Delayed Transfer of Care Plan Gateshead

1. Introduction

Over the next five years, the Urgent and Emergency Care system needs to make changes so that it becomes more efficient and reduces the number of people who are admitted to hospital when they could be better cared for at home.

In order to do this, Newcastle Gateshead Clinical Commissioning Group and all of its key stakeholders believe that it is essential that we transform the whole urgent and emergency care pathway, from end to end. This system-wide approach is the only way to create a sustainable solution and ensure that future generations can have peace of mind that when the unexpected happens, services in Newcastle and Gateshead are able to provide a rapid, high quality and responsive service. However, this transformation must also take place in the face of one of the most challenging financial and organisational environments the health and social care setting has ever experienced

Newcastle Gateshead Clinical Commissioning Group has worked closely with a range of stakeholders, including the public and patients, to assist and influence the design of local urgent and emergency care services to build on what currently works well and identify areas for improvement. This has enabled a shared vision to be developed which is aligned to National and Local strategies as well as NHS England's Urgent and Emergency Care Review recommendations:

Right Care, Right, Time, Right Place – a modern sustainable 24 hour, 7 days a week urgent and emergency care pathway designed to meet the needs of the people of Newcastle and Gateshead'

In order to successfully achieve our Vision and improve the care provided to Newcastle and Gateshead patients, three principles have been identified for service development and transformation, each with a number of key priorities:

1. Intervention before Admission;
2. Supported discharge;
3. Integrated, Primary, Community and Voluntary Provision.

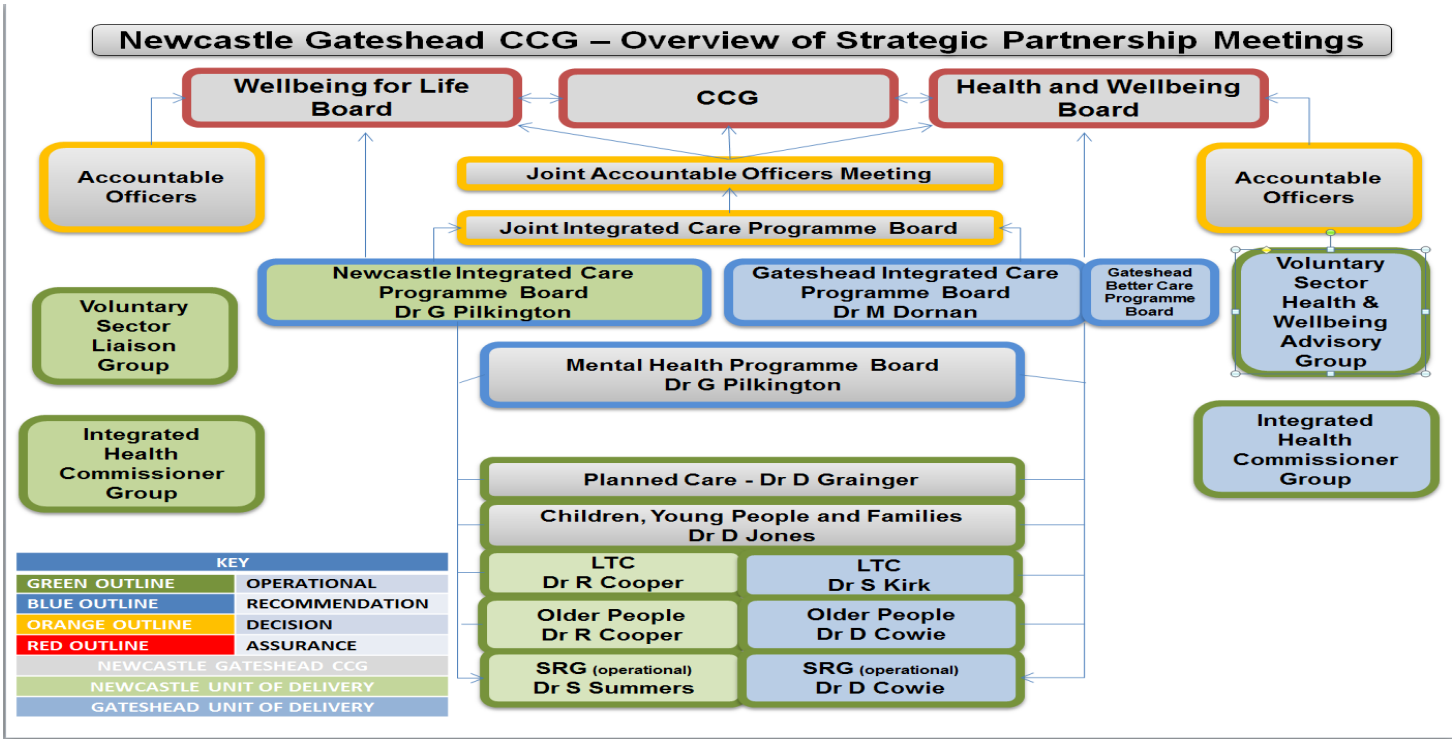
This plan has been developed to support the implementation of one of the three principles - Supported Discharge – to promote rapid and supported discharge from hospital to the most appropriate place for recovery in a planned manner rather than an extended length of stay in an acute hospital bed.

