A&E Delivery Board
June 7th 2017

Delayed Transfer of Care: Discharge Management Update

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NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group
NHS Darlington Clinical Commissioning Group

Agreement across all stakeholders to approach Delayed Transfers of Care across a number of key principles:

- Facilitation of Patient Flow
- Integrated Health and Social Care Discharge Team
- Trusted Assessment
- Integrated Community Assessment
- Sharing of Risk
- Funding Implications

The Model: Home Safe, Sooner

Person is clinically optimised and do not require an acute hospital bed but may still require care services are discharged home or into another community setting where assessment for longer-term care and support needs is then undertaken in the most appropriate setting and the right time for the person.

Integrated Discharge Team

- Discharge Liaison Service (NTHFT)
- Emergency Care Therapy Team (NTHFT)
- Acute Therapies (NTHFT)
- Assessment Reablement Team ART (SBC)
- Social Workers (HBC/SBC)
- CHC Nurse Assessor (NECS)
- Citizens Advice Bureau/Stockton Welfare Advice Network
- Home from Hospital Service – Hospital of God (Hartlepool only)

Choice Policy

Earlier conversations taking place – 'drop in' sessions. Ward 42 biggest users of the policy – reduction in number of days between DST and discharge.

Positive working relationships and processes in place to support implementation.

Partners working on a draft SOP to support reporting of DToC's.

Stockton NESTA Challenge

Stockton-on-Tees

D2A:

IDT front of house care planning for people not suitable for reablement into domiciliary care includes Fast Tracks (Home Safe Sooner D2A Pathway) To be rolled out fully across hospital June 2017 once permanent social worker in place.

Existing pathways into Rapid Response.

Hartlepool

D2A:

Planned elective orthopaedic pathway.

IDT restarts for domiciliary care under 72 hours.

Existing pathways into Rapid response.

Stockton-on-Tees

Improved flow from hospital into Rosedale beds following refinement of admissions policy.

Additional Social worker support to Rosedale to support ongoing care.

Designated Community Matron supporting clinical care reducing readmissions/flow.

Hartlepool

Additional SW in IDT support flow into Westview Lodge.

Stockton-on-Tees

Nursing home residents returned back to nursing home for reassessment support by IDT members

Hartlepool

Rossmere Park opened additional 20 nursing beds.

Nursing home residents returned back to nursing home for re-assessment supported by IDT members.

Home First

Intermediate Care
Assessment/Reablement/ Rehabilitation Centres

Rosedale - Stockton
Westview Lodge
Hartlepool

Residential Care Homes
Nursing Residential Care Homes

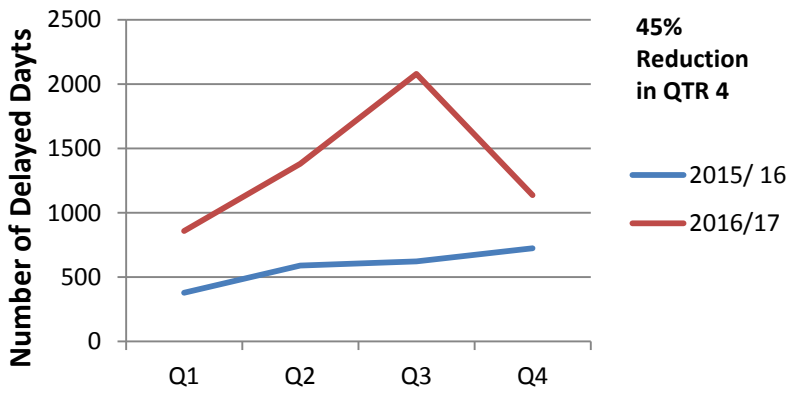
High Impact Change Model: Managing Transfers of Care
Assessment of Progress

