Rotherham Health Select Commission

21st September 2017

Delayed Transfers of Care (DTOC)

Lead Officer:	Ian Atkinson – NHS Rotherham CCG Nathan Atkinson – Rotherham Met Rotherham CCG Dominic Blaydon – The Rotherham NHS Foundation Trust

Purpose:

The purpose of the report is to update the Rotherham Health Select Commission on progress with regard to reducing Delayed Transfer of Care (DTOC) at The Rotherham NHS Foundation Trust.

Background:

NHS England defines patients as ready to transfer out of the hospital setting when:

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

Delays in discharge can be linked to a number of different reasons, common areas of delay relate to patients waiting for assessment and decision regarding continuing care, patients waiting for care packages to be established in the community or awaiting a care home package.

One of the four national conditions set out in the 2017 Better Care Fund planning guidance requires Health and Care systems to work jointly to reduce delayed transfer of care (DTOC) to a level of no more than 3.5% of patients at any one time being classified as DTOC within the hospital setting (equates to an average 15 patients at any one time).

Historically the Rotherham Health and Care Community has performed well on DTOC, consistently delivering below the 3.5% target. However throughout 2017 (although comparable to many other areas of the country) The Rotherham NHS Foundation Trust (TRFT) has reported a more challenged position is terms of delivery of the DTOC indicators, as highlighted below.

Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
4.1%	4.2%	6.0%	5.1%	5.9%	5.4%

Analysis of key issues and of risks

Taking a proactive approach in response to the increase in DTOC levels locally, TRFT and RMBC commissioned a joint external evaluation of discharge processes in the hospital in April 2017. The two day review of current transfer of care was carried out by a senior advisor from the Care and Health Improvement Programme, Local Government Association and a Discharge Planning Manager from University Hospitals of North Midlands NHS Trust.

The report recommendations (below) were agreed and signed up to by all Rotherham partners and these recommendations now form the basis of the Rotherham DTOC Action Plan.

i. Development of a 7 day a week integrated discharge team to develop a shared understanding and common approach to simple and complex discharges to improve patient outcomes and working relationships; aid management of overall discharge planning; improve effectiveness of referrals and reduce duplication
ii. Simplify Pathways and Assessment Processes including Home First
iii. Implement timely Escalation Process and Response, review who and how teams respond to pressures and how they are de-escalated including review of potentially 'stranded patients' to help improve patient flow and outcomes for individuals
iv. Agree Joint reporting and Data Set to have a standard, single version of the truth to provide a firmer foundation for problem solving as a system and allow for focus on the right problems rather than assumed issues
v. Awareness and Training to improve understanding of DTOC's and Care Act requirements

2. Activity to Date

Following a self-assessment based on the national High Impact Change Model and the review recommendations jointly commissioned by TRFT and RMBC, the following activity has taken place in relation to the action to integrate the discharge functions:

- 2 dedicated workshops with cross system stakeholders from the CCG, RMBC, TRFT and RDaSH including health, social care and therapy staff
- Visit to Doncaster Integrated Discharge Team combining physical health, mental health and social care
- Planned event with staff teams
- Identification of £135,000 from the Improved better care fund grant to support the transformation required within the DTOC action plan.

3. Approach

It has been agreed by partners that a two phased approach will be taken to the project to realise early benefits in time for winter resilience activity.

Phase 1: September 2017

- Integration of the Transfer of Care Team (TOC) and Hospital Social Care Team within a single leadership model
- Re-location of the TOC team to the current Social Care offices on D level, TRFT

- Scoping of phase 2 for wider integration based on successful models elsewhere including: development of a 7 day service, leadership, roles and responsibilities, data capture and reporting

Phase 2: April 2018

The vision for phase 2 is dependent on the scoping exercise, but early discussions would suggest the potential for an integrated team of nurses, allied health professionals (including physiotherapists and OTs) and social care who work together to provide integrated rapid assessments and co-ordinate services to facilitate discharge for patients who are medically well enough to be discharged but may require additional support in the community.

Patient, Public and Stakeholder Involvement:

Provider workshops have taken place over the last few weeks regarding integration of health and social care teams (hospital discharge). Further workshop and engagement will take place as progress is made.

RCCG has attended the Rotherham Patient Participation group to talk through DTOC plans and receive feedback.

Recommendations:

Health Select Commission is asked:

To note the content of the report including Appendix 1 DTOC Action Plan