Reporting to:	**Trust Board, Thursday 28th January 2016**
Title	Winter Plan Update
Sponsoring Director	Debbie Kadum, Chief Operating Officer
Author(s)	Debbie Kadum, Chief Operating Officer
Previously considered by	Hospital Executive Committee
Executive Summary	An initial analysis of the Christmas and New Year period has been undertaken in a year on year comparison to this period 2014/15. It shows in broad terms that the Trust performance better over this period this year.
Strategic Priorities 1. Quality and Safety 2. People	☒ Reduce harm, deliver best clinical outcomes and improve patient experience. ☒ Address the existing capacity shortfall and process issues to consistently deliver national healthcare standards ☐ Develop a clinical strategy that ensures the safety and short term sustainability of our clinical services pending the outcome of the Future Fit Programme ☐ To undertake a review of all current services at specialty level to inform future service and business decisions ☐ Develop a sustainable long term clinical services strategy for the Trust to deliver our vision of future healthcare services through our Future Fit Programme ☐ Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work
3. Innovation 4 Community and Partnership 5 Financial Strength: Sustainable Future	☐ Support service transformation and increased productivity through technology and continuous improvement strategies ☐ Develop the principle of 'agency' in our community to support a prevention agenda and improve the health and well-being of the population ☐ Embed a customer focussed approach and improve relationships through our stakeholder engagement strategies ☐ 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 ☐ 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 ☐ Risk to **sustainability** of clinical services due to potential shortages of key clinical staff ☒ 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 ☐ 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 ☐ If we do not have a clear **clinical service vision** then we may not deliver the best services to patients ☐ 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 ☒ Effective ☒ Caring ☒ Responsive ☒ Well led
☒ **Receive** ☐ **Review** ☒ **Note** ☐ **Approve**	**Recommendation** The Trust Board is asked to RECEIVE and NOTE the findings of the analysis of the Christmas and New Year period 2015/16.

Paper 4

WINTER PLAN UPDATE

January 2016

1 BACKGROUND

The Trust implemented its internal Winter Plan in full at the end of November 2015. The highest impact change was the redesignation of 44 surgical beds to medical beds across both sites (16 on RSH and 28 on PRH) with elective orthopaedic work running through a mobile day surgery unit at PRH.
The plan runs until mid-March and is currently on plan to remain within the allocation of £1M which has been internally generated.

2 IS THE PLAN WORKING?

The plan runs until mid-March so it is too early to assess the full impact of the plan at this stage. However, a direct comparison of the 2 week Christmas and New Year period 2015/16 to 2014/15 has been undertaken and shows that the Trust has performed better. This is in the context of the lost bed days to medically fit for discharge patients being at their highest for 2 years during December 2015 in the lead up to the Christmas period.

In summary the analysis has shown:

1) Overall A&E attendances remained broadly the same;
2) Breaches at RSH decreased by 17.7% against a rise in attendances of 6%;
3) The number of patients aged over 75 years attending ED is the same however the number of those admitted from A&E has risen by 5%;
4) There has been a 20% increase in the number of zero length of stay (LOS) admissions compared to the same period last year, which is reflective of the plan to increase these by enhancing the ambulatory care model on both sites. This supports a reduction in length of stay;
5) There has been a 15.9% decrease in the number of deaths when comparing to the same period of time last year. However, whilst it is difficult to attribute cause and effect, the absolute number is less;
6) In the first week of January 2016, despite extreme pressure (level 4) only 13 patients had their elective procedure cancelled in comparison to 31 the previous year;
7) De-escalation from level 4 on 4th January 2016 to level 2 on 7th January 2016 is a key success factor. Last year the Trust was on level 3 consistently through until April.
8) Whilst de-escalation occurred more quickly the Trust implemented the Hospital Full Protocol on 4 consecutive days from 3rd to 7th January 2016;
9) NHS England and the TDA jointly challenged Trust's to have 20% of their beds empty on Christmas Eve. This required all partners to work together to achieve this. The target for SaTH was 130 beds and we achieved 117. No doubt having bed capacity going into two consecutive long weekends helped;
10) Staff reporting that pressures felt less.

4 SUMMARY AND NEXT STEPS

The table below shows that despite an increase in attendances and emergency admissions, performance in the first 3 weeks of 2016 was 2.22% better than the same period last year. This high level initial analysis does not take into account other measures which would be monitored but this will be included in the full formal review of the Winter Plan at the end of March 2016.

ED PERFORMANCE		
Week Ending	**Week Comparison**	**Quarter 4 Comparison**
3/1/16	+6.02%	+6.02%
10/1/16	-4.61%	0.88%
17/1/16	+5.54%	+2.22%

ED ATTENDANCES				
Week Ending	**Increase in Attendances (Week)**		**Increase in Attendances (Q4)**	
3/1/16	+6.16%	+153 patients	+6.16%	+153 patients
10/1/16	+4.65%	+104 patients	+5.45%	+257 patients
17/1/16	+4.75%	+102 patients	+5.23%	+359 patients

EMERGENCY ADMISSIONS				
Week Ending	**Increase in Admissions (Week)**		**Increase in Admissions (Q4)**	
3/1/16	-.50%	-5 patients	-0.50%	-5 patients
10/1/16	+8.52%	+78 patients	+3.82%	+73 patients
17/1/16	+9.62%	+84 patients	+5.64%	+157 patients

Escalation levels were lower this Christmas and New Year period in comparison to last year, and 4 hour performance significantly better at RSH against an increase in attendances.

It is difficult to say for certain how much of this can be attributed to the Trust's Winter Plan or in the partnership working which delivered 113 empty beds on Christmas Eve.
A LHE review of the winter so far is being undertaken by the Chief Operating Officers on 27th January 2016 and will directly inform the development of the Easter Plan for the end of March.

5 ACTION REQUIRED

1) Bring back a full review of the Winter Plan to March Trust Board – COO
2) The Trust Board is requested to NOTE the findings of the analysis of the Christmas period.

Debbie Kadum
Chief Operating Officer
January 2016

Deloitte.

Shrewsbury and Telford Hospital NHS Trust

Internal Audit Report: Delayed Transfers of Care (DTOC)

IA15/16PR01

27 November 2015

The Shrewsbury and Telford Hospital NHS Trust

Paper 8

Contents

Distribution List

For Action
Debbie Kadum – Chief Operating Officer
Ian Donnelly – Assistant Chief Operating Officer
Capacity team

For Information
Audit Committee

Auditors
Gus Miah - Head of Internal Audit
Emma Foreman - Senior Manager
Jessica Seymour - Manager

Report Summary	
Area Significance	High
Assurance level	Moderate

Recommendations Raised	
High	2
Medium	6
Low	2

Date of fieldwork: August 2015
Date of draft report: September 2015
Date of final report: November 2015

1. Executive Summary

Background

This audit forms part of the 2015/16 Internal Audit Plan as requested and agreed with the Audit Committee in April 2015, and is supplementary to the discharge management audit IA13/14PR03.