Changes	Not yet Est.	Plans in Place	Est.	Mature	Exempl.
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.				★	
Change 2: Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual			★		
Change 3: Multi-disciplinary/Multi-Agency Discharge teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities promotes effective discharge and good outcomes for patients.				★	
Change 4: Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need to wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.				★	
Change 5 : Seven-Day Service. Successful, joint working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.			★		
Change 6: Using trusted assessors to carry out a holistic assessment of ned avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.		★			
Change 7: Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choice and reaching decisions about thir future.				★	
Change 1: 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.			★		

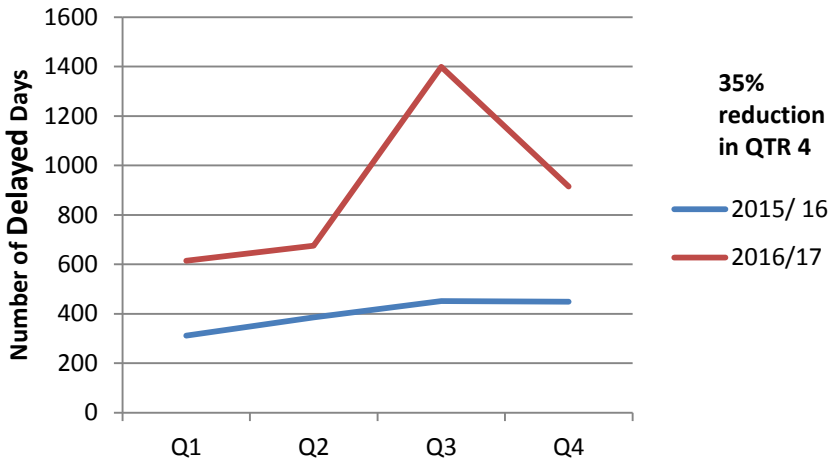
Impact

Delayed transfers of care from hospital per 100,000 population (18+)		2014/15				2015/16				2016/17			
		Q1 2014/15 (Apr14-Jun14)	Q2 2014/15 (Jul14-Sep14)	Q3 2014/15 (Oct14-Dec14)	Q4 2014/15 (Jan15-Mar15)	Q1 2015/16 (Apr15-Jun15)*	Q2 2015/16 (Jul15-Sep15)	Q3 2015/16 (Oct15-Dec15)	Q4 2015/16 (Jan16-Mar16)	Q1 2016/17 (Apr16-Jun16)	Q2 2016/17 (Jul16-Sep16)	Q3 2016/17 (Oct16-Dec16)	Q4 2016/17 (Jan17-Mar17)
Hartlepool LA (Days delayed due to all reasons - NHS, Social Care or Both)	**Quarterly Rate (Actual)**	**956.8**	**1011.9**	**863.0**	**698.9**	**519.0**	**811.4**	**854.0**	**991.4**	**1174.9**	**1892.5**	**2848.4**	**1553.3**
	Quarterly Rate (Plan)	***956.8***	***956.8***	***956.8***	***823.8***	***755.1***	***686.5***	***617.8***	***547.8***	***342.4***	***342.4***	***342.4***	***341.2***
	Numerator (Actual)	694	734	626	509	378	591	622	724	858	1382	2080	1138
	Numerator (Plan)	*694*	*694*	*694*	*600*	*550*	*500*	*450*	*400*	*250*	*250*	*250*	*250*
	Denominator	72534	72534	72534	72833	72833	72833	72833	73024	73024	73024	73024	73265
Stockton-on-Tees LA (Days delayed due to all reasons - NHS, Social Care or Both)	**Quarterly Rate (Actual)**	**368.5**	**373.1**	**473.8**	**584.6**	**204.0**	**251.8**	**295.6**	**292.0**	**400.0**	**439.0**	**909.8**	**591.7**
	Quarterly Rate (Plan)	***368.5***	***292.8***	***284.9***	***386.5***	***347.9***	***276.4***	***269.0***	***365.1***	***130.1***	***130.1***	***130.1***	***129.3***
	Numerator (Actual)	560	567	720	894	312	385	452	449	615	675	1399	915
	Numerator (Plan)	*560*	*445*	*433*	*591*	*532*	*423*	*411*	*561*	*200*	*200*	*200*	*200*
	Denominator	151971	151971	151971	152926	152926	152926	152926	153769	153769	153769	153769	154639

