Appendix A

Berkshire West 10 Delayed Transfers of Care (DToC) **Peer Challenge Report**

March 2018

Final draft

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Executive Summary

The Berkshire West Integration Board asked the Local Government Association to undertake a Peer Challenge into the issue of Delayed Transfers of Care (DToC) in the area. The work was commissioned by Nick Carter the Berkshire West Integration Board Chair and Chief Executive of West Berkshire Council on behalf of the partners represented on the Board. Everyone involved was looking for some further insight into the issue of why there are different DToC figures between West Berkshire Council, Reading Borough Council and Wokingham Borough Councils. This would build upon previous work in this area to explain why this is the case and make recommendations that the partnership could take forward. The specific scope of the work was to answer two questions about the DToC outcomes and data:

a) *"Why there is a discrepancy on DToC performance over the three areas of the Berkshire West 10?"*

b) *"Are the designed interventions to improve DToC across the areas the correct ones?"*

The key message from the peer team is that the performance across the whole of the Berkshire 10 needs to improve and the system needs to stop comparing performance internally but look externally to see where the best practice is improving outcomes for older people who are delayed in hospital. After due consideration the peer challenge team would like to make three key recommendations to the commissioners of the review:

1. The Berkshire 10 to consider how they are going to change the culture from one of competition to one of collaboration across the organisations to achieve safe and timely discharges home for older people who are in hospital.

2. The Berkshire 10 should establish daily discharge meetings – face to face – to establish real time management of DToCs which then report to a weekly senior leadership DToC sign off. Other best practice changes set out in the 8 High Impact Changes (HICs) need to be implemented equally across the system.

3. The Councils and the Clinical Commissioning Groups need to establish a joint commissioning approach which maximises joint resources and stimulates a new approach from the market to meet the new demand.

The report outlines the activity and details that lead to these three overarching recommendations that are covered in the main body of the report with other background, explanation and comment.

Report - Background

1. The Berkshire West Integration Board asked the Local Government Association (LGA) to undertake a Peer Challenge into the issue of Delayed Transfers of Care (DToC) in the area. The work was commissioned by Nick Carter the Berkshire West Integration Board Chair and Chief Executive of West Berkshire Council on behalf of the partners represented on the Board. Everyone involved was looking for some further insight into the issue of why there are different DToC figures between West Berkshire Council, Reading Borough Council and Wokingham Borough Councils. This would build upon previous work in this area to explain why this is the case and make recommendations to solve the problem that the partnership could take forward. The specific scope of the work was to answer two questions about the DToC outcomes and data:

    a) "Why there is a discrepancy on DToC performance over the three areas of the Berkshire West 10?"

    b) "Are the designed interventions to improve DToC across the areas the correct ones?"

2. A peer challenge is designed to help an organisation and its partners assess current achievements, areas for development and capacity to change. The peer challenge is not an inspection. Instead it offers a supportive approach, undertaken by friends – albeit 'critical friends' with no surprises. All information was collected on a non-attributable basis in order to promote an open and honest dialogue.

3. The members of the peer challenge team were:

    - **Sarah Mitchell**, LGA Associate
    - **Avril Mayhew**, Senior Adviser, Care and Health Improvement Programme, LGA
    - **Angela Parry**, LGA Associate
    - **Sharon Longworth**, Adviser, Care and Health Improvement Programme, LGA
    - **Marcus Coulson**, Challenge Manager, LGA

4. Prior to the peer challenge exercise the peer challenge team considered previous DToC reports and other benchmarking information and completed a case file audit with two out of the three councils in order to understand the history and context of the situation across the Berkshire West area and the difference in performance by the three Councils.

5. The team was on-site from Tuesday 30th January – Friday 2nd February 2018. The programme for the on-site phase included activities designed to enable members of the team to meet and talk to a range of stakeholders from the three councils, local hospitals and other National Health Service (NHS) organisations. These activities included:

- A case file audit
- interviews and discussions
- focus groups with managers, practitioners, frontline staff, external partners and people using services / carers
- reading documents provided by the Councils and NHS organisations

6. The peer challenge team would like to thank everyone with whom they spoke for their open and constructive responses during the challenge process. All information was collected on a non-attributable basis and the team was made very welcome and would in particular like to thank Stephanie Clark, Berkshire West 10 Integration Programme Manager for her tireless and invaluable assistance in planning and undertaking this peer challenge which was very well planned and delivered.

7. Prior to being on-site the team considered over twenty documents including an assessment of the performance of all the partners involved in DToC in the Berkshire West 10 area. Whilst on-site the team had over 50 meetings with at least 75 different people. The peer challenge team have spent over 200 hours with the Berkshire West 10 Integration Board organisations and its documentation, the equivalent of 28 working days.

8. Our feedback on the last day of the challenge gave an overview of the key messages. This report builds on the initial findings and gives a detailed account of the peer challenge.

Scope

The Peer Challenge Team were set two exam questions to answer:

1. Why is there a discrepancy on DToC performance over the three areas of the Berkshire West 10?

2. Are the designed interventions to improve DToC across the areas the correct ones?

The Peer Team's answers to these questions are as follows:

1. Why is there a discrepancy on DToC performance over the three areas of the Berkshire West 10?

1.1. Performance Data

To answer this first question the peer team looked specifically at key performance data – the DToC performance of the three Councils not only in comparison to each other but in relation to all other Councils. The national data set shows (Appendix One to this report) that none of the three areas in the Berkshire 10 are performing well on Social Care DToC. How they perform in relation to each other, is less relevant to how they perform nationally – the metric being designed to demonstrate how well they are meeting patient outcomes and delivering safe and timely discharge.