The key principles for an effective discharge and transfer of care system are that:

- these are facilitated by a whole system approach;
- the engagement and active participation of individuals and their carers as equal partners is central to the delivery of care and in planning of a successful discharge;
- discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across primary, hospital and social care services;
- staff operate within a framework of integrated multi-disciplinary and multi-agency team working, to manage all aspects of the discharge process; and
- transitional and intermediate care services are utilised so that existing acute hospital capacity is used appropriately, and individuals achieve their optimal outcome.

The majority of discharges from hospital can be managed effectively, however, a small number of complex patients, if delayed, can have a disproportionately high impact on bed occupancy. Identifying complexities early in the patient journey ensures that complications can be foreseen and overcome.

The majority of the delays that occur are multifactorial, but many relate to communication and co-ordination between acute, community and social care, while others are concerned with internal hospital systems.

For patients in need of social care, the inappropriate placement in an acute hospital when they are medically fit and safe for discharge can have far-reaching risks. Patients risk complications, the loss of confidence and independence; families' and carers' lives can be disrupted; staffing pressures are impacted upon; and the hospital is less able to accommodate patients requiring admission for urgent treatment or elective procedures effectively. The Trust has, on a continuing basis, a number of patients who are reported to be delayed in their transfer of care (DTOC) and this has presented performance, financial and also quality concerns.

Summary of recommendations raised

	Strategic	Financial	Operational
High priority	-	-	2
Medium priority	-	-	6
Low priority	-	-	2

Audit objectives

The review aimed to identify the effectiveness of the Trust's internal approaches to ensuring that delayed transfers of care are minimised and prevented. It will also identify areas where there are common challenges to the effective transfer of care for those deemed 'fit to transfer' or those that result in an adverse patient and carer experience.

Overall Rating	Moderate	
The level of non-compliance puts some system objectives at risk. There is a basically sound system of internal control for other system objectives.		

1. Executive Summary

Key Findings and Recommendations

The Trust has, since our 2013/14 Discharge Management report, maintained its focus on discharge arrangements, and a number of our previous recommendations have been progressed including an update of the Discharge Policy and the more systematic issue of patient information regarding discharge.

In regard to the identification, escalation and management of patients who are delayed in their transfer of care there are some areas of good practice, particularly in regard to Board Rounds and in the actions of the Discharge Hub; however, there are also some areas for improvement in the operation of this process. Based on our interviews, sample testing and desktop review of reports and policies, we have identified two high and seven medium priority recommendations.

The **high priority recommendations** have been identified in relation to:

- the fit to transfer (F2T) worklist currently gives a distorted picture of the numbers and status of patients who are medically fit for discharge. Improvements to Board level reporting would improve understanding of internal and external delays, and causal factors so that action can be taken to resolve emerging or longer term trends (Recommendation 4); and
- A lack of alignment between the date that patients are reported as Medically Fit for Discharge on Patient Safety at a Glance (PSAG) boards and the date recorded within the medical notes (Recommendation 6).

The **medium priority recommendations** refer to the following areas which were identified:

- Continuous discharge planning for frail patients with a long term instability of condition (Recommendation 1);
- Delays in assessments, either because referrals have not yet been made or because all relevant staff were not sufficiently aware of the discharge plans (Recommendation 2);
- Variations in the understanding of definitions and recording of patients who are medically fit or fit to transfer (Recommendation 5);
- A lack of communication to ward staff on the reportable status of delays (Recommendation 7);
- Significant variations in documented discharge communications meaning that all relevant staff are not always sufficiently aware of discharge or transfer plans (Recommendation 8); and
- Occasions when patients are waiting therapy assessments with delays due to a lack of physical resource. Standards have been set but compliance with these is not always possible. Board or Committee level oversight of these gaps is not apparent (Recommendation 9).

We have also made **three low priority recommendations** which are linked to;

- embedding compliance with the Discharge Policy (Recommendation 3);
- Medical responsibilities should be documented in the discharge policy. (Recommendation 10)

1. Executive Summary

The scope of 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. This included a review of:

	Audit Scope
1	10 in-patient episodes to understand where the patient has been deemed fit to transfer, and the points at which avoidable delays occurred.
2	Standard Operating Procedures for the identification of delayed transfers of care.
3	How patients on the Fit to Transfer list are escalated internally and externally, and if in line with hospital policy.
4	The involvement of the ward co-ordinators and members of the MDT in the delayed transfer of care decision.
5	The process for recording the date and time of the delay, and how “fit to transfer” is communicated to the MDT and documented in the medical and nursing notes.
6	The processes by which patients and their carers / relatives are informed about the “fit for transfer” decision and whether they are provided with Trust information about their discharge pathway.
7	The communication and escalation processes between the clinical teams, social services and the MDT for patients who are entered onto the Fit to Transfer list.
8	The extent to which patients on the Fit to Transfer list are discussed at relevant meetings and the decisions made regarding the arrangements for discharge.

1. Executive Summary

Audit Approach

The following procedures were adopted to enable us to evaluate potential risks and gaps in control and thus enable us to recommend improvements:

- Discussions with key members of staff in order to ascertain the efficacy of systems in operation:
  - Debbie Kadum - Chief Operating Officer
  - Ian Donnelly - Assistant Chief Operating Officer . Unscheduled Care
  - Andy Aldridge - Head of Capacity (Princess Royal Hospital)
  - Grainne Buggy - Head of Capacity (Royal Shrewsbury Hospital)
  - Rachel Roebuck - Head of Capacity (Royal Shrewsbury Hospital)
  - Amanda Walshaw - Head of Occupational Therapy
  - Jill Dale - Head of Physiotherapy
  - Louise Gill - Head of Nursing
  - Mark Cheetham - Care Group Medical Director
  - Kerrie Allward - Shropshire Social Work
  - Rachael Brown - Appropriate representative from Shropshire Community Trust
  - Gemma McIver - Shropshire CCG
  - Diane Beasley - Telford And Wrekin CCG
  - Matrons, Ward Managers and members of the Discharge Liaison Team
- Evaluation of the current systems of internal control through case study and other non-statistical sample testing of 10 in-patients who are (or have been) on the “fit to transfer” list but whose discharge was subsequently delayed. This included:
  - site visits to review the sample of patients (Scheduled and Unscheduled Care);
  - sample testing to assess whether the actual delays recorded are in line with that recorded on the “fit to transfer” list. Discrepancies were investigated;
  - observation of the discharge management processes in operation, and assessment of whether the delay was caused by internal or external factors and whether there were any points along the pathway that could have been managed differently in order to have effected a more timely discharge / transfer from hospital.
  - identification of control weaknesses and potential process improvement opportunities;
  - discussions of our findings with management and further development of our recommendations; and
  - preparation and agreement of a draft report with the process owner.

Restriction of use and limitations

We wish to draw to your attention that this report may only be used in accordance with our contract and may not be made available to third parties, except as may be required by law.

Management should be aware that our internal audit work was performed according to Public Sector Internal Audit Standards (PSIAS) which are different from internal audits performed in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. Similarly, the assurance classifications provided in our internal audit report are not comparable with the International Standard on Assurance Engagements (ISAE 3000) issued by the International Audit and Assurance Standards Board.

