Birmingham University [*'The billion dollar question': embedding prevention in older people's services – 10 'high impact' changes*, University of Birmingham's Health Services Management Centre, HSMC policy paper 8, August 2010] said that in practice intermediate care has tended to concentrate on....rehabilitation in residential settings, with fewer services addressing avoidance. It also says that there is a "tendency to focus on the physical and practical aspects of rehabilitation rather than broader social and emotional aspects."
- 6.3.5 The research paper says that "There is a significant diversity locally in terms of how intermediate care is conceived and implemented". At present each acute trust and PCT pursues its own policy in regard to the development of interim care. There are isolated pockets of good practice but a co-ordinated common City-wide approach – a 'community based budget' type of initiative - is likely to be more effective. NHS Trust Chief Executives should establish a joint method of identifying and implementing City-wide best practice. This seems to be an obvious area where the establishment of pooled budgets of the type which are already being used in learning disability and mental health should be considered in order to support implementation of a City-wide approach. *Reference recommendation R04.*
- 6.3.6 It is unlikely that new purpose-built intermediate accommodation will be created in the foreseeable future because there are strong pressures to reduce both NHS and local government public spending. But the lack of it causes some delayed discharges. So it will need to be



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 put 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 that its step-down care (based in an acute hospital) is working well, and many patients are able to return to their own homes when previously they would have gone into care homes.

- 6.3.9 The first floor of the Kenrick Centre in Harborne has been purpose-built and equipped for intermediate care. However it remains unused because of legal issues about its ownership, in particular whether the Council has the legal right to sublet part of the building. Members were advised that the centre was built on land owned by a charitable trust. While the Council had been allowed to build on the land it could not lease the building to another party. There was evidence from NHS South that the PCT had not signed up to use the centre as it was not felt there to be a shortage of community assessment beds in South.

- 6.3.10 In October 2010 the Chairman of the Health & Adults Overview & Scrutiny Committee discussed this with the UHB Director of Partnerships. Various possibilities were raised which might help to move the situation forward such as the suggestion that the Council could retain the lease but the Trust could second in health staff to enable the facility to be used as intended, though without subletting. Collaborative working needs to continue towards a solution that will bring the capacity available at the Kenrick Centre into use as soon as possible.

Reference Recommendation R09



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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;
- exploring the need for advocacy services to be commissioned for ex-patients;
- identifying how best to make a brokerage service available to ex-patients so that they can find services that they need; and
- in the medium term, exploring whether this or other similar volunteer-staffed enterprises could progress to developing a paid staff organisation, perhaps staffed by former volunteers who have proven their skills and trustworthiness, to provide personal assistants to citizens who have direct payments, personal budgets or – eventually – individual budgets.

6.4.5 This has considerable potential for reducing the incidence or average duration of delayed transfers of care. In some cases this service could avert or delay the need for a patient to be provided with a residential home or nursing home placement. *Reference Recommendation R10.*

6.4.6 In some parts of the City there is another scheme, under which elderly residents can call in a handyperson to do one-off tasks requiring some technical knowledge, ranging from replacing a fuse or re-washing a tap to repairing a sagging shelf. The resident is not charged for labour or for low-cost materials. Commissioners could usefully consider extending this scheme to cover the whole of the City.

6.4.7 Housing Directorate can provide accommodation-related support services financed by Supporting People, a grant programme that provides local housing related support to services to help vulnerable people live independently at home, rather than being hospitalised, being given institutional care or being homeless. This can be a key factor in enabling a hospital leaver to return to live in the community after discharge.

6.4.8 Committee members are aware that inpatients are not the only citizens needing and waiting for domiciliary service packages or placements in private care homes or nursing homes: there are likely to be far more people in the community waiting for those services.

6.5 Awaiting community equipment or adaptation

6.5.1 This accounts for 3% of delayed discharges. The Department of Health requires reporting of the reasons for delayed discharges under ten headings one of which is “waiting for aids or adaptations”. This includes two dissimilar areas.