At the time of the review out of a possible ranking of 1-152 where a high score denotes poor performance, Reading ranks highest at 142, West Berkshire is next at 104 and Wokingham is next at 92 – none of these levels of performance are good. The discrepancy is negligible and the performance trend for November 2017 showed that Reading and West Berkshire's performance was improving and Wokingham's performance is worsening. January's 2018 performance figures have since confirmed this trend, for social care delays Wokingham ranked 100, West Berks 98 and Reading 97. We acknowledge that our focus has been on Social Care data as we did not have the time to look at hospital flow as part of NHS delays.

The key message from the peer team is therefore that the performance across the whole of the Berkshire 10 needs to improve and the system needs to stop comparing performance internally but look externally to see where the best practice is improving outcomes for older people who are delayed in hospital.

The peer team want to strongly emphasise this message as it has become ingrained in the culture, beliefs and behaviour of staff - for example a hospital discharge social worker we spoke to in Wokingham believes that their performance in discharge is excellent with little room for improvement and in a step down facility we visited staff did not want to offer their facilities to the other two councils for fear of their DToC figures improving as a result. Not only is it a misconception that any local performance is particularly good, it is not putting patients' needs first if the competition between Councils is at risk of overriding the best interests of patients.

The data collection in the Royal Berkshire Hospital (RBH) appears robust and there are agreed sign off arrangements with the Councils – these feel more secure in West Berkshire and Wokingham than in Reading where discussions about data sign off are ongoing. One system for data validation – ideally daily real time updating and weekly sign off – would ensure that there is one version of the truth about the delayed transfers at RBH. We observed a different level of discharge focus and resource between the three Councils and different approaches to drive and pace. The peer team wholly recognise that the numbers of people delayed in hospital are a small proportion of the Adult Social Care caseload but they remain a policy priority and the Better Care Fund (BCF) is specifically targeted at ways of working and services which facilitate safe and timely discharge. The key to successfully managing flow and discharge is to be truly patient centred and for senior leaders to focus on the detail of the patients delayed on a daily basis, until they can be sure that all staff and managers share a culture of getting people home as soon as possible.

1.2. The HUB

Having established that the performance could improve across all of the three Councils, we then looked at why the performance was variable and focussed on the process of referral from the acute trust to the three social services discharge teams. The routing of referrals through the HUB we believe, creates inbuilt delays and unnecessary handoffs and potential risks. The main variable for the different delays appears to be the co-location of the Wokingham discharge team with the HUB as referrals go directly to them and not via a nurse led triage system. The peer team was concerned about the routing of hospital discharge referrals via the hub which is off site from the hospital and not in line with best practice approaches to hospital discharge. The most effective social care discharge model is one where the social workers attend the daily ward and board rounds, work with the medical and nursing staff to pull patients through and out of the hospital, starting assessments and care procurement in parallel and working closely with therapists, care providers, voluntary sector etc. to ensure patients are returned home as soon as possible after treatment. We would urge you to visit Musgrove Park Hospital in Taunton to see how they work with Somerset Council and other partners in the system to understand the difference in the way of working. The development of daily patient centred case discussions, encouraging patients to ask the four key questions and being focussed on a home first model can all be seen there.

Our analysis of case files from West Berkshire and Wokingham supported our view that referrals that are processed off site via the HUB was not in line with best practice. There was not enough early face to face contact by social care staff with ward staff and patients and too much was done via phone calls and emails. If DToCs are to be reduced, relationships between hospital staff and social care staff need to be ones of trust and confidence, nurtured by daily, face to face, multidisciplinary working seven days a week. Again whilst the location of the HUB might marginally benefit one council more than others, the number of hand offs, the dislocation from the hospital, and the lack of presence on the wards meant that there is opportunity for the performance to improve across all three councils.

In addition to the hand offs and potential risks generated by a HUB model the peer team were concerned by the number of care pathways patients followed out of hospital, potentially adding to the different performance in different areas. Clarity of

pathway routes out of hospital is essential and where that can be streamlined for all councils will undoubtedly increase the number of simple discharges done by the ward staff and reduce the number of patients who become complex and costly, resource intensive discharges. This was demonstrated in the case files the team read where there was little consistency in the relationship between cohorts of patients and their pathway out of hospital and some patients had been put on the wrong pathways resulting in less than ideal, sometimes unnecessary, residential care outcomes.

1.3 8 High Impact Changes

The discrepancy between the Councils and the lack of understanding about the standard of performance across the Berkshire 10 is further illustrated in the 8 High Impact Changes self assessments (Appendix Two of this report) which were completed by the Councils and Clinical Commissioning Groups (CCGs) as part of the BCF process. In the summary document which compares the assessment of progress against the 8 High Impact Changes it is clear that West Berkshire and Wokingham have overstated their position by judging themselves as established against Changes 1-3. For example we did not see evidence of emergency admissions having a provisional discharge date set within 48 hours, we did not see evidence of daily Multi-Disciplinary Teams attended by Adult Social Care, voluntary sector and community health or discharge to assess arrangements. West Berkshire and Wokingham have also overstated their performance in relation to Changes 4-6 in relation to care home provision and seven day working. Changes 7 and 8 show West Berkshire as Mature in relation to the Choice Change 7 but we did not see comprehensive evidence of this and all Councils have overrated themselves in relation to the support in Care Homes in Change 8.