Our internal audit testing was performed on a sample basis and focused on the key controls mitigating risks. Internal audit testing was performed on a sample basis and focused on the key controls mitigating risks. Internal audit testing is designed to assess the adequacy and effectiveness of key controls in operation at the time of an audit. Definitions of the assurance classifications and recommendation classifications used in this internal audit report are provided in Appendix C.

Acknowledgements

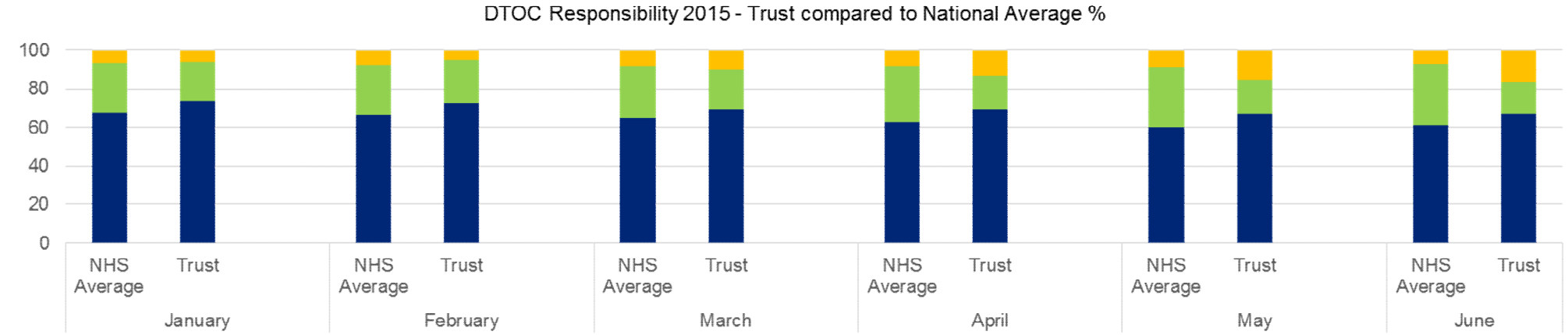
We would like to thank all staff involved for their co-operation during the internal audit.

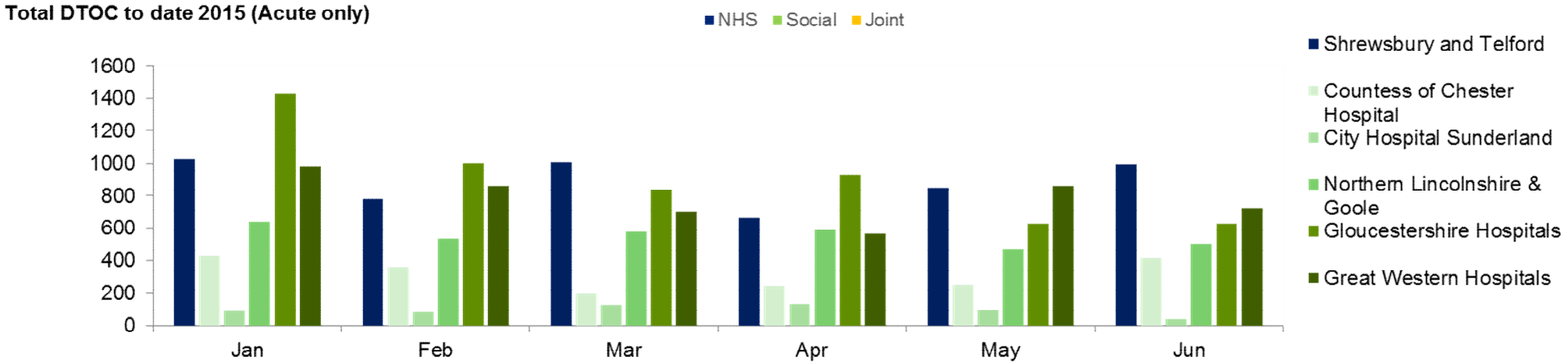
2. Key Findings

Background

The Trust's average length of stay in 2013/14 (latest public data) was 4.1 days which is better than the national average of 4.6 for all NHS trusts. In line with the national picture, the majority of DTOCs at the Trust in 2015 are attributable to NHS delays although the percentage is consistently higher than those of the NHS national average. Delays associated with social care are lower. The Trust has previously had a similar level of DTOCs in comparison to some other comparable district general hospitals, but the level of DTOCs has not reduced in the summer months to the extent that it has elsewhere.

The Trust has developed its Patient Status at a Glance (PSAG) boards to support a case management approach in MDT meetings, whilst the Discharge Hub proactively supports complex discharges. The Trust has provided training and communications to staff in relation to the discharge process and Consultant Job Plans have been updated to include time for attendance at board rounds. The Trust is re-establishing a Service Improvement Team to further improve the operational processes and hopes to further benefit from its work with Virginia Mason in the USA.





2. Key Findings

Inpatient Episode Testing

10 in-patient episodes were selected by longest delay (5 at each site) to understand where the patient had been deemed fit to transfer and the points at which avoidable delays occurred. Our findings in relation to the cases selected are recorded throughout this report and in Appendix A. Key findings from this testing were:

- 'Medically Fit for Discharge' or MFFD is not consistently recorded in the medical notes either in terminology or at the time at which the PSAG board is updated to confirm that this is the case. In our sample, only two of the dates were aligned and six patients were entered onto the F2T list before a formal record was made. For two patients, MFFD was never recorded in the notes. There is a risk that the length of delay could be over-reported if these dates are not correctly recorded. Refer to **Recommendation 5**, consistency of definitions, and **Recommendation 6**, recording of delays.

p. 21-27	MFFD per medical notes	F2T List	Difference
1	06/08/2015	06/08/2015	0
2	06/08/2015	04/08/2015	-2
3	05/08/2015	31/07/2015	-5
4	11/08/2015	11/08/2015	0
5	31/07/2015	30/07/2015	-1
6	Never	19/08/2015	NA
7	17/08/2015	18/08/2015	1
8	13/08/2015	12/08/2015	-1
9	Never	18/08/2015	NA
10	06/08/2015	10/08/2015	4

Figure 1: Sample testing on reported MFFD dates

- Where patients moved between being MFFD and not, discharge planning did not always continue during these periods of illness (sample 1, 9). There were also four occasions where assessments were delayed, either because the referral had not yet been made or because all relevant staff were not sufficiently aware of the discharge plans (sample 1, 2, 6, 8). Refer to **Recommendation 1**, frail patients with long term conditions and **Recommendation 2**, referrals for assessment.
- The DTOC status of patients was not recorded in the medical or nursing notes for nine out of ten episodes in our sample (sample 2-10). Ward staff, when asked, were unaware of the reportable status of delays in all cases. Refer to **Recommendation 7**, raising awareness of DTOC status.
- Discharge communications were inconsistently documented in the medical notes, nursing notes or separate communication logs. In our sample of DTOCs, which were all complex discharges, the discharge planning section of the admission booklet had been completed in nine out of ten cases; however, the referrals section had only been completed in one case (sample 7). That said, all of the patients in the sample had been seen by a social worker, physiotherapist and occupational therapists; a number were also seen by the rapid assessment interface and discharge (RAID) team and other members of the MDT (dietitian, alcohol liaison). Refer to **Recommendation 8**, separately identifiable discharge notes.

