| | |
|---|---|
| **Reporting to:** | **Trust Board, Thursday 28th January 2016** |
| **Title** | Medically Fit For Discharge Update |
| **Sponsoring Director** | Debbie Kadum, Chief Operating Officer |
| **Author(s)** | Debbie Kadum, Chief Operating Officer |
| **Previously considered by** | Hospital Executive Committee |
| **Executive Summary** | This short paper provides an update on the latest position with regards to reducing the number of patients medically fit for discharge, and delayed transfers of care. |
| **Strategic Priorities**<br>1. Quality and Safety<br><br><br><br><br><br><br>2. People | ☒ Reduce harm, deliver best clinical outcomes and improve patient experience.<br>☒ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards<br>☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme<br>☐ To undertake a review of all current services at specialty level to inform future service and business decisions<br>☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme<br>☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work |
| 3. Innovation<br><br>4 Community and Partnership<br><br><br>5 Financial Strength: Sustainable Future | ☒ Support service transformation and increased productivity through technology and continuous improvement strategies<br>☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population<br>☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies<br>☐ Develop a transition plan that ensures financial sustainability and addresses liquidity issues pending the outcome of the Future Fit Programme |
| **Board Assurance Framework (BAF) Risks** | ☒ If we do not deliver **safe care** then patients may suffer avoidable harm and poor clinical outcomes and experience<br>☒ If the local health and social care economy does not reduce the **Fit To Transfer** (FTT) waiting list from its current unacceptable levels then patients may suffer serious harm<br>☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff<br>☒ If we do not achieve safe and efficient **patient flow** and improve our processes and capacity and demand planning then we will fail the national quality and performance standards<br>☐ If we do not get good levels of **staff engagement** to get a culture of continuous improvement then staff morale and patient outcomes may not improve<br>☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients<br>☐ If we are unable to resolve our structural inbalance in the Trust's **Income & Expenditure** position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment |

| | |
|---|---|
| **Care Quality Commission (CQC) Domains** | ☒ Safe<br>☒ Effective<br>☒ Caring<br>☒ Responsive<br>☒ Well led |
| ☒ **Receive** ☐ **Review**<br>☒ **Note** ☐ **Approve** | **Recommendation**<br>The Trust Board is asked to RECEIVE and NOTE the update on Medically For For Discharge and the work underway to recover and improve patient flow and performance in this area. |

**Paper 5**

# MEDICALLY FIT FOR DISCHARGE UPDATE

## January 2016

### 1 BACKGROUND

Contained within the monthly Integrated Performance Report (IPR) is a standing item on the number of patients who are medically fit for discharge.

The Board will be aware that the local health and social care economy has for over 18 months now, agreed, that the number of patients fit to leave SaTH, and the bed days lost as a result of this not happening, is too high.

These numbers include patients who are formally agreed delayed transfers of care (DTOC's).

At the end of December 2015 the lost bed days as a comparison to the previous year had risen to 18,400 lost bed days against 14,200, an increase of over 29%.

An internal report into this by the Trust's auditors was received by the Audit Committee in December 2015 (the Trust received moderate assurance). The scope of this work was to evaluate the processes in place for the identification of patients who are delayed in their transfer of care and the strategies for managing key risks which affect the achievement of discharge management objectives. The audit report can be found in the Board Information Pack.

As described previously the patients are coded into reason why they are delayed, as we have an integrated care services (ICS) and equivalent service within T&W CCG, this is a joint health and local authority delivered service; majority of delays will fall under a health remit.

> *"A patient that is medically fit for discharge is where a clinical decision has been made that the patient is ready to transfer. This is from a medical perspective only (usually the consultant or team that the patient is under). The patient therefore has not had a MDT decision at this point, and the patient may require further therapy or social care input prior to an MDT agreement and therefore not a reportable Delayed Transfer of Care delay (DToC)".*

### 2 CURRENT POSITION

2.1 The audit report action plan is being progressed internally. A progress report against the action plan will be reviewed at the next Audit Committee taking place on 4th February 2016.