The peer team have highlighted this discrepancy in the assessment because we believe that it undermines your understanding of what needs to be done to improve DToC performance. The 8 High Impact Changes are the fundamental best practice elements of good patient flow and discharge practice, which if put in place consistently and sustainably will deliver safe and timely discharge and produce good outcomes for patients. Each change needs proactive implementation, preferably with the Councils working together consistently in the system around the acute hospital, tightly project managed to ensure that the implementation of each change complements the other.

The peer team acknowledges that all partners need to implement seven day working across all provision including transport, pharmacy and care provision and all partners have a part to play in achieving this. This requirement is not new – systems with low levels of DToCs have had seven working in place for some time.

1.4 Commissioning the Care Market

It was clear from the discussions with the peer team that the three Councils and the CCGs were taking different approaches to commissioning the care market. It was also clear that there was not an immediate understanding of the market factors influencing the availability and cost of care – a key factor being the number of self funders in the market which will dictate prices and capacity, knowing the usual price paid for beds by the Councils and how often that is supplemented, why and when.

Managing the market effectively will directly impact on DToC performance and will account for some of the discrepancy across the Berkshire 10. Whilst the availability of domiciliary care is a challenge for many Councils in high employment, high cost housing areas it cannot be the reason why an older person stays in hospital for too long. It is counterproductive as they will become more dependent and need more care at a higher cost. Managing the care market separately drives up costs as providers play commissioners off against each other and Councils and CCGs do not get the economies of geographic or organisational scale. We heard from Continuing Health Care (CHC) commissioners that they pay double the price of beds for their patients than the Councils do, for beds in the same nursing home.

Taking a joint commissioning approach to managing the care market across the Berkshire 10 and the CCGs, engaging self funders in a debate about a fair price for care across the whole of Berkshire, looking at creative solutions to the employment of care staff in more rural areas which includes employing staff directly, the use of personal assistants through personal budgets, micro providers and employment through the NHS. Having a shared risk approach to paying the right price for residential and nursing home care will all help to manage DToCs more effectively and evenly across the patch. Aim for collaborative not competitive commissioning which maximises your collective resources to deliver performance and improve outcomes.

1.5 Shared Narrative

There is a local narrative about DToC performance locally that is affecting the way staff work together. In addition to competing with each other, the team observed that the narrative is creating a culture of possible complacency amongst some Wokingham staff who appear to believe that their performance is better than it actually is in comparison with best practice areas. Reading staff appeared to have lost their confidence but were recognising an improvement in leadership and delivery in recent months and the peer team picked up a sense of helplessness in West Berkshire which was primarily in relation to feeling unable to influence the domiciliary care market.

2. Are the designed interventions to improve DToC across the areas the correct ones?

2.1 High Impact Changes

As already mentioned in the report, successful implementation of the 8 HIC is essential to improve DToC performance as they set out the basic best practice elements of effective patient flow and safe and timely discharge. In areas where a number of Councils work with an acute trust, it is good practice to work together to jointly implement the HICs in partnership across the system. This would make best use of scarce resources, provide a coordinated and simplified route out of hospital along the three care pathways and help to manage the care market response to discharges.

The Berkshire West 10 Integration Board has an opportunity to challenge the current assessments of the 8 HICs and to develop an action plan and delivery mechanism to implement the changes across the whole system, proactively project managing the plan centrally on behalf of all partners. This would be a good focus for the work that needs to be done collaboratively and it would address many of the concerns of the peer team already expressed. The peer team would be very happy to help with this through facilitating a workshop to start this process working with the current joint appointment for the Berkshire 10. Implementing the changes will put in place the interventions needed to deliver the best DToC performance and will enable the system to review the current ways of working and amend practice accordingly.

2.2 People before Process

The peer team observed some well-established processes of assessment which were confirmed by the case file audits. There was a concern that process had on occasions overtaken the relationship with the patient, not putting them at the centre of the decision making in relation to their discharge. The role of the HUB in accepting referrals and passing them to the teams via triage builds in unnecessary hand overs and delay before anyone has seen or spoken to the patient so there is a worry that decisions are being made on behalf of the patient. Putting the patient at the centre of decision making creates better outcomes for people and more efficient and effective care arrangements. It also helps everyone to share and manage risk creating the right environment for a Home First culture.

The peer team met some very committed and passionate staff who undoubtedly wanted to do the very best for the people they serve and they are keen to find new ways of working that would achieve that culture. Starting this approach through a new relationship with the acute wards will help to start those conversations with patients and their families – we acknowledge that some staff are doing this but it needs to be a consistent approach by all Councils and hospital staff and one that is supported by systems and processes and not vice versa

2.3 Reliance on Residential Care

The case file audits identified some examples of overuse of residential care and the peer team saw cases of people whom that they thought could return home if the right services had been in place or if the patient and their family had been involved more actively earlier on in the process. Where there has been pressure to discharge,

nationally, we have seen an increase in residential placements, many intended to be short term but drifting into long term. This is a short term fix as it uses up capacity in the care market, increases prices and produces poor outcomes for people. Investing in more short term 24-hour wrap-around care required to get people home quickly but safely to be assessed is the best practice approach.

Commissioning collaboratively across the Berkshire 10 can make this cost effective and achievable, provide a unified approach to the route out of hospital, reduce costs for all and improve performance. Reliance on residential care is not only about the market availability but about how the system collectively responds to the pressure on the hospital and to the expectations of families – it is harder to implement Home First under those conditions but essential to achieve patient flow. It is harder still if there are a number of Councils working out of the hospital as achieving culture and behaviour change requires a collaborative approach to change. A review of all the DToC interventions collectively to implement the best for the whole system would be valuable and would give you the answer to this questions. Coordinated implementation of the behaviour and culture change to achieve Home First supported by a joint approach to manage the market so the right type of care is there to receive people seven days a week is the outcome the system needs to achieve. Then the DToC performance will improve across all of the Berkshire 10.