In addition to the observations above, we note that three out of 10 patients (sample 5, 8, 10) (30%) had a fall while they were a delayed transfer of care. Whilst no harm was incurred in these cases, it demonstrates the potential safety risk arising from DTOCs. Also, two patients became medically unfit after initially being determined MFFD. One of these would have resulted in a chargeable readmission if discharged (sample 1).

Recommendation 1: Frail patients with long term conditions (Medium Priority)
It is recommended that where patients move back and forth between being medically and not medically fit during the episode, discharge planning should not cease, particularly for frail patients with a long term instability of condition. These patients could be retained on the worklist in order to continue discharge planning while also providing an overview of the delays that have occurred.

Recommendation 2: Referrals for assessment (Medium Priority)
It is recommended that "awaiting assessment" should only be recorded when there is confirmation that the assessment has been requested. If the individual recording the need for an assessment has been unable to request it, they should record this. EDDs should be maintained as accurately as possible to support the Discharge Hub and multi-disciplinary teams to plan assessments and manage discharges efficiently. EDDs should be recorded in the medical notes in addition to the PSAG board.

2. Key Findings

Inpatient Episode Testing (continued)

The reasons for delay provided on the F2T list are categorised according to the reportable DTOC guidance. We compared the reasons given in the F2T list to the case notes for each episode in our sample. In some instances, more than one reason for delay applied over time, but only the most current reason is reported. This is useful for addressing delays for individual patients but does not give a clear picture of causes over time. One instance was noted where the reason given did not clearly match the notes. Refer to **Recommendation 4**, the F2T worklist should be updated to more accurately reflect the reasons for delays over time while clearly identifying which are internal and external.

p. 21-27	Reason per F2T List	Reason per medical notes	
1	Nursing Care Home Placement	12 day wait for Powys LHB to organise DST.	✓
2	Completion of assessment	8 days of internal assessment. 4 days awaiting placement as social work recruiting for the package of care. Combination of factors – longest delay reason reported.	✓
3	Patient or family choice	Choice Policy – family arranging funding for placement.	✓
4	Care package in own home	Social work exploring options for care package	✓
5	Completion of assessment	Confusion over whether patient was going to nursing or residential home led to assessment delays.	✓
6	Completion of assessment	Assessments completed internally whilst awaiting a discharge to assess bed.	✓
7	Nursing Care Home Placement	Awaiting community hospital bed, which would normally be ‘Further non-acute NHS Care’.	✗
8	Completion of Assessment	No availability at Whitchurch, discharge to assess referral made as a second option and awaiting assessments.	✓
9	Patient or family choice	Home access visit to fit equipment – self funded care package causing delay.	✓
10	Further non-Acute NHS Care	Awaiting a community hospital bed	✓

2. Key Findings

Standard Operating Procedures

The Trust finalised its latest operating policy for the discharge planning process in May 2015. DTOCs are defined within this and in line with the Situation Report Guidance from NHS England (Sitreps). The Capacity team were aware of, and held copies of the latest versions of these. In addition, DTOC definitions have been agreed in writing in relation to Discharge to Assess (D2A).

The Mental Capacity Act had also been utilised in relation to several of the patients in our sample.

The revised Discharge Policy is relatively new and the Trust continues to work to embed the policy in practice. Our main observations are:

- Discharge to assess continues to be in a piloted at the Trust and wards at both sites are trialling new discharge pathways however these are not widespread. We understand that this initiative is currently being assessed in order to determine continuation or otherwise.
- It is unusual for a Discharge Hub to take such significant ownership of the discharge process and, while we have been told that ward coordinator roles were established in support of greater ownership of discharges, we have seen evidence of ward staff who have a lack of understanding of arrangements that are being made. Wards should not act in isolation from, or contradict the Discharge Hub's actions, but they should be supported by the Discharge Hub to take greater ownership of their discharges while building their skills in handling difficult discharge conversations with commissioners and families. Refer to **Recommendation 3**, embedding the Discharge Policy.
- The aims and objectives of the Discharge Policy state that 'Comprehensive records are maintained within the patients' medical notes of the discharge planning' and 'Discharge checklists are completed for all patients following an in-patient stay'. We did not see consistent evidence of this (see page 21 and 27 for examples).
- The responsibilities outlined in the policy do not include medical responsibilities.

Recommendation 10: Medical responsibilities (Low Priority)
It is recommended that a section on medical responsibilities be added to the discharge policy.

- The policy requires that all ward based patients will be provided with access to written information relating to discharge within 24 hours post admission via the Discharge Leaflet. There have been improvements in this regard since our last review, and audits of Choice Letter 1 issues are being undertaken. The Trust needs to monitor the findings of these audits to ensure increased compliance. This could also be extended further by assessing whether Choice Letter 2 has been issued in all episodes where it would have been expected (appendix D). Refer to the previous page; in our sample Choice Letter 2 was only issued to the self-funded patient seeking a placement and not to the patients awaiting a care package (one funded, one self-funded) or the five patients awaiting funded placements.
- The policy states that the EDD should be set within 24 hours of admission and recorded in the patient's medical notes and on PSAG. Currently this date tends only to be recorded on the PSAG board (the EDD was evident in the medical notes in only one of our 10 cases). In all cases, the EDDs on the F2T list did not correlate with those that were on the PSAG boards. The policy also says that patients should be informed of their expected date of discharge as soon as confirmed by the medical team responsible for their care. Staff that we spoke with did not feel that EDDs are appropriately captured or communicated and did not always understand the importance of this information (the EDD should be used to manage patient and carer expectations, but should also help therapists to prioritise care. Similarly, there is a requirement to give 24 hours notice to social services of a patient's likely need for community care on discharge, Community Care Act 2003). Refer to **Recommendation 2**.
- At the Fit to Transfer meeting(s) the policy requires each patient on the list to be 'owned' by a member of the Health and Social Care team and actions agreed to progress each case. While there were occasions where actions were made clear these are not documented, and the F2T / DTOC lists do not have owners identified. Refer to **Recommendation 4**.

Recommendation 3: Embedding the Discharge Policy (Low Priority)
It is recommended that the Discharge Policy should be re-launched and discussed at team meetings to encourage ward staff to take ownership of their patients discharges. Wards should, whilst not acting in isolation from, or contradicting the Discharge Hub's actions, be also supported by the Discharge Hub to take greater ownership of their discharges while building their skills in handling difficult discharge conversations with commissioners and families. Rolling audits of key aspects of the Discharge Policy should be scheduled to ensure compliance, such as record keeping, the issue of Choice Letter 2s, and EDDs.

2. Key Findings

Internal and external escalation of patients on the 'Patients safe to transfer list' / fit to transfer list (F2T)

There are a number of lists that are available in regard to patients who are seen to be delayed in their transfer of care. These include:

1. The F2T work list for patients fit to transfer: this includes all patients identified as medically fit with the number of days and reasons for delays highlighted. There is also a summary which lists the total numbers of patients by category of delay;
2. The DTOC daily position: this gives an overview of the reportable delays by reason (including whether health or social) and commissioner; and
3. Weekly returns to the TDA.