2.2 A review by the Emergency Care Improvement Programme (ECIP) undertaken in November 2015 has identified discharge and interface as a priority for the health and social care system to focus on.

The LHE will receive expert support from the ECIP team in progressing this workstream with the expected outcome of reducing the number of patients who are medically fit for discharge and to meet the national stretch target of no more than 2.5% of patients being classified as delayed transfers of care. There are actions specific to SaTH within the recommendations given.

*NB*. The ECIP report is included in the Board Information Pack. The section on interface and discharge planning is at section 6, pages 10 to 13.

2.3 Since the last report to Board there has been a noticeable change in the level of support we are receiving from our partners. This has resulted in:

2.3.1 The discharge hub meetings now attended by a Commissioner representative alongside the local authority and Shropshire Community Trust, whose role is to support the removal of any barriers to the discharge of a patient with complex needs;

2.3.2 A review is held of why a complex discharge failed to happen on the estimated date of discharge in order to learn lessons and put mitigating actions in place;

2.3.3 The significant delays experienced in accessing packages of care across the county have been addressed with these numbers reducing since January. The local authorities expect to have sufficient numbers of domiciliary care hours in place from 18th January 2016 to meet current demand;

2.3.4 Should there be insufficient hours of domiciliary care available to meet demand then the council has agreed that a bed in an appropriate alternative care setting can be agreed. This agreement is in place until 31st January 2016;

2.3.5 Commissioners and providers are working more collaboratively along the complex discharge pathway.

## 3 IMPACT

The medically fit for discharge list continued to show an increase in the number of lost bed days, with a drop off at the end of December (predicted). This drop off is in line with previous years as pre-Christmas improvement in complex discharge numbers.

The following table highlights the numbers of patients and bed days lost.

| Discharge Month | No. Patients | Lost Bed days | Average Days on List | Average Patients per week |
|---|---|---|---|---|
| Jan-15 | 464 | 1922 | 4 | 116 |
| Feb-15 | 421 | 1882 | 4 | 105 |
| Mar-15 | 422 | 2068 | 5 | 106 |
| Apr-15 | 408 | 2009 | 5 | 102 |
| May-15 | 362 | 1793 | 5 | 91 |
| Jun-15 | 411 | 2020 | 5 | 103 |
| Jul-15 | 384 | 1974 | 5 | 96 |
| Aug-15 | 348 | 1744 | 5 | 87 |
| Sep-15 | 360 | 1782 | 5 | 90 |
| Oct-15 | 380 | 1857 | 5 | 95 |
| Nov-15 | 379 | 2349 | 6 | 95 |
| Dec-15 | 428 | 2662 | 6 | 107 |
| **Total** | **4767** | **24062** | **5** | **99** |

The main reasons for discharge delays remain:

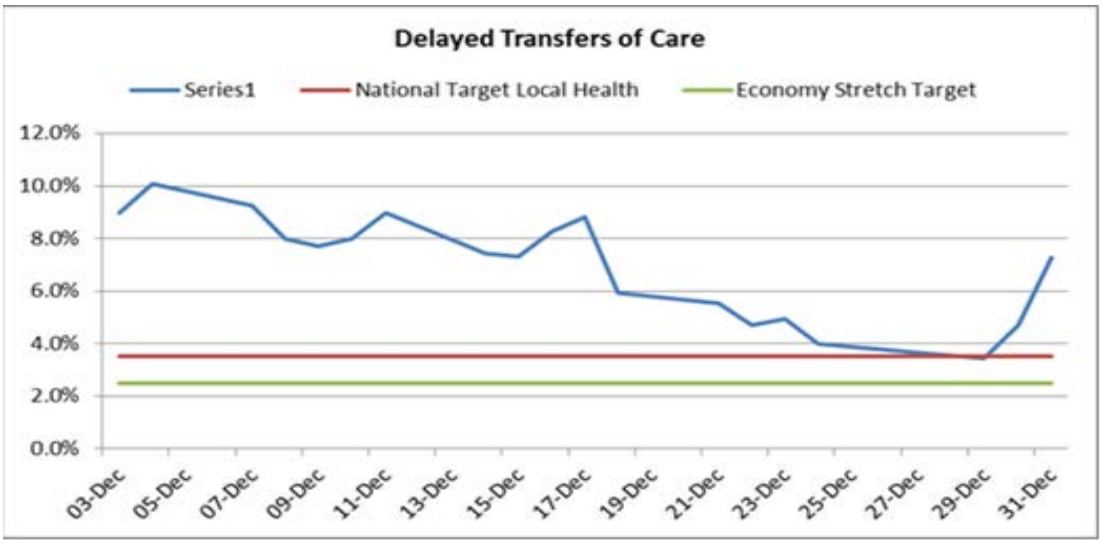
a) Domiciliary care provision;
b) Nursing/residential home placements;
c) Further non-acute care including rehabilitation.