2.4 Multiple Pathways out of Hospital

The case file audits showed that there are multiple pathways for patients out of hospital both within and across Council areas. This was triangulated through discussions with staff. This reduces the likelihood of effective simple discharges which then reduce the burden on social care as it removes inappropriate referrals but it also can lead to patients being on the wrong pathway into residential care rather than home. There were also therapy led services in the hospital getting people home and hand holding until they were settled which seemed to be an excellent model to build on as part of the review mentioned above. Agreeing and clarifying the three simple key pathways across the systems and applying them every time through consistent clinical decision-making is key but requires the whole system to agree the pathways and train staff to use them – together. Again, resourcing the pathways is key but that is not just about supply – getting the access criteria right to be as open and flexible as possible e.g. to accept people with dementia and high nursing need is key to it making a real difference to the level of delays. Nationally, systems invest a lot in reablement, rehabilitation and intermediate care services but make the criteria so tight that the majority of patients cannot access them therefore making them expensive and inefficient.

2.4 Step Up and Step Down Services

We saw some excellent examples of step up and step down facilities which were not being used to their full potential. The residential step up and down service in one facility we viewed had vacancies which could be offered to people from the other Council areas but were not because, we were told, this might improve the other Council's DToC figures. Maximising all the resources across the Berkshire 10 for the benefit of all is essential to improve all the DToC performance. What we did see was dedication of the staff and a great service which could be key to the pathways mentioned earlier.

We also heard about step down facilities in extra care housing used for those patients who are traditionally harder to place. Extending the use of those across the Berkshire10 and engaging other agencies in moving on those people who get stuck in those facilities would also provide a valuable resource for the pathways. Again, we met committed and engaged staff keen to make things work but also staff who believed that they were already performing well in managing DToCs, belying the national position.

2.5 Hand Holding not Hand Offs

We were impressed by the Hand Holding service which reaches out from the hospital and wonder if it can become more of a whole system approach, a cultural change that engages everyone in a patient centred approach.

2.6 Triangulated Information

This LGA Peer Challenge been different in that it has looked at three councils and focussed on one element of performance and tried to answer two key questions on behalf of the Berkshire 10 Group. In doing so it has been light touch in some ways spreading conversations over four days with a number of different stakeholders. However, the messages we have heard and information we have gathered has been triangulated across the system and we therefore feel some confidence about the answers to the two questions we have been set. There is a real opportunity here for the whole system to improve the performance of every Council and the NHS but most importantly to improve the outcomes for patients and their families.

2.7 Continuing Health Care

The peer team remained concerned about some aspects of Continuing Health Care and how it is applied in the system. Our concern is whether patients are paying for care when they should be getting it free from the NHS – either as a self funder or through paying charges for council funded care. The levels of CHC funding are very low and yet individual package costs appear relatively high. This affects the price of care in the market for all commissioners. The danger of having very low levels of CHC funding, apart from not being equitable for patients, is that other professionals stop referring people for CHC funding and are therefore denying them their right to assessment. We cannot say if this is happening routinely, but we would urge the system to review this, particularly as, we believe, the last review of CHC was in 2012. CHC assessments are still being done in the acute hospital although that varied across the system and is another element of the process worth reviewing.

National standing out of 211 CCGs	Organisation	Total CHC funded Per 50k of Population
ENGLAND AVERAGE		**58.82**
204	NHS NEWBURY AND DISTRICT CCG	19.33
205	NHS WOKINGHAM CCG	18.78
206	NHS NORTH AND WEST READING CCG	18.45
207	NHS SOUTH READING CCG	8.78

Given the low numbers of patients receiving CHC and the costs of care we heard about – possibly paying double the council rate for nursing home beds – we were surprised that there was not greater immediate awareness of the cost and numbers – a danger that because the numbers are low, the impact of the higher price on the wider market is not understood. This will contribute to a lack of beds available at the price the councils can afford.

2.8 Mental Health

Another area the peer team wanted to highlight was Mental Health, particularly the liaison role in West Berkshire as it demonstrated a marked improvement in mental health delays across the system. We were a little concerned by the Section 117 funding panel delays and heard of one patient with complex needs who had been delayed in hospital since January 2017. We also heard that there was not enough out of hospital provision for complex needs which is another opportunity to take through a joint commissioning approach.

3. Recommendations for Action

These are the specific recommendations from the presentation delivered on the last day of the peer challenge by the team:

- Start collaborating, stop competing: create a new narrative from the Integration Board
  - Change the message to be Home First, patient centred
  - Hand holding not hand offs
- Establish joint H&SC commissioning across all authorities
- Develop a joint demand and capacity plan across H&SC
- Develop a joint H&SC workforce strategy which delivers
- Focus on getting it right for the patient not the organisations and DToC numbers will fall
- Have earlier conversations with patients and families
- Maximise your use of step up and step down facilities
- Move from weekly to daily sign off of DToCs until you are confident about the data
- Ensure that all data is fully reconciled before submission
- Get your social care support into the hospital and provide the social work service and community support seven days a week
- Clarify the access to care pathways to ensure equality for patients
- Use step up and step down resources strategically across all the councils
- Develop creative solutions to lack of domiciliary care e.g. personal budgets, community connectors
- Implement Trusted Assessment with the care market
- Use Case File Audits to identify hidden delay
- Ensure a strong patient voice as a self funder and as a stranded patient
- Work in a Co-productive way to develop the voluntary sector offer in managing patient flow and delayed transfers
- Look outside for best practice in other systems
- Work together to manage the price of care
- Review your implementation of the High Impact Changes
- Establish greater leadership collaboration
- Establish a Hospital based multiagency discharge hub
- Consider how Councils can act on behalf of each other in the hospital
- Simplify pathways - 3 pathways out

Immediate next steps

We appreciate the senior leaders of the Berkshire 10 will want to reflect on these findings and recommendations in order to determine how the group wishes to take things forward. There is already the agreement for Lead Peer Sarah Mitchell to present the findings from this report at the Integration Board meeting on 18th April 2018 where these issues can be explored further.