The F2T and DTOC lists are circulated to a range of senior internal and external stakeholders. The former is intended to be an operational worklist and one which should be used by the DLT, MDT and social services to manage discharges, with escalation of issues as required. While external stakeholders that we spoke to understood this, and recognise that there is a need for openness and transparency, it includes more internal delays than they expected (i.e. completion of assessments, rehabilitation within the Trust).

They and the majority of Trust staff interviewed also feel that the list read cold does not give a true overview of the situation and, as it stands, we have noted the following:

- Narrative which is sometimes misleading and includes statements such as 'awaiting social'. This does not in all cases reflect the status of the patient. (Refer to Appendix A for examples);
- A lack of clarity in regard to the status of the delays i.e. the length of time that a patient has been delayed for each of the reasons specified, and which of the delays are currently reportable;
- Categories which do not show whether a delay is internal or external, NHS, social or joint. 'Completion of assessment', for example, can be internal or external, while 'awaiting placement' can relate to social services, bed availability, or enforcement of the Choice Policy (which is the Trust's responsibility), and 'awaiting care package' can include social services, self funders or internal assessments which are incomplete. Similarly, the DTOC list does not show whether a delay is attributable to the Trust or not;

We have also had comments about the potential for the inclusion of complex discharges onto the list (with clearly defined escalation points / triggers), as some staff feel that these are the types of discharge that may become delayed if not progressed in a timely manner. Staff did comment, however, that the ownership of complex discharges more generally is, in some cases, becoming overly centralised to the discharge liaison team (DLT) with less ownership by ward staff (also see comments on previous page).

The F2T list includes one day delays which may not always be delays given that the list is run daily at 8.30am. If wards have updated their PSAG boards before this time, a one day F2T will be added to the list despite only being confirmed that day (e.g. a list run on the 18th August includes 1 day delays from both the 17th August but also the 18th). On the days of our sample testing, 51% of the delays on the F2T list were one day or less. One day delays are not, however, included as reportable delays.

The Board also receives information on discharges through occasional and regular updates including through the performance of unscheduled care standards by exceptions reports. These detail the number of days that patients have been on the F2T lists by reasons for delay, but again do not identify whether the delays are internal, external or formally reportable.

Based on the current reporting to the Board, therefore, it is not possible to understand which delays are internal and controllable and which delays are external and more difficult for the Trust to address except through the support of other stakeholders. Refer to **Recommendation 4**.

2. Key Findings

Internal and external escalation of patients on the 'Patients safe to transfer list' ' / fit to transfer list (F2T) (continued)

The majority of delays are dealt with at an operational level and escalated by the Discharge Hub to senior managers when required; it is not clear how engaged senior medical staff are in this process. There may also be occasions when it is necessary to escalate further to an Executive Director who can then raise it at an appropriate level with their commissioner, social services, or other health provider counter parts. Some internal and external stakeholders feel that more discharge issues should be resolved locally and that senior staff, and in particular the CCGs, are too involved in the operational detail of patients. Also, we have been told that while this type of escalation may help with individual cases, there is often a lack of learning or systematic resolution of the root causes of delays. An example where action could be taken, for example, is the provision of new dosette boxes to patients. Currently, requests for these are sent to GPs who have 72 working hours to write the prescription; this may mean a 5 day delay if the request is sent on a Thursday or Friday.

There are Strategic Resilience, and Urgent Care working groups but we have been told that these are not focussed on broader strategic issues.

Understanding that other elements of the DTOC decision do not need to take place in an acute setting, the TDA definition of a Medically Fit for Discharge Patient is used as a measure for flagging capacity constraints within the Trust. It is important, therefore, for the Board and senior managers to fully understand the reasons for delays so that local or whole economy solutions can be achieved. The 'Discharge to Assess' model is just one example of how support can be given to reduce the MFFD numbers of patients within the acute sector by carrying out the other decisions / interactions in a non-acute setting.

More thematic analysis is therefore required for Board members and external stakeholders in order to understand the root causes of delays. This will allow focus on more systematic ways of improving pathways of care and ensuring that the patient is looked after in the safest and most cost effective setting.

Recommendation 4: Prioritising Board Reporting (High Priority) It is recommended that the F2T list should be reviewed to ensure that it more accurately reflects the status of patients who have been assessed as DTOCs, the reasons for delays over time, and has responsible owners allocated to actions. Thematic analysis, which clearly defines internal and external delays, should be reported to the Board and external stakeholders, and used to resolve key issues within the local health economy.

We note that Recommendation 9 from our 2013/14 report, Discharge Management, has been closed in recommendation tracking awaiting the roll out of Discharge to Assess. We have proposed a change to the wording of the prior year recommendation so that it does not refer to discharge to assess and can be implemented. **Prior Year Recommendation 9: Junior doctor good practice** It is recommended that junior doctors should meet to discuss and share the actions that they take to promote timely discharge of patients to ensure that good practice is communicated across all wards.

Discussions at relevant meetings and decisions made

Patients who are on the F2T worklist (including those who are reportable DTOCs) are discussed twice daily at Discharge Hub meetings. As referenced in our previous report we saw little active challenge of incomplete actions within these meetings and it was not clear, for example, which of the patients were reportable delays and which were the priority for sorting. There is a version of the F2T list with details of the number of reportable days and the assigned definition of current DTOCs and this is used by the Discharge Hub as their worklist for managing the delays. This is not, to our knowledge, circulated with the F2T list or discussed separately. Refer to Recommendation 16 from 2013/14 Discharge Management report.

The two Local Authorities are represented at the hub meetings however an assistant for Shropshire is present at PRH rather than a qualified social worker and, although helpful, this level of staff is not always sufficiently aware of, or able to make some of the key decisions required.

2. Key Findings

Delayed transfer of care decision

As noted in our inpatient episode testing, further clarification over definitions of DTOCs and medically fit patients should be provided to staff to ensure that DTOCs are accurately reported. Key definitions include:

> Medically Fit for Discharge: a clinical decision that the patient is ready to transfer. This is from a medical perspective only.
>
> Fit to Transfer: multi-disciplinary assessments are complete and the patient is safe to discharge or transfer.
>
> Delayed Transfer of Care: a patient is ready for transfer when a clinical decision has been made that the patient is ready for transfer; **and** a multi-disciplinary team decision has been made that the patient is ready for transfer; **and** the patient is safe to discharge / transfer.

We have been told (and have previously observed) that the 'medically fit for discharge' status of patients is discussed at the morning board rounds or on the Consultant ward rounds and entered onto the PSAG boards accordingly. This information helps to generate the F2T list which are used by the discharge team in order to track delayed transfers and discharges. Staff, including those in senior positions, confirmed a degree of confusion in the terminology used for patients who are delayed in their discharge or transfer of care and were unclear on the differences between, and the official definitions of, delayed transfers of care versus medically fit and fit to transfer. Also, the Discharge Policy references 'fit to transfer' however the lists that are used at the Trust are headed 'fit to transfer' which can mean different things and it could be that the "fit to transfer" title of this document is misleading.