Hartlepool Delayed Transfers of Care



Stockton Delayed Transfers of Care



Reasons for Delays

Hartlepool LA

Year	Delay Reason	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	2015/16 Total	Variance 2016/17 YTD to 2015/16 FY
2016/17	A_COMPLETION_ASSESSMENT	0%	0%	0%	0%	1%	21%	18%	18%	25%	31%	10%	21%	14%	3%	+12%
	B_PUBLIC_FUNDING	0%	0%	0%	0%	0%	0%	1%	0%	6%	0%	0%	0%	1%	0%	+1%
	C_FURTHER_NON_ACUTE_NHS	0%	15%	6%	3%	1%	6%	7%	2%	0%	4%	5%	9%	5%	6%	-2%
	DI_RESIDENTIAL_HOME	12%	12%	6%	3%	0%	6%	12%	8%	15%	19%	9%	7%	10%	13%	-3%
	DII_NURSING_HOME	67%	61%	44%	54%	64%	59%	44%	52%	24%	23%	47%	35%	46%	53%	-7%
	E_CARE_PACKAGE_IN_HOME	10%	1%	0%	0%	0%	0%	5%	3%	2%	1%	0%	3%	2%	0%	+2%
	F_COMMUNITY_EQUIP_ADAPT	0%	0%	1%	0%	0%	0%	0%	1%	1%	0%	4%	0%	1%	1%	-0%
	G_PATIENT_FAMILY_CHOICE	7%	11%	43%	40%	33%	6%	12%	16%	26%	22%	25%	23%	22%	24%	-3%
	H_DISPUTES	0%	0%	0%	0%	0%	0%	2%	0%	1%	0%	0%	0%	0%	0%	+0%
	I_HOUSING	3%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%	+0%

Stockton-on-Tees LA

Year	Delay Reason	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total YTD	2015/16 Total	Variance 2016/17 YTD to 2015/16 FY
2016/17	A_COMPLETION_ASSESSMENT	0%	1%	14%	0%	11%	25%	21%	15%	20%	28%	23%	28%	18%	2%	+15%
	B_PUBLIC_FUNDING	0%	0%	0%	0%	0%	0%	2%	0%	0%	2%	0%	0%	1%	0%	+0%
	C_FURTHER_NON_ACUTE_NHS	26%	29%	8%	3%	22%	14%	9%	15%	2%	7%	25%	8%	13%	13%	-0%
	DI_RESIDENTIAL_HOME	15%	20%	11%	44%	20%	28%	39%	35%	32%	23%	12%	31%	28%	18%	+10%
	DII_NURSING_HOME	21%	18%	16%	11%	3%	14%	11%	16%	20%	5%	14%	10%	13%	15%	-1%
	E_CARE_PACKAGE_IN_HOME	3%	0%	13%	0%	2%	6%	2%	7%	4%	6%	12%	1%	5%	1%	+3%
	F_COMMUNITY_EQUIP_ADAPT	3%	0%	3%	0%	0%	0%	0%	1%	0%	1%	1%	4%	1%	2%	-1%
	G_PATIENT_FAMILY_CHOICE	32%	31%	35%	41%	43%	14%	15%	8%	23%	27%	13%	15%	20%	45%	-25%
	H_DISPUTES	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	-1%
	I_HOUSING	0%	0%	0%	0%	0%	0%	0%	2%	0%	0%	0%	4%	1%	2%	-1%

Next Steps

- Continue to build upon the NESTA recommendations
- Develop locally agreed SOP for DToC Categories
- Explore pathway for people returning to residential care following admission
- Rollout of trusted assessment unplanned NEL (Ortho) HBC following planned care.
- Refresh DToC Trajectories for 17/18 by end June 2017 with an expectation of a return to 3.5% DTOC rate for the country as a whole by September 2017 (NHSE)
- Agree local performance framework for DToC schemes
- Link Discharge work with CQUIN for 17/18 & 18/19 – Supporting proactive and safe discharge.