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- 6.5.2 One is awaiting semi-permanent adaptations to the patient's home, such as a floor lift, or stair lift, which are installed by Housing Directorate and can involve delay depending on how easy or otherwise it is to make the adaptations to the particular dwelling. The evidence from Housing was that major adaptations can require 11 to 12 weeks notice to be given to the contractor.
- 6.5.3 The other is the loan of beds, hoists, bath lifts, mobility aids and other small items of equipment and to a small but growing extent, assistive technology. This equipment is managed through the Integrated Community Equipment Team in Adults and Communities Directorate. This service generally works well as equipment is provided into hospitals directly as buffer stocks and as a result delays are infrequent. Occasionally equipment is out of stock due to manufacturer difficulties and occasionally equipment has to be individually sourced if it is a specialised request.
- 6.5.4 Whilst both types of aids and adaptations will still need to be combined for reporting to the Department of Health, each should be recorded separately for internal reporting and accountability purposes. *Reference recommendation R11.*

6.6 Patient or family choice; and Disputes

- 6.6.1 Patient or family choice - for example if the patient is considering accepting a community care package or if the family is considering whether and how they might be able to care for the patient, or where a patient or their family have persistently refused all practicable offers of services - causes 7% of delayed discharges, and disputes between agencies cause another 1%. Feedback from Birmingham East & North PCT said that choice/eviction policies should be developed that give patients graduated notice of a requirement to leave hospital and make their own arrangements if a dispute becomes unlikely to be resolved.

6.7 Awaiting suitable housing

- 6.7.1 This causes 5% of delayed discharges. There are two main reasons why.
- 6.7.2 Firstly several witnesses told us that assessment of an inpatient's post-discharge needs should be done as early as possible. Whenever that assessment indicates that there is a need for social housing, the person responsible for avoiding or minimising a delayed transfer of care should notify Housing Directorate, so the search can begin early. Delay can be lengthened if the person responsible for avoiding or minimising a delayed transfer is late notifying Housing.
- 6.7.3 Whilst many towns and cities north of the Midlands have surplus public housing, Birmingham has a shortage, and long lists of eligible people waiting for tenancy. Patients leaving hospital are amongst the groups given top priority for social housing. But even if the priority groups were the only ones needing social housing the supply would still fall short of demand. Generally the accommodation in areas where people most want to live is let quickly, so much of the available



unlet accommodation is in less popular areas, and where demand is for accommodation close to family or a carer it may be restricted to one small area. The more complex and specific the patient's housing needs are, the longer the delay is likely to be before suitable accommodation becomes available. For example feedback from Birmingham East & North PCT told us that many people are stepped down into interim care beds while they wait for Extra Care Sheltered Housing places.

- 6.7.4 Housing Directorate is rapidly approaching getting all its properties up to the Decent Homes standard, is now building new homes for social rent and supporting extra care developments in the City, and the Council and other agencies are doing all they can to improve the quality of life and support for vulnerable people. So in the medium to long term we can expect housing to be a smaller cause of delays.
- 6.7.5 Witnesses from Housing said that 100 priority points are awarded to applicants and transfer cases who are in hospital and cannot return home because of medical and/or mobility reasons. Once the housing application is received, complete with supporting documentation and proofs, the assessment process is expedited and priority is awarded within 3 to 5 days. Referrals are usually received from a hospital social worker or liaison worker and liaison with family members and key workers is maintained throughout the process. Customers (patients) are offered support to ensure that they are able to bid for suitable properties and assisted bidding is offered to them. A Housing Manager manages and monitors progress throughout and liaises with the customer and/or their representative to update on progress, bid on their behalf and advise when they have been short listed or offered more suitable accommodation. A recent development is that Delayed Transfer Housing Officers, paid for from Supporting People funding, are now based with hospital-based social work teams.
- 6.7.6 Sometimes patients need particular adaptations to a property, and if so their name and details should be added to the Disabled Persons Housing Register once the housing application detailing that need is received. When a property that is already adapted becomes available, a referral is made to the Disabled Persons Housing Register team, who will identify a suitable applicant and make an offer. Where required and practicable an Occupational Therapist will also attend the viewing.
- 6.7.7 Where a property has been adapted and the resident has died or moved elsewhere, Housing will first try to identify a suitable applicant. If that is not possible discussions will take place with the Independent Living Team to identify if there are any customers awaiting adaptations who would benefit from a move. If no applicant is identified after this time, the property will be allocated as general needs housing and any working stair lifts or other adaptations will be removed and stored for re-use. If an existing tenant or household no longer requires the adaptation to their property they are given additional priority if they wish to move from the property so that it becomes available to others who need the adaptation.