Within the medical notes of the patients that we reviewed we noted a variety of comments in relation to medically fit status, and even for the same patient. Comments included: medically fit for discharge; medically safe for discharge; medically fit; plan discharge; and home when therapists happy. These were all used in conjunction with the declaration of being medically fit for discharge on the PSAG board. Refer to Appendix A for inpatient episode findings.

Some ward staff anecdotally stated that they press the medically fit button on the PSAG board when they need help with a complex discharge, rather than when the patient is medically fit.

The Discharge Policy states, and we have been told, that DTOCs are agreed at the Fit to Transfer meeting; however, our observations would suggest a lack of clarity in regard to those which are reportable delays and those which are not. We observed social service delays being validated and agreed more formally, but saw little evidence of the remaining health delays being agreed with appropriate members of the MDT to ensure that they were reportable items.

Also of note in this regard is the evidence that we have seen through our in-patient testing that MFFD is not consistently recorded in the medical notes at the time at which the PSAG board is updated and the patient enters the F2T list. Until this record is formally made it could be contested that a reportable delay should not be made.

There was no record within the medical or nursing notes of the patients reviewed that a decision had been made to formally report their DTOC status. Staff on all of the wards visited did not know if their patients were reportable delays or not.

Recommendation 5: Consistency of definitions. (Medium Priority)
It is recommended that all staff be made aware of the definitions described and that these should be used and applied consistently in line with Trust policy (and when recording in the medical and nursing notes that a patient is MFFD).

Recommendation 6: Recording of delays. (High Priority)
For all reportable DTOCs, the Discharge Liaison Team should check and ensure that the date that the patient was reported as MFFD on PSAG aligns with the medical notes and that appropriate members of the MDT are consulted prior to the decision being made. Ward staff should also take ownership in this regard.

Recommendation 7: Raising awareness of DTOC status (Medium Priority)
It is recommended that the Discharge Hub clearly discuss and document which patients are reportable DTOCs and that ward teams be made aware of those confirmed. The DTOC status and reason for delay should be recorded in the patient notes in all cases.

2. Key Findings

Patient and carers involvement and information provided

As referenced in our previous report the Trust Choice Policy sets out requirements for the issue of standardised letters to facilitate discharge:

- Choice letter 1 - welcome and leaving hospital leaflet;
- Choice letter 2 (a and b) - funded placements; and
- Choice letter 3 - notification that patients who cannot find available placement will be transferred to alternative accommodation. None of these have been issued at the Trust.

The issue of choice letter 1 remains variable and some nursing staff that we spoke with remained unaware of these. In 8 of the wards visited in our sample, however, the ward clerks have taken responsibility for ensuring that all admitted patients are provided with the required information and this is recorded on a list or in the admissions book. We could not find any evidence of this being recorded in the patient's notes or of discussions regarding the discharge process. The ward in Sample 1 had not yet introduced this process but stated that they had plans in place to add this to the admission paperwork. The Discharge Hub administrators at RSH are currently auditing the issue of these letters and findings to date have been mixed.

Choice letter 2s are issued by members of the Discharge Hub and ward staff were not aware that a letter had been issued to one of their patients for any of the episodes in our sample. Very few Choice letter 2s are currently issued (12 at the time of testing) and we would expect this to increase as the process becomes fully embedded. Ward staff also need to be more involved and should take greater responsibility for managing complex discharges, whereas they are currently very reliant on the support of the Discharge Hub. Refer to **Recommendation 3**.

The information that is given to relatives beyond these letters, either verbally or in writing is not always evident. Social and discharge communications are generally documented within the physical care sections of the nursing notes and these vary significantly, with some patients having very little or no narrative on this aspect of their stay. Similarly, discharge information from the DLT and social workers is inconsistently documented in the medical notes and it is quite challenging to see where more complex patients are in the discharge process. See **Recommendation 6 and 8** in this regard.

Reasons for delays

Reasons for delays in discharge or transfers of care are wide and ranging; however, of note in relation to this review is the significant variation in ward communications regarding discharge which means that all relevant staff are not always sufficiently aware of the discharge plans and this in itself can lead to delays. Some wards, for example, use green sheets to capture relevant information, while the rehabilitation wards have discharge summary sheets. The majority of wards that we visited, however, had no systematic process for the documentation of discharge planning arrangements. We found some commentary in the medical notes (including from therapists, and to a lesser extent social workers and discharge team members) but there were limited updates in the physical care sections of the nursing notes and difficult to find.

Recommendation 8: Separately identifiable discharge notes (Medium Priority)
It is recommended that the nursing team consider whether it would be appropriate to separate the discharge referrals and social / discharge notes from the physical health nursing notes so that this information is easier to see and more clearly distinguishable for nurses, social workers and other members of the MDT, reviewing the advantages of splitting out these notes against the risk of splitting notes over multiple places. Agreement needs to be reached about the multi-disciplinary communications that are required in order to ensure that ward staff understand and can take greater ownership of discharge arrangements that have been made to date.

In line with good practice, the Trust has adopted a multidisciplinary approach to the leadership of the therapy teams, and the Head of Occupational Therapy manages the Scheduled Care teams while the Head of Physiotherapy manages Unscheduled Care. This allows more joint assessments to be undertaken and more appropriate cover arrangements at board rounds. While there are standards for referrals and physiotherapists, for example, will try and see patients each day, this is not always possible. There is also potential for ward staff to help with walking practice and mobilising but time pressures may limit the extent to which this occurs. Some posts have recently been appointed to however we have been told that there have been a number of therapist vacancies at the Trust.

2. Key Findings

Reasons for delays (continued)

Expectations are such that physiotherapists will see patients on a daily basis where required, while occupational therapists will prioritise their assessments although the lack of accurate EDDs can make this more difficult. A prioritisation tool is also used and this requires therapists to see the most unwell patients first. DTOC patients may then become the lowest priority given that they have been declared MFFD. Statistics of patients who have been seen / not seen are kept and shared with the Care Groups, Executive Directors and Commissioners but we are unaware of this information being shared at Board or Committee level. There are a number of delays on the F2T and DTOC list which are attributable to awaiting assessments from this group of staff.

Recommendation 9: Therapy input (Medium Priority)
It is recommended that the Therapies team should revisit the standards for assessing patients by therapy groups. Monitor compliance and escalate exceptions to relevant Committees of, and / or the Board. Reportable DTOCs should be notified to members of the multi-disciplinary team so that any outstanding assessments can be prioritised.

Staff have said, and we have observed, that a number of patients are moved inappropriately due to demands on beds. Clinical site managers have a risk assessment tool for transferring patients however staff that we spoke with were unsure how this was individually applied and said that thresholds of risk would change depending on the escalation status of the hospital and site. Similarly, we have been told that external transfers can also be driven by the level of escalation that a site might be on.

As mentioned earlier in the report, Shropshire is currently piloting the discharge to assess model of care on two wards at RSH and two wards at PRH. This is jointly commissioned by the CCGs and Local Authorities. Telford CCG utilise an enablement model which is positively regarded. Powys LHB is more challenging and has often been referenced as having a 'postcode lottery' in regard to the provision of services and discharge arrangements. The Board is sighted on this but should consider recommendation 4 in this regard.