Specifically this plan will ensure a reduction in Delayed Transfers of Care and ensure that within the footprint of the Newcastle Gateshead Clinical Commissioning Group, high quality responsive care and support is given to people who have been in hospital and need support for their transfer of care when they are ready for safe discharge. It has been developed by key partners of the Newcastle and Gateshead System Resilience Groups to assist local key stakeholders to deliver the identified targets and trajectories for reducing Delayed Transfers of Care.

2. Governance

Progress in implementing this plan and achieving the specified target will be reported to the Newcastle and Gateshead System Resilience Group and Integrated Health and Care Programme Boards.

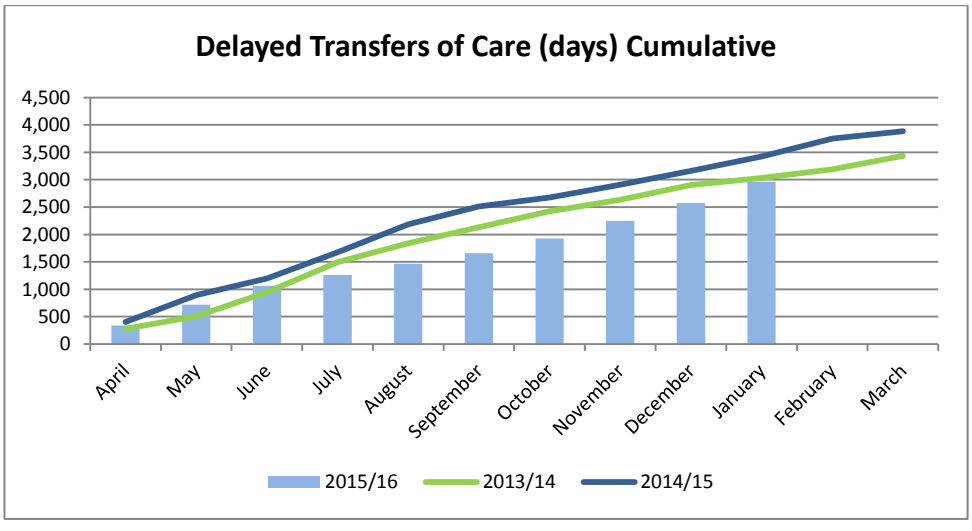
The diagram below represents the current governance arrangements to support robust accountability of the Better Care Fund work programme (and DTOC plan):

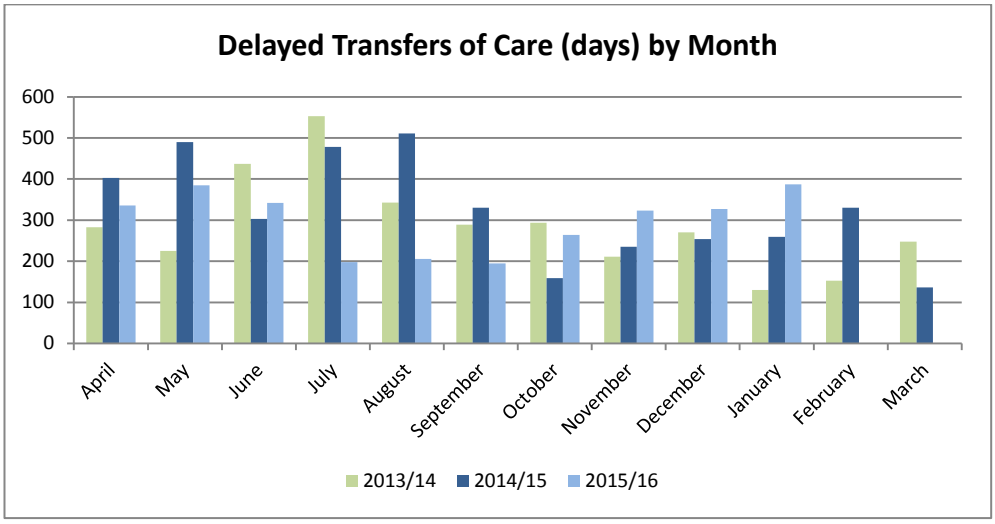


3. Situational Analysis

Gateshead

Current performance, trends, and causes of delays





A comparison of delayed days in Gateshead over 2015/16 Jan year to date shows a reduction in the number of delayed days in 2013/14 and 2014/15 by 13.4% overall (NHS and social care attributed). 2014/15 had seen an increase of 13.2% over the 2013/14 level, and 2015/16 has seen a recovery to the 2013/14 level.

2015/16 performance against trajectory for Q3 to date is currently 10.1% below trajectory. However January alone saw a total of 387 delays against a Q4 trajectory of 475, making achievement of the full year trajectory appear a challenge. There has been an upward trend in delayed days since October 2015.