As part of the peer challenge process, there is an offer of further activity. The LGA is well placed to provide additional support, advice and guidance on a number of the areas for development and improvement and we would be happy to discuss this. Mona Sehgal, Principal Adviser is the main contact between the three councils and the Local Government Association. Her contact details are, email: Mona.Sehgal@local.gov.uk, Telephone: 07795 291006.

In the meantime we are keen to continue the relationships we have formed throughout the peer challenge. We will endeavour to provide signposting to examples of good practice and further information and guidance about the issues we have raised in this report to help inform ongoing consideration.

Marcus Coulson
Programme Manager
Local Government Association
Tel: 07766 252 853
Email: marcus.coulson@local.gov.uk

March 2018
On behalf of the Peer Challenge Team.

Conditions for Success

The following Conditions for Success are a set of useful questions for the BW10 system members to pose to themselves as a way of measuring how improvements are being considered and achieved. These have been developed as an output from the Hospital to Home Programme which visited over 30 health and care system leaders in 2017 to carry out one day peer reviews. This can be explored further at the Integration Board meeting on 18th April 2018.

Leadership

a) Is there is a desire and commitment to make things better for local people?
b) Has time been invested to build relationships and trust?
c) Have the system leaders agreed a collective ambition and vision?
d) Are there clear lines of decision making and accountability?
e) Have plans been simplified and prioritised?
f) Is there distributed leadership across the system?

Culture

a) Is cultural change actively driven by the system leaders?
b) Has time been invested to create a compelling narrative?
c) Is there a shared understanding of safe timely discharge?
d) Is there systematic learning about how the system works and support for staff to be involved in continuous improvement?
e) How is success celebrated?

Performance

a) Has work been undertaken to simplify, standardise and streamline services, pathways and processes?
b) Is there agreed shared system responsibility for performance?
c) Is there a single agreed dataset to drive system improvement?
d) How is flow and capacity managed across the whole system?
e) Has there been a systematic and sustainable approach to implement and embed the 8 High Impact Changes?

Community Capacity

a) How is the system capacity aligned to meet population need?
b) What is the role of the third sector to improve community resilience?
c) How has the system moved to a position of less reliance on bed based solutions to drive home first models of care?
d) Is there co-production of the future market strategy and flexible employment opportunities?
e) Are there pooled budgets and risk share arrangements underpinned by evidence?

Contact details

For more information about the Berkshire West Delayed Transfers of Care (DToC) Peer Challenge please contact:

For information on the LGA's Delayed Transfers of Care Programme contact:
Avril Mayhew
Senior Advisor - Delayed Transfers of Care Programme
Care and Health Improvement Programme, Local Government Association
Email: avril.mayhew@local.gov.uk
Tel: 07770 688395

For information on the LGA's Adults Peer Challenge Programme contact:
Marcus Coulson
Programme Manager – Adults Peer Challenge Programme
Local Government Association
Email: marcus.coulson@local.gov.uk
Tel: 07766 252 853

Care and Health Improvement Programme

The care and health improvement programme provides support for social care, integration and health as well as supporting the transforming care programme for people with learning disabilities and/or autism. The sector-led improvement programme for care and health, is co-produced and delivered with ADASS, the Association of Directors of Adult Social Services in England. For more information see: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement

For more information on **Managing Transfers of Care** see this link: https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience

For more information on **Adults Peer Challenges** see our website https://www.local.gov.uk/our-support/peer-challenges/peer-challenges-we-offer/safeguarding-adults-and-adult-social-care

Appendix 1 - LA Level comparison – all England

Comparison with expectations set for September 2017		Social care delays rank	NHS delays rank	ALL delays rank	Total Delayed Days per day per 100,000 18+ population (NB includes, NHS, social care and jointly attributable)			NHS Delayed Days per day per 100,000 18+ population			Adult Social Care Delayed Days per day per 100,000 18+ population			Delayed Days attributable to both NHS and social care per day per 100,000 18+ population		
Region	LA Name	Nov-17	Nov-17	Nov-17	Target Sept 17	Gap	Nov 17 actual	Target Sept 17	Gap	Nov 17 actual	Target Sept 17	Gap	Nov 17 actual	Target Sept 17	Gap	Nov 17 actual
South East	Reading	142	95	131	10.9	-6.6	17.5	5.5	-1.5	7.0	2.8	-6.8	9.6	2.6	1.7	0.9
South East	West Berkshire	104	111	132	11.9	-5.6	17.5	5.5	-2.5	8.0	3.6	-0.4	4.0	2.8	-2.8	5.6
South East	Wokingham	92	47	55	8.4	0.7	7.7	5.5	1.1	4.4	2.6	-0.7	3.3	0.3	0.3	0.0

FIGURES SHOWN NOW REFER TO THE DAILY AVERAGE - DTOC BEDS
Ranks now reversed in line with LG Inform - the higher the rank, the higher the rate