Although some evidence of joint working between the hospital sites, we have been told that this is not robust. While variances in practice may be expected due to the culture, geography and demographics, we would also expect to see more collaboration to ensure further standardisation of approach but also an increased understanding of the respective CCGs and particularly given that PRH's strongest relationships are with Telford and Wrekin CCG and local authority, whilst RSH's strongest relationships are with Shropshire.

3. Recommendations

Priority Level		Definition
High		Recommendations which are fundamental to the system and upon which the organisation should take immediate action.
Medium		Recommendations which, although not fundamental to the system, provide scope for improvements to be made.
Low		Recommendations concerning issues which are considered to be of a minor nature, but which nevertheless need to be addressed.

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
1	**Recommendation 1: Frail patients with long term conditions (Medium Priority)** It is recommended that where patients move back and forth between being medically and not medically fit during the episode, discharge planning should not cease, particularly for frail patients with a long term instability of condition. These patients could be retained on the worklist in order to continue discharge planning while also providing an overview of the delays that have occurred.	Medium	Partially Yes – re discharge planning continuing Need to consider alternative to MFFD worklist as adding patients to this when they are not medically fit will inflate numbers	A separate list for patients who move between being medically fit for discharge and unfit will be held by the Discharge Liaison coordinator within the discharge hub. This will be discussed at Hub meetings separate to the MFFD list daily to ensure discharge planning continues. This will be trialled for 6 months in the first instance	Heads of Capacity 31/1/16

3. Recommendations

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
2	**Recommendation 2: Referrals for assessment (Medium Priority)** It is recommended that “awaiting assessment” should only be recorded when there is confirmation that the assessment has been requested. If the individual recording the need for an assessment has been unable to request it, they should record this. EDDs should be maintained as accurately as possible to support the Discharge Hub and multi-disciplinary teams to plan assessments and manage discharges efficiently. EDDs should be recorded in the medical notes in addition to the PSAG board.	Medium	Yes	Heads of capacity will check before recording “awaiting assessment” following confirmation that the assessment has been requested. Daily Board Rounds now included in consultant job plans. One of the tasks of the board round is the setting of the EDD. The Effective Board round has been described and communicated to consultants at regular intervals during the year, and also communicated to the new junior doctor intake each year. Audit of EDD recording to be undertaken 31/3/16.	Heads of Capacity 1st part. 31/12/15 Care Group Medical Directors 2nd part. 31/3/16

3. Recommendations

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
3	**Recommendation 3: Embedding the Discharge Policy (Low Priority)** It is recommended that the Discharge Policy should be re-launched and discussed at team meetings to encourage ward staff to take ownership of their patients discharges. Wards should, whilst not acting in isolation from, or contradicting the Discharge Hub's actions, be also supported by the Discharge Hub to take greater ownership of their discharges while building their skills in handling difficult discharge conversations with commissioners and families. Rolling audits of key aspects of the Discharge Policy should be scheduled to ensure compliance, such as record keeping, the issue of Choice Letter 2s, and EDDs.	Low	Yes – however we would not expect ward staff to hold these type of conversations with commissioners, this needs to be done through the Discharge Hub	Head of Capacity to discuss with Heads of Nursing to ensure discharge policy is relaunched. Heads of Nursing to disseminate policy through various meetings to Ward level. Will be an agenda item and minuted at ward meetings.	Heads of Capacity 31/3/16
4	**Recommendation 4: Prioritising Board Reporting (High Priority)** It is recommended that the F2T list should be reviewed to ensure that it more accurately reflects the status of patients who have been assessed as DTOCs, the reasons for delays over time, and has responsible owners allocated to actions. Thematic analysis, which clearly defines internal and external delays, should be reported to the Board and external stakeholders, and used to resolve key issues within the local health economy.	High	Yes The MFFD information is already included in the Board Information Pack – will consider incorporating this into main report along with analysis of DTOC patients and clear definitions for both	Process to formally recognise patients on the MFFD list who are Sitrep delays to be agreed. Analysis of DTOC's to be included in the Board information pack with definitions. Heads of Capacity to discuss with external partners prior to reconfiguration of MFFD list to ensure it meets the needs of all partners and ECIP best practice.	Heads of Capacity 31/12/15 COO 3/12/15 (Next Trust Board) 31/12/15

3. Recommendations

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
5	**Recommendation 5: Consistency of definitions. (Medium Priority)** It is recommended that all staff be made aware of the definitions described and that these should be used and applied consistently in line with Trust policy (and when recording in the medical and nursing notes that a patient is MFFD).	Medium	Yes	Discharge Liaison Hub coordinator to put information sheet together for all wards with consistent definition's to be used following ECIP guidance. This will also be filtered through Ward meetings and minuted.	Heads of Capacity 31/1/16
6	**Recommendation 6: Recording of delays. (High Priority)** For all reportable DTOCs, the Discharge Liaison Team should check and ensure that the date that the patient was reported as MFFD on PSAG aligns with the medical notes and that appropriate members of the MDT are consulted prior to the decision being made. Ward staff should also take ownership in this regard.	High	Yes	Ward process to be agreed.	Heads of Capacity 31/12/15
7	**Recommendation 7: Raising awareness of DTOC status (Medium Priority)** It is recommended that the Discharge Hub clearly discuss and document which patients are reportable DTOCs and that ward teams be made aware of those confirmed. The DTOC status and reason for delay should be recorded in the patient notes in all cases.	Medium	Yes	Process now in place to formally recognise patients on the MFFD list who are Sitrep delays to be agreed. Discussed in Hub. If allied with Ref. 6 above this will ensure documentation is in notes also	Heads of Capacity 31/12/15

3. Recommendations

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
8	**Recommendation 8: Separately identifiable discharge notes (Medium Priority)** It is recommended that the nursing team consider whether it would be appropriate to separate the discharge referrals and social / discharge notes from the physical health nursing notes so that this information is easier to see and more clearly distinguishable for nurses, social workers and other members of the MDT, reviewing the advantages of splitting out these notes against the risk of splitting notes over multiple places. Agreement needs to be reached about the multi-disciplinary communications that are required in order to ensure that ward staff understand and can take greater ownership of discharge arrangements that have been made to date.	Medium	Yes – will consider the practicalities and risks of this approach	The practicalities and risks of this have been considered. Benefit of this is limited compared to the risk of splitting patient information and the loss of information gained. Having considered the options we believe our current system fit for purpose.	Heads of Capacity 20/11/15 – action closed
9	**Recommendation 9: Therapy input (Medium Priority)** It is recommended that the Therapies team should revisit the standards for assessing patients by therapy groups. Monitor compliance and escalate exceptions to relevant Committees of, and / or the Board. Reportable DTOCs should be notified to members of the multi-disciplinary team so that any outstanding assessments can be prioritised.	Medium	Yes	Patients waiting for assessment by SaTH Therapists are clearly visible on daily work list report available each day for each therapist. Management Team review FTT list (generated at 7am) and escalate therapy actions to teams each day by 9am. KPI's for time to assessment to be agreed: In-progress based upon PSAG / SQL reporting system.	Head of Therapies 31/1/16

