## Delayed Transfer of Care (DToC)

### Summary points

The arrival of Covid-19 in March 2020 changed the way people were effectively processed out of hospital and the existing model was halted, with immediate effect. The Department of Health & Social Care were quick to introduce the Hospital Discharge to assess operating model.

This meant that all recording under the pre-March 2020 model stopped and the new Pathway recording model was introduced. The concept being; Following an hospital admission and appropriate medical care, the ongoing priority is ensuring that everyone receives the right care, in the right place, at the right time, and the prevention of infection in care homes (and elsewhere). In doing so the wellbeing of residents and their relationships with friends and family is considered and supported.

### New reporting method:

This new model has 4 x pathways, each with varying degrees of support from the NHS, local authority and various partner organisations. The discharge to assess model pathways are:

- Pathway 0 - 50% of people – simple discharge, no formal input from health or social care needed once home.
- Pathway 1 - 45% of people – support to recover at home; able to return home with support from health and/or social care.
- Pathway 2 - 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
- Pathway 3 - 1% of people – require ongoing 24-hour nursing care, often in a bedded setting. Long-term care is likely to be required for these individuals.

The rationale is that patients will still receive high quality care from acute and community hospitals but will not be able to stay in a bed as soon as this is no longer necessary. For 95% of patients leaving hospital this will mean that (where it is needed), the assessment and organising of ongoing care will take place when they are in their own home. This includes the discharge of people who are infectious with COVID-19

### Actions taken locally:

It is considered bad practice for a patient to be delayed in hospital awaiting a long term care act assessment and that this assessment should now take place in a community setting, after a period of intermediate care, ideally back in their own home or alternatively in a step down bed. Therefore, following the announcement that the NHSE guidance disbanded the DTOC coding and recording infrastructure, there was a rapid change to the systems & practices and were updated appropriately:

- There are no longer social work hospital teams based at the BRI or Southmead. Instead they have moved out into a multiagency (with Sirona Bristol's local community health provider) and support the Community Integrated Care Bureau (CICB) which reviews all the

Single referral Forms (SRFs) that come in from the hospital and decides the best step down pathway for that patient
- All supported discharges now receive a period of intermediate care either in a community bed or in their own home. This is now a full 'Discharge to Assess' model for hospital discharge
- As a result, DTOC waiting for a social work assessment in hospital do not exist anymore – at peak these DTOCs were at over 1,000 days per month. Had such delays still existed during COVID the hospitals would have not been able to cope
- An access and Flow dashboard has been created to allow a strategic overview and to give managers the opportunity to respond strategically to demand.

**Impact:**

Whilst there is presently no National Data or Equalities data available, weekly benchmark comparisons are undertaken and included alongside the Access & Flow dashboard, to give context across the three local authorities within the region.

Investment in intermediate care pathways has increased allowing for over 100 supported discharges every week out of hospital on to our step-down pathways. This is all in line with NHSE guidance COVID-19: Hospital discharge service requirements (publishing.service.gov.uk)

**Further data / links / consultations:**

- Bristol City Council: Help after leaving hospital - bristol.gov.uk

**Date updated:** March 2021