Agenda Item No: 6

DELAYED TRANSFER OF CARE

To: **Health and Wellbeing Board**

Meeting Date: **26th July 2018**

From: **Amy Page**
Discharge Transformation Director

Recommendations: **The Health and Wellbeing Board is asked to:**

a) **Note the Delayed Transfer of Care (DTOC) Governance arrangements;**

b) **Note performance against trajectory; and**

c) **Note the Main issues and Programme risk register.**

	Officer contact:		***Member contact:***
Name:	Amy Page	Names:	Councillor Peter Topping
Post:	Discharge Transformation Director	Post:	Chairman
Email:	amy.page3@nhs.net	Email:	Peter.Topping@cambridgeshire.gov.uk
Tel:	Tel 07813 177232	Tel:	01223 706398 (office)

1.0 PURPOSE

1.1 The purpose of this paper is to provide assurance to the Health & Well Being Board of:

a) Progress against plan in implementing the Integrated Discharge Teams on each of the provider sites
b) Progress against plan in achieving the target numbers for our Delayed Transfer of care patients across our system
c) Continued remedial actions to ensure rigour and pace are consistently applied to the 'rhythm of the day' such that the ward nurse shift leaders with the operational discharge teams know what is expected of them every day to develop a sense of accountability for each patients discharge pathway

2.0 BACKGROUND

2.1 The guidance states that:

A SitRep delayed transfer of care from acute or non-acute (including community and mental health) care occurs when a patient is ready to depart from such care and is still occupying a bed.

A patient is ready for transfer when:

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

2.2 Delayed transfer of care (DTOC) is the terminology applied to patients who are medically fit for discharge and in need of complex discharge support which requires members from health and social care to work together to achieve the agreed discharge pathway for each patient in turn.

2.3 The metric that is measured is the number of occupied bed days at a point in time, the national and local target is to achieve no more than 3.5% of occupied bed days. Our business intelligence team have then translated the number of occupied bed days into a count of patients by County. These numbers are recognised and owned by the system and the delivery teams at each of the acute and non-acute hospitals.

2.4 There is a long-standing historical issue with the high numbers of DTOC patients in our local system. This remains a significant concern, both in terms of our patients' ongoing health and well being and in terms of being able to evidence a cohesive system approach to repairing and redesigning the systems and processes to ensure delivery of the DTOC target through a sustainable approach

2.5 There has been a recent change in leadership for the Delayed Transfer of Care Programme with Jan Thomas' appointed as the Accountable Officer for the Clinical Commission Group (CCG).

Amy Page commenced in post as the Discharge Transformation Director.

A team of Discharge Programme Leads has been appointed with a designated site lead at each of our provider sites:

- Sue Graham is at Cambridge University Hospital (CUH)
- David Allison is at Peterborough City Hospital (PCH)
- Eliza Bautista is at Hinchingbrooke Hospital (HH)
- Katie Wilson at Cambridgeshire and Peterborough Foundation NHS Trust (CPFT) and
- Debbie McQuaid from the Local Authority have joined the team and
- Sam Merridale is the Programme Management Office (PMO) Lead

2.6 With the revised programme approach comes a revised programme structure and programme governance which are included in this briefing. The Programme Director reports monthly to the Chief Executive Officers (CEO) DTOC group where there is the opportunity to escalate any emerging risks and be specific about the actions that are required by each of the Systems CEO's. Likewise, it is the Systems CEO's opportunity to challenge the Programme Director about delivery and performance issues

2.7 The Programme Delivery Group meet bi-weekly and this Group is the vehicle for design of the Programme and its delivery. Whilst the plan initially was to have a Steering Group and an Operational Group, the guidance from the CEO DTOC Group was to move to one unified programme delivery group to ensure cohesion, enable quick responses to emerging risks and as an enabler to the pace of delivery.

2.8 The Programme team meet weekly to ensure every opportunity is taken to share the teams individual experiences, skill sets and expertise and that all opportunities to apply cross-fertilisation of ideas into practice are taken in a consistent way so that we move towards one discharge narrative across our system. Achieving a standardised approach to delivery is one of our core objectives whilst recognising there is always the need for local situations to be taken into account

3. MAIN ISSUES

3.1 Performance remains challenging across all sites.

The performance document attached at **Appendix 1** evidences performance against trajectory for the first few weeks of the programme. The points in time when each of the Leads commenced on their respective sites have been referenced. There was a positive impact on performance at both Cambridge University Hospital (CUH) and Hinchingbrooke Hospital (HH) when the Site Leads landed on site and began to utilise their skills.

At Peterborough City Hospital (PCH), David commenced in the BH Week where we experienced many senior people from multiple organisations being on leave which led to delays in decision making and impacted on performance as evidenced in the gradual increase through that week and into early part of the following week.

3.2 The Programme team have recently met to scope the detailed programme of work required to achieve a stepped change in performance

3.3 The most recent performance data is attached **(Appendix 1*)***

This data sheet captures the trajectory and the actual performance relating to the number of occupied bed days blocked by delayed transfer of care patients as a percentage of a well-defined hospital bed base. This data is then translated into a performance chart for each of our hospital sites.

3.4 One of the programmes identified risks is maintaining momentum and day to day delivery through the summer weeks given the experience we had over the May Bank Holiday week when the impact of many senior officers being on leave from multiple organisations severely compromised patient flow.

All sites are now completing a 'Summer staffing plan' to ensure that every day, there is an accountable person with decision making authority at all the relevant meetings to mitigate against variation in performance during the major summer holiday period.