			Nov-17			Oct-17			Sep-17		
Row Labels	Change in DTOC beds, all, per 100,000 (compared to last month)	Change in DTOC beds, social care, per 100,000 (compared to last month)	Social care DTOC rate (Rank)	NHS DTOC rate (Rank)	Total DTOC rate (Rank)	Social care DTOC rate (Rank)	NHS DTOC rate (Rank)	Total DTOC rate (Rank)	Social care DTOC rate (Rank)	NHS DTOC rate (Rank)	Total DTOC rate (Rank)
HAMPSHIRE	-0.1	-1.1	150	140	150	149	134	149	148	127	148
READING UA	-0.7	2.0	142	95	131	135	113	134	125	120	128
SOUTHAMPTON UA	-2.4	-0.5	138	116	136	143	117	140	145	126	143
PORTSMOUTH UA	0.4	0.0	125	58	90	121	55	79	119	60	85
BRIGHTON & HOVE UA	-3.2	-1.4	112	82	103	124	93	122	74	101	96
OXFORDSHIRE	-4.3	-2.0	107	139	143	128	139	146	104	131	144
EAST SUSSEX	-2.3	-1.0	106	106	106	118	110	120	130	122	131
WEST BERKSHIRE UA	-4.5	-0.9	104	111	132	110	126	141	102	96	126
WEST SUSSEX	-2.1	0.1	103	133	117	92	141	129	97	145	133
WINDSOR & MAIDENHEAD UA	0.2	-0.9	101	138	121	109	123	121	81	136	122
WOKINGHAM UA	0.5	0.5	92	47	55	71	36	47	58	64	58
KENT	-0.3	-0.4	80	105	91	86	103	89	95	90	84
SURREY	-1.1	0.1	75	84	80	69	99	80	65	98	72
SLOUGH UA	1.5	1.5	73	55	51	27	59	32	17	91	44
BRACKNELL FOREST UA	0.9	-2.6	70	125	113	111	77	102	101	97	99
ISLE OF WIGHT UA	2.6	-1.6	67	76	53	90	2	20	34	2	4
BUCKINGHAMSHIRE	-1.1	0.1	58	108	82	51	115	82	64	121	91
MEDWAY TOWNS UA	-2.1	0.3	55	30	26	40	86	52	37	59	37

Appendix 2 - Self Assessment against the 8 High Impact Actions

	Not yet established	Plans in place	Established	Mature	Exemplary
Change 1: Early Discharge Planning. In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.	• Early discharge planning in the community for elective admissions is not yet in place. • Discharge planning does not start in A+E	• CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning. • Plans are in place to develop discharge planning in A+E for emergency admissions	• Joint pre admission discharge planning is in place in primary care. • Emergency admissions have a provisional discharge date set in within 48hrs	• GPs and DNs lead the discussions about early discharge planning for elective admissions • Emergency admissions have discharge dates set which whole hospital are committed to delivering	• Early discharge planning occurs for all planned admissions by an integrated community health and social care team. • Evidence shows X% patients go home on date agreed on admission
Change 2: Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.	• No relationship between demand and capacity in care pathways • Capacity available not related to current demand • Bottlenecks occur regularly in the Trust and in the community • There is no ability to increase capacity when admissions increase –tipping point reached quickly • Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	• Analysis of demand underway to calculate capacity needed for each care pathway • Analysis of demand variations underway to identify current variations • Analysis of causes of bottlenecks underway and practice changes being designed • Analysis of admissions variation ongoing with capacity increase plans being developed • Staff training in place to ensure understanding of the need to increase senior clinical capacity	• Policy agreed and plan in place to match capacity to care pathway demand • Analysis completed and practice change rolled out across Trust and in community • Analysis completed and practice changes being put in place and evaluated • Staff understand the need to increase capacity when admissions increase • Staff understand the need to increase senior clinical support when necessary	• Capacity usually matches demand along the care pathway • Capacity usually matches demand 24/7 to match real variation • Bottlenecks rarely occur and are quickly tackled when they do • Capacity is usually automatically increased when admissions increase • Senior clinical decision making support is usually available and increased when necessary	• Capacity always matches demand along the whole care pathway • Capacity always matches demand 24/7 reflecting real variations • There are no bottlenecks caused by process or supply failure • Capacity is always automatically increased when admissions increase • Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7
Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients	• Separate discharge planning processes in place • No daily MDT meeting in place • CHC assessments carried out in hospital and taking "too" long	• Discussion ongoing to create Integrated health and ASC discharge teams • Discussion to introduce MDTs on all wards with Trust and community health and ASC • Discussion between CCG and Trust to establish discharge to assess arrangements	• Joint NHS and ASC discharge team in place • Daily MDT attended by ASC, voluntary sector and community health • Discharge to assess arrangements in place with care sector and community health providers	• Joint teams trust each other's assessments and discharge plans • Integrated teams cover all MDTs including community health provision to pull patients out • CHC and complex assessments done outside hospital in people's homes/extra care or re-ablement beds	• Integrated teams using single assessment and discharge process • Integrated service supports MDTs using joint assessment and discharge processes • Fully integrated discharge to assess arrangements in place for all complex discharges