7 Conclusion

- 7.1.1 The problem of delayed transfers of care is a longstanding and intractable issue which affects the quality of life of some of the most vulnerable people in the City. Whilst progress has been made in recent years, the complexity of the health and social care economy in Birmingham means that the issue of whole system ownership of the problem is at the heart of any solution. At a time of fundamental change in Birmingham's health and social care commissioning and provider structures a City-wide approach is more crucial than ever.
- 7.1.2 Despite significant investment and effort there remains a considerable strain on the current health and social care system across Birmingham. This is currently felt most acutely in the area of delayed transfers of care which has reached unacceptable levels and has been identified as an area needing significant improvement. This is in spite of a reduction of delayed transfers being one of the key targets (NI 131) in the Birmingham Local Area Agreement.
- 7.1.3 It is a complex problem and the causes of the increase are many. What is clear is that the solution will require an approach where the health and social care sectors work together to optimise the limited public sector resources available in order to deliver the best outcomes for the citizens of Birmingham. We need to address the challenges in a co-ordinated way and to adopt a "Community Based Budget" approach to solving this problem.



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



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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

Jonathan Lloyd, Director of Strategic Delivery, Birmingham & Solihull Mental Health Foundation Trust

Shirley Mallon, Commissioner, NHS Birmingham East & North

Sarah-Jane Marsh, Chief Executive, Birmingham Children's Hospital

Liz McCarthy, Complex Discharges Nurse Specialist, Heart of England Foundation Trust

Steve Peak, Chief Executive, Birmingham Women's Hospital

Lorraine Rea, Deputy Divisional Manager – Medicine & Elderly Care, Sandwell & West Birmingham Hospitals Trust

Mary Ross, Clinical Director of Therapy Services, Heart of England Foundation Trust

Ellen Ryabov, Chief Operating Officer Heart of England Foundation Trust

Chris Steven, Principal Public Health Information Analyst, NHS South Birmingham

Dr Peter Thebridge GP, Chair of the Professional Executive Committee, NHS Birmingham East & North

Margaret Savage, Assistant Director for Medicines Management, NHS Birmingham East & North

Chris Spencer-Jones, Director of Public Health, NHS South Birmingham

Rita Symons, Director of Commissioning & Strategy, NHS South Birmingham

Viv Tsesmelis, Director of Partnerships, University Hospitals Birmingham Trust

Dr Peter Wallis, Consultant Geriatrician & Clinical Director of Elderly Services, Heart of England Foundation Trust

Angela Young, Commissioner, Heart of Birmingham teaching Primary Care Trust

Other Witnesses

Two elderly people who had each experienced delayed transfers of care were interviewed at their homes by Iram Choudry and Tony Green, Scrutiny staff, on Friday 1 October 2010.



Other support for the review

Two staff in the Council's Business Information Unit, Ann-Marie Burden and James Mountford, supplied up to date statistical information about delayed discharges at frequent intervals during the review.

At the most intensive of the Member-led evidence-gathering events on 29 September Rose Haarhoff from Scrutiny performed a vital role in managing visitor/witness flows.

Committee Manager Viv Smith supported the review group before, during and after all its formal meetings.