3. Recommendations

Ref	Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
10	**Recommendation 10: Medical responsibilities (Low Priority)** It is recommended that a section on medical responsibilities be added to the discharge policy.	Low	Yes	HoC to draft responsibilities. Liaise with Care Group medical directors prior to adding	Heads of Capacity 31/1/16

Ref	Updated Recommendation	Priority	Agreed? (Yes/No/Partially)	Management Action Plan	Owner/date
Prior Year 9	**Prior Year Recommendation 9: Junior doctor good practice** It is recommended that junior doctors should meet to discuss and share the actions that they take to promote timely discharge of patients to ensure that good practice is communicated across all wards.	Low	Yes	The Drive 4 Discharge program supported by weekly communication with junior doctors at their Monday morning forum helps ensure discharge is appropriately prioritised. This weekly meeting also helps to distribute junior doctor workforce across the wards in support of these activities being performed. Daily 3pm huddles to plan for next day discharges are to be embedded as part of the rollout of the SAFER bundle.	Care Group Medical Directors 31/3/16

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 1: DTOC timeline (RSH) Powys LHB	
Admission Day 1	Discharge planning commenced – anticipating sending patient home with a package of care. Referrals in the discharge planning section of the nursing notes not completed.
Day 2	RAID review- 'identify dementia needs and ask the ward to start the CHC Checklist'.
Day 6	Assessed and discharged from physiotherapy. Recorded as "medically fit" in the medical notes.
Day 10	Not medically fit due to an infection. Removed from F2T list.
Day 12	'Discharge tomorrow' written in medical notes.
Day 13	Patient not discharged but reasons for this not documented- not clear in medical notes whether the patient is now MFFD.
Day 20	Physiotherapy assessment.
Day 28	Mental capacity checklist completed.
Day 38	Best interests checklist completed.
Day 44	Second person confirmed best interests checklist.
Day 57 DTOC	Described as "Medically stable" but further medical intervention required and recorded in the medical notes. CHC and DST required - request faxed to Powys LHB. Discharged from physiotherapy. Recorded as "Medically Fit" and entered onto F2T list.
Day 61	'Delayed discharge' written in medical notes.
Day 62	Flagged as awaiting EMI bed availability. CHC completed which confirms EMI requirement.
Day 62-69	Delayed discharge recorded daily in medical notes.
Day 69	DST meeting with Powys CCG- for EMI home.

We note that if discharge had not been delayed, a reportable readmission would have been likely due to a subsequently identified infection.

Sample 1: Observations

- Discharge planning commenced on the admission date. Known social factors were also documented in the nursing notes at an early stage. Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not despite this being a complex discharge. Similarly, the discharge checklist was not completed around day 12 when a discharge date had first been arranged.
- The CHC Checklist was requested by RAID on Day 2, but was not completed until Day 57 despite initial arrangements for discharge on day 12. [The first CHC checklist was not signed by the person completing it]
- Medically fit was documented in the notes but not clear on all occasions about the medical status of the patient.
- Communications regarding discharge were not updated consistently throughout the episode with very little clearly documented in the nursing notes.
- Current DToC reason (Nursing Care Home Placement) appears to have been appropriately applied.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 2: DTOC timeline (RSH) Shropshire CCG	
Admission Day 1	Pre-existing carer at home recorded in nursing notes. Assessment of capacity completed. Referrals in the discharge planning section of the nursing notes not completed.
Day 6	Physiotherapy and Alcohol Liaison nurse review.
Day 10	"Discharge Planning" recorded in medical notes. Plan for nursing home with note that patient lacks mental capacity. Planned multi-disciplinary team meeting (MDT) for Day 17. RAID assessment and physiotherapy assessment completed.
Day 14,24,30	Occupational therapy assessment.
Day 17	No record of MDT occurring.
Day 22	"Awaiting bed in Uplands".
Day 23	RAID assessment.
Day 27	Recorded as "Clinically stable."
Day 29	"Awaiting psychologist to assess".
Day 31	"Awaiting social assessment".
Day 34	Not medically fit.
Day 40	Nursing: discharge plan to transfer to Uplands.
Day 41 DTOC	Not for Uplands per Discharge Hub: funding questions mentioned for first time. Appears on F2T list but MFFD not recorded in medical notes.
Day 43	"Medically fit" recorded in medical notes. Whitchurch option to be considered if Uplands delayed.
Day 44	Discharge hub involvement documented in notes.
Day 47	Capacity assessment and psychology assessment requested.
Day 49, 51	Occupational therapy assessed again and suggested additional mental capacity assessment.
Day 50	Discharged by physiotherapy.
Day 54	Social work - 2nd visit but first not recorded. Confirmed package of care required.
Day 55	Meeting to discuss discharge planning and temporary placement so that Headway can recruit package of care. Awaiting interim placement.

Sample 2: Observations

- Discharge planning was recorded in the nursing notes from the admission date. However, the discharge and referrals section of the admission booklet were not completed.
- There was no record to confirm if the MDT had occurred on the day that it was planned for.
- It took over a week for the DST meeting to take place with the commissioner. Our discussions with ward staff suggested this is a common delay with Powys LHB [This contrasts with the Shropshire CCG example in our sample where the DST meeting was arranged within 24 hours]. Per discussion with the Discharge Hub, this issue has been escalated.
- The patient was added to the F2T list 2 days before they were recorded as "Medically Fit" in the medical notes.
- The patient was clinically stable and "awaiting assessment" from a psychologist from day 27 and 29 respectively but it was not recorded that the assessment had been requested until day 47. Capacity and psychological assessments were only started when the Discharge Hub team intervened and it is not clear what ownership the ward staff took for these referrals.
- There was a lack of clarity regarding the discharge destination of this patient throughout their stay. Communications were limited, with very little written in the nursing notes. Also, the social worker only wrote on the second visit and the Discharge team on one occasion.
- Current DToC reason (Completion of assessment) appears to have been appropriately applied although expectation that reason may change going forward as now waiting interim placement pending package of care being available.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 3: DTOC timeline (RSH) Shropshire CCG	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 3	RAID requested and chased on same day. Mental Capacity Checklist completed. Physiotherapist flagged that no EDD documented.
Day 6	RAID review, identified need for EMI.
Day 7	Noted as awaiting EMI placement (but assessments not complete)
Day 7 DTOC	F2T list - not stated medically fit
Day 10	Social Work assessed mental capacity. Best Interest meeting requirement identified.
Day 11	"Remains medically stable". Best interest meeting and DST to be arranged Deprivation of liberty (DoLS) assessment requested
Day 12	Medically fit for discharge documented in medical notes Best interests and DST planned for today Shown as awaiting placement.
Day 31	Recorded as ready to go tomorrow subject to funding. Letter 2 issued but not recorded in medical or nursing notes.“

Sample 3: Observations

- Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not despite this being a complex discharge.
- The patient was not recorded as MFFD in the medical notes until 5 days after they were added to the F2T list.
- Shropshire social services were responsive, with the DST and best interests meeting scheduled within 24 hours of request.
- The ward staff interviewed were unaware that a Letter 2 had been issued.
- Discharge communications were limited, with very little in the nursing notes or those written being buried in the physical health progress notes.
- Current DToC reason (Patient or family choice) appears to have been appropriately applied although MFFD was not confirmed at time of