As domiciliary care provision continued to be a problem at the end of December the Shropshire local authority and Shropshire CCG agreed to spot purchase beds for patients delayed and increase their efforts to increase the number of domiciliary care hours available.

Delayed Transfers of Care (DToC) are delayed discharges which are externally Sitrep reportable to bodies including the TDA and Monitor. These are agreed each day by a multi-disciplinary team including acute, community and local authority colleagues. The official definition of a delayed transfer of care is:

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

Delayed Transfers of Care are above the national stretch target of 2.5%. The following graph highlights improvement up until the 29th December. Following the post-Christmas and New Year period the numbers are again falling. January's position is not yet available but indicative figures are around 5.5%.




A summary of the reasons for DToC's is shown below

| | | RSH | | | | | | PRH | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Health | | Social | | Joint | | Health | | Social | | Joint | |
| Month | Reasons for delay - awaiting: | Delays | Lost Beddays | Delays | Lost Beddays | Delays | Lost Beddays | Delays | Lost Beddays | Delays | Lost Beddays | Delays | Lost Beddays |
| December 2015 | A) Completion of assessment | 42 | 63 | 21 | 44 | 0 | 0 | 103 | 160 | 5 | 7 | 3 | 5 |
| | B) Public Funding | 1 | 1 | 2 | 3 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 |
| | C) Further non acute NHS care (including intermediate care, rehabilitation etc) | 188 | 800 | 0 | 0 | 0 | 0 | 81 | 193 | 0 | 0 | 0 | 0 |
| | D i) Residential Care Home Placement | 10 | 32 | 16 | 207 | 0 | 0 | 2 | 3 | 0 | 0 | 14 | 28 |
| | D ii) Nursing Care Home Placement | 44 | 195 | 54 | 379 | 3 | 8 | 16 | 67 | 30 | 113 | 89 | 345 |
| | E) Care package in own home | 20 | 58 | 36 | 239 | 152 | 997 | 13 | 27 | 10 | 14 | 36 | 430 |
| | F) Community Equipment/adaptions | 49 | 123 | 0 | 0 | 0 | 0 | 21 | 30 | 0 | 0 | 0 | 0 |
| | G) Patient or family choice | 10 | 26 | 0 | 0 | 7 | 44 | 29 | 148 | 0 | 0 | 0 | 0 |
| | H) Disputes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | I) Housing - patients not covered by NHS and Community Care Act | 3 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 15 | 0 | 0 |
| December 2015 Total | | 367 | 1,312 | 129 | 872 | 162 | 1,049 | 265 | 628 | 49 | 151 | 142 | 808 |

## 4 NEXT STEPS

- The work to ensure that capacity to meet complex discharge demand is ongoing and will be further enhanced through the Interface and Discharge Planning workstream supported by the ECIP team.
- SaTH has shared with its partners the capacity required to clear to backlog of patients on the medically fit for discharge list. The Chief Operating Officers across the local health and social care system are meeting to agree a plan to deliver this.

## 5 ACTION REQUIRED

- The Trust Board is requested to **RECEIVE** and **NOTE** the progress being made in reducing the number of bed days lost due to medically fit for discharge and delayed transfers of care within the acute hospital.

*Debbie Kadum*
*Chief Operating Officer*
*January 2016*