Overall, Gateshead has seen a reduction in days delayed attributed to social care 2015/16 Jan YTD compared to the same period in 2014/15 (461). The net number of delays attributed to the NHS has remained unchanged. The most significant reduction in social care delayed days has been attributed to patients awaiting nursing home placement (287).

There is an overall net increase in the number of NHS attributed delayed days at Gateshead Health. The major contributing factor for these delayed days is for patients awaiting further non-acute NHS care, including intermediate care, rehab etc. There was a decrease in the number of days lost for Gateshead patients in NUTH for NHS attributed delays (158). There has been an increase in the number of days delayed for Durham patients attending Gateshead Health of 103 days, 62 attributed to the NHS and 41 to social care.

Trajectory Rationale

The rate of delayed transfers as a % of occupied bed days at GH is routinely below the 2.5% nationally recommended limit. Projected outturn for Gateshead 2015/16 is 3% above the 2015/16 plan. Therefore 2016/17 proposed plan is to achieve the 2015/16 trajectory. **This would equate to a 2.9% reduction in 2016/17 over the 2015/16 projected outturn.**

4. Current Schemes + Local Measures

The following table highlights Newcastle and Gateshead Better Care current schemes and aligned local measures

Gateshead Better Care	Local measures
Single Point of Access	Number of GP referrals to the Single Point of Access (Increase)
Alignment of District Nursing	Percentage of housebound patients with a care plan (increase)
Establish an elderly care 'coordinator role' and alignment of hospital based frailty team with community nursing teams	Proportion of A&E attendances amongst over 75s resulting in admission (decrease)
Establish a dementia pathway across Gateshead	Number of referrals to the challenging behaviour team (increase)
Expansion of Ambulatory Care Pathways	Number of referrals to the RICC team (increase)
Establish a 24/7, seamless palliative care service	Proportion of patients on receiving palliative care with a preferred place of death recorded in primary care (increase)
Establish an Urgent Domiciliary Care Service	Proportion of referrals received from the Single Point of Access
Alignment of Discharge Support Teams and Coordination Officers	Proportion of emergency admissions amongst over 75s leading to discharge within 72 hours (increase)
Expansion of Intermediate Care Services – increase 'step up' intermediate care beds, introduce 'roving GP' to aid decision making and mental health support	Proportion of all referrals which are step up
Expansion of the Gateshead Care Home Initiative	Emergency admission rate for care home residents with a care plan (decrease)
Enhance a Seamless Falls Service	Admission rate for fractured neck of femur amongst those aged 65+ (rate per 100,000)

5. Alignment to CCG Operational Plan 2016/17

Clearly our DTOC plan is embedded within the CCG operational plan and support the 9 National Must Dos, especially around achievement of access targets for A&E. Below shows a summary of 'specific interventions' that will help achieve A&E targets and indirectly help with 'hospital flow' and discharges

Gateshead
➢ The Trust held a 2 day multi-disciplinary accelerated discharge event in early January with the following key areas for development identified (*and developed into their **MADE** plan which is incorporated within our local plan [to date]):* ➢ Surge/ Escalation Planning must cover all parts of the hospital ➢ Patient flows 7 days a week / manage demand throughout the course of the day ➢ 'Discharge to Assess' model being implemented. ➢ Senior review of the care plan and its delivery, for every patient, in every bed, seven days a week. ➢ Specific cohorts of patients must be assertively managed e.g. frail, older people ➢ Specific communication message to use services wisely and promote use of primary care ➢ Funded CHC co-ordinator to manage patient pathway for those seeking long term placements ➢ Improved GP access through the Prime Ministers Challenge Fund is being delivered in and out of hours ➢ Increased capacity is available to enable patients to access a GP - whilst the Emergency Care Centre and Blaydon WiC have a GP working as part of the team 8am - 10 pm. ➢ A Minor Ailment Scheme has been commissioned with Pharmacies to enable rapid access and support. ➢ The team working in the ECC is undertaking rapid assessment and treat (RAT) streaming to enable patients to be seen appropriately (includes extra nurses funded through SRG monies) ➢ Reduction of inappropriate admissions – the trust is developing a range of approaches • appointment of a physio and OT in A&E (in post), • Additional social work and frailty nurse capacity • new "interface geriatrician" at the front door with rapid access to elderly care advice when the interface geriatrician is not present

6. Alignment to ‘best practice’ (8 High Impact Interventions *plus*)

We have triangulated work in both acute providers (e.g. Gateshead MADE action plan and Newcastle ‘Perfect Week’) to develop our plan based on best practice and the 8 high-level Impact Interventions (see attached plan for Gatesehad). This will be taken forward through the System Resilience Group and oversight will be provided through the BCF Programme Board and Integrated Care Programme Board as required.

7. Engagement

Engagement with providers on DTOC issues and the DTOC plan going forward will be through the System Resilience Group.