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	Not yet established	Plans in place	Established	Mature	Exemplary
Change 4: Home First/Discharge to Access. Providing short-term care and re-ablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	• People are still assessed for care on an acute hospital ward • People enter residential /nursing care too early in their care career • People wait in hospital to be assessed by care home staff	• Nursing capacity in community being created to do complex assessments in the community • Systems analysing which people can go home instead of into care –plans for self funder advice • Work being done to identify homes less responsive to assess people quickly	• People usually return home with reablement support for assessment • People usually only enter a care / nursing home when their needs cannot be met through care at home • Care homes assess people usually within 48 hours	• People return home with reablement support from integrated team • Most people return home for assessment before making a decision about future care • Care homes usually assess people in hospital within 24 hours	• All patients return home for assessment and reablement after being declared fit for discharge • People always return home whenever possible supported by integrated health and social care support • Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours
Change 5: Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.	• Discharge and social care teams assess and organise care during office hours 5 days a week • OOHs emergency teams provide non office hours and weekend support • Care services only assess and start new care Monday –Friday • Diagnostics ,pharmacy and patient transport only available Mon-Fri	• Plan to move to 7 day working being drawn up • New contracts and rotas for health and social care staff being drawn up and negotiated • Negotiations with care providers to assess and restart care at weekends • Hospital departments have plans in place to open in the evenings and at weekends	• Health and social care teams working to new 7 day working patterns • New contracts agreed and in place • Staff ask and expect care providers to assess at weekends • Hospital departments open 24/7 whenever possible	• Health and social care teams providing 7 day working • New staffing rotas and contracts in place across all disciplines • Most care providers assess and restart care at weekends • Whole system commitment usually enabling care to restart within 24hrs 7 days a week	• Seamless provision of care regardless of time of day or week • New staffing rotas and contracts in place and working seamlessly • All care providers assess and restart care 24/7 • Whole system commitment enabling care always to restart within 24hrs 7 days a week
Change 6: Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	• Assessments done separately by health and social care • Multiple assessments requested from different professionals • Care providers insist on assessing for the service or home	• Plan for training of health and social care staff • One assessment form /system being discussed • Care providers discussing joint approach of assessing on each others behalf	• Assessments done by different organisations accepted and resources committed • One assessment format agreed between organisations /professions • Care providers share responsibility of assessment	• Discharge and social care teams assessing on behalf of health and social care • Single assessment in place • Some care providers assess on each others behalf and commit to care provision	• Integrated assessment teams committing joint pooled resources • Resources from pooled budget accessed by single assessment without separate organisational sign off • Single assessment for care accepted and done by all care providers in system

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	Not yet established	Plans in place	Established	Mature	Exemplary
Change 4: Home First/Discharge to Access. Providing short-term care and re-ablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	• People are still assessed for care on an acute hospital ward • People enter residential /nursing care too early in their care career • People wait in hospital to be assessed by care home staff	• Nursing capacity in community being created to do complex assessments in the community • Systems analysing which people can go home instead of into care –plans for self funder advice • Work being done to identify homes less responsive to assess people quickly	• People usually return home with reablement support for assessment • People usually only enter a care / nursing home when their needs cannot be met through care at home • Care homes assess people usually within 48 hours	• People return home with reablement support from integrated team • Most people return home for assessment before making a decision about future care • Care homes usually assess people in hospital within 24 hours	• All patients return home for assessment and reablement after being declared fit for discharge • People always return home whenever possible supported by integrated health and social care support • Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours
Change 5: Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.	• Discharge and social care teams assess and organise care during office hours 5 days a week • OOHs emergency teams provide non office hours and weekend support • Care services only assess and start new care Monday –Friday • Diagnostics ,pharmacy and patient transport only available Mon-Fri	• Plan to move to 7 day working being drawn up • New contracts and rotas for health and social care staff being drawn up and negotiated • Negotiations with care providers to assess and restart care at weekends • Hospital departments have plans in place to open in the evenings and at weekends	• Health and social care teams working to new 7 day working patterns • New contracts agreed and in place • Staff ask and expect care providers to assess at weekends • Hospital departments open 24/7 whenever possible	• Health and social care teams providing 7 day working • New staffing rotas and contracts in place across all disciplines • Most care providers assess and restart care at weekends • Whole system commitment usually enabling care to restart within 24hrs 7 days a week	• Seamless provision of care regardless of time of day or week • New staffing rotas and contracts in place and working seamlessly • All care providers assess and restart care 24/7 • Whole system commitment enabling care always to restart within 24hrs 7 days a week
Change 6: Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	• Assessments done separately by health and social care • Multiple assessments requested from different professionals • Care providers insist on assessing for the service or home	• Plan for training of health and social care staff • One assessment form /system being discussed • Care providers discussing joint approach of assessing on each others behalf	• Assessments done by different organisations accepted and resources committed • One assessment format agreed between organisations /professions • Care providers share responsibility of assessment	• Discharge and social care teams assessing on behalf of health and social care • Single assessment in place • Some care providers assess on each others behalf and commit to care provision	• Integrated assessment teams committing joint pooled resources • Resources from pooled budget accessed by single assessment without separate organisational sign off • Single assessment for care accepted and done by all care providers in system