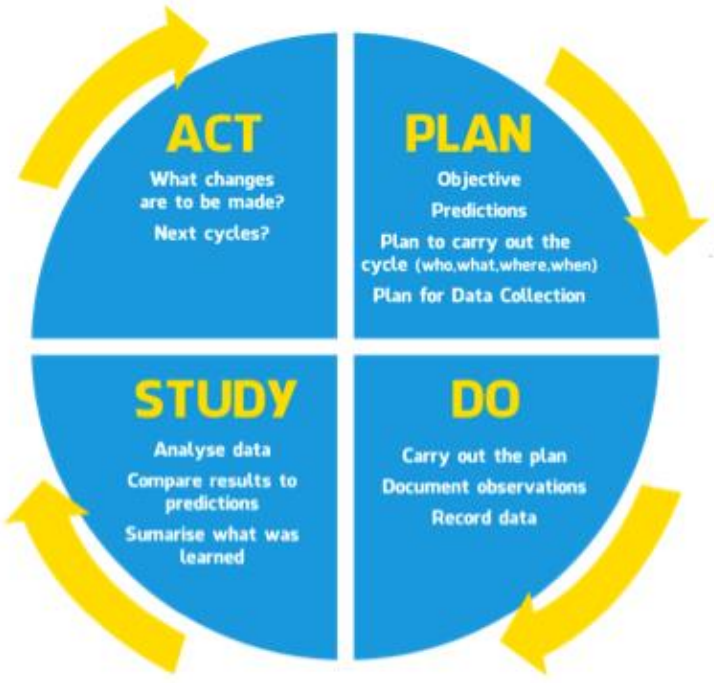
3.5 At CUH, a change in the senior discharge team leader role led to variation in the consistency of approach becoming an issue which led to a loss of traction in the improvement trajectory. We did not foresee that such a change would have such an impact and is a risk we are now sighted on and will develop mitigation plans to prevent this re-occurring during the Programme.

3.6 Implementation of the Integrated Discharge Teams is variable across the System with CUH having this approach further developed. It is now being progressed through North West Anglia Foundation Trust (NWAFT) with the learning from CUH to enable this to take place at pace.

3.7 At CUH, the point of delivery, (POD) pilots are supporting admission avoidance for our older people with the aim of achieving a 25% reduction in admissions into the assessment wards.

3.8 A key component to enable working in an integrated manner is space to bring the respective discharge team members together and this is currently being scoped to mobilise at pace with the assistance of the Chief Operating Officer.

3.9 Discharge to Assess pathway 1 has been piloted at PCH on 4 wards from Monday 2nd July, with the intention to apply a Plan, Do, Study, Act (PDSA) approach to enable rapid deployment across NWAFT and also apply the learning from this approach to CUH.



3.10 A recovery plan is in place and consists of all sites maintaining the rigour of holding daily DTOC meetings in the morning to ensure that every patient in this category has a daily MDT review with agreed discharge pathway management that all parties are aligned with. This process either ensures patients move along their discharge pathway, or are validated from the list.

To prevent those that are validated from the list potentially being put to one side, these patients are then captured in the weekly long-stay patient meetings that are held to ensure that all patients both on and off the DTOC list have a meaningful multidisciplinary team (MDT) review with agreed discharge pathways agreed by all parties.

3.11 Programme governance has been established with agreed Terms of Reference for the Programme Delivery Group who's role is primarily:-

'To ensure that all elements of the Cambridgeshire and Peterborough Discharge Pathways are functional and resilient in times of high demand/pressure, and deliver high quality, timely and safe services to all our patients/service users through an Integrated Discharge Team approach'

The full Terms of Reference and Programme Governance structure are attached for information **(Appendix 2)**.

These were reviewed and amended by the CEO DTOC Group, which meets monthly, prior to the first Programme Delivery Group which meets bi-weekly with cross organisational membership at both strategic executive level and also from operational delivery perspective to ensure traction, timely progress and to enable decisions taken to be mobilised into actions taken at pace to make a difference The Programme also reports monthly via a standing item on the agenda for both A & E Delivery Boards at CUH and NWAFT.

3.12 A programme risk register has been initiated and is reviewed at every Programme Delivery Group meeting to ensure this remains fit for purpose and that all risks and mitigating actions provide assurance that everything is being done that can be done to ensure the patients have the best and most clinically appropriate experience possible along their respective discharge pathways. The strategic risks are taken to the CEO DTOC group for review and attention. This is attached for information **(Appendix 3)**.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 The Discharge Transformation programme will achieve the optimum performance for our delayed transfer of care patients and is relevant to priorities (2, 3, 4, 5,6) of the Health and Wellbeing Strategy:

- Priority1: Ensure a positive start to life for children, young people and their families.
- Priority 2: Support older people to be independent, safe and well.
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices.
- Priority 4: Create a safe environment and help to build strong communities, wellbeing and mental health.

- Priority 5: Create a sustainable environment in which communities can flourish.
- Priority 6: Work together effectively.

Source Documents	**Location**
Delayed Transfer of Care Programme Delivery Group Terms of Reference Programme plan Highlight reports by Site Lead – CUH; HH; PCH Risk register Comms and engagement plan Performance monitoring	These documents are held by the Programme Director, Leads and with the PMO Lead who holds the pen on all of these documents except the highlight reports which are produced by each of the relevant site leads due to the site specificity required