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	Not yet established	Plans in place	Established	Mature	Exemplary
Change 7: Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be areal help to patients in considering their choices and reaching decisions about their future care.	• No advice or information available at admission • No choice protocol in place • No voluntary sector provision in place to support self funders	• Draft pre admission leaflet and information being prepared • Choice protocol being written or updated to reduce < 7 days • Health and social care commissioners co designing contracts with voluntary sectors	• Admission advice and information leaflets in place and being used • New choice protocol implemented and understood by staff • Voluntary sector provision in place In the Trust proving advice and information	• Patients and relatives aware that they need to make arrangements for discharge quickly • Choice protocol used proactively to challenge people • Voluntary sector provision integrated in discharge teams to support people home from hospital	• Patients and relatives planning for discharge from point of admission • All staff understand choice and can discuss discharge proactively • Voluntary sector fully integrated as part of health and social care team both in the trust and the community
Change 8: Enhancing Health in Care Homes. Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	• Care homes unsupported by local community and primary care • High numbers of referrals to A+E from care homes especially in evenings and at weekends • Evidence of poor health indicators in CQC inspections	• CCG and ASC commissioners working with care providers to identify need • Specific high referring care homes identified and plans in place to address • Analysis of poor care identifies homes where extra support and training needed	• Community and primary care support provided to care homes on request • Dedicated intensive support to high referring homes in place • Quality and safeguarding plans in place to support care homes	• Care homes manage the increased acuity in the care home • No unnecessary admissions from care homes at weekends • Community health and social care teams working proactively to improve quality in care homes	• Care homes integrated into the whole health and social care community and primary care support • No variation in the flow of people from care homes into hospital during the week • Care homes CQC rates reflect high quality care

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Appendix 3 – Berkshire West DToC Peer Challenge Case File audit – summary feedback

As part of the overall peer review 30 case files across two of the Councils were reviewed. This was a sample of patients who had been reported as being delayed in Royal Berkshire hospital.
Main themes

- Most of the patients remained in hospital over the Christmas and New Year period. From the files reviewed there did not appear to be any sense of urgency in making arrangements for people to return home for Christmas. In the majority of these cases we did not see any clinical rationale for them to remain in hospital.
- There were many gaps in recording across all of the case notes reviewed, often for periods of one week or more. For example a best interest meeting was held on the 2nd January for one patient. There was then no further record of activity recorded until 9th January. See also case example below
- We saw little evidence from the case notes of discussions with patients about their wishes and outcomes. We saw several examples of family members expressing views about what was needed for discharge – for example one patient's plan to return home was aborted following a family member intervention. This patient then moved to a residential home, however we saw no record of any direct discussion with the patient even though she was viewed as having capacity.
- It was evident from the case notes that availability of care provision was a contributing factor in the patient's delay and availability to assess was often an issue. We saw an example of a care provider not visiting as planned to do the assessment because they could not get parked on site. Patients who had been referred to Reablement/ICT services were on occasions not being offered start dates for at least a week.
- We saw little evidence from the case notes of an early social care presence on the wards and/or MDT and board round discussions. Much of the liaison happens off site via telephone conversations. We saw numerous examples of days 'wasted' where for example social care staff are unable to speak to relevant ward staff in order to process referrals or progress chase and telephone messages are left. This can amount to quite significant delays and wastage both in terms of patient time and bed days.

File Audit Case Example
Mrs P
Hospital length of stay: 24th October 2017 to 5th January
Mrs P was admitted to Royal Berkshire Hospital on 24/10/2017.

A package of care was being arranged by the hospital Occupational Therapist (OT) on 17/11/2017 (as Mrs P was deemed medically fit for discharge) with an OT visit to home booked in for 20/11/2017. Mrs P was still in hospital on 21/11 and there followed a number of phone calls and discussions which seemed to delay Mrs P's exit from hospital.

21/11 Social Work call to the ward with no response.

22/11 Social Work call to the ward with no response.

22/11 Hospital decide to keep Mrs P in for night time observation. Best Interest Decision meeting booked for 28th November.

25/11 Notes on the file suggest that the granddaughter was warned that Mrs P was no longer medically fit for discharge and that the discharge may be cancelled.

29/11 Discharge planning meeting. Mrs P has another infection – 72hr diary arranged.

2/12 Social Worker makes three telephone calls to the ward. No reply. No decision regarding discharge destination.

Six days pass.

8/12 Occupational Therapist reports that Mrs P is now medically fit for discharge and "has been for a few days".

There is no evidence in the notes of contact during the six day period from either the Social Work team to the hospital or vice versa.

9/12 Daughter contacts the Social Worker. Mrs P is not confused and does not have dementia (as was queried in the notes).

Quote from the notes with reference to care on the ward from daughter; "She is not incontinent, but when she asks to go to the toilet, they tell her to go in her pad as they are busy and they will change her later".

Three days pass

12/12 Social Work call to the ward with no response (no visit)

13/12 Discussion about an option of rehabilitation. This has been refused. Daughter is not happy with this decision. Physiotherapist agrees that Mrs P should go home

Five days pass

18/12 Mrs P has a transient cerebral ischemic attacks (TIA)

19/12 Intermediate Care Team referral accepted

Three days pass

23/12 No discharge due to lack of capacity in reablement team for double up calls

Six days pass (including Christmas)

29/12 Mrs P is deemed no longer suitable for reablement and a package of care consisting of 4 times per day homecare is required.

One day passes

30/12 Agreement to order key safe and arrange package of care

Three days pass

02/01/18 Key safe ordered and package of care arranged

A further two days passed with discussions about bed sensors etc.

Overall comments

Mrs P finally returned home on 5th January 2018, after 73 days in hospital. Her actual return home was not planned as well as it might have been, as there were issues recorded with no medication, no discharge letter and an incorrect package of care.

The first plan for her discharge was recorded in November, but a number of missed calls, changing decisions and missed opportunities, along with what appears to be a lack of communication and little (recorded) discussion with Mrs P herself, resulted in numerous delays and what can only have been distress to this individual and her family.

On reading this file, the reviewer concluded that had there been an earlier and consistent social care presence on the ward and continuous conversation with the individual, a number of these delays could have been avoided.

Case reference number available upon request should any of the above issues wish to be explored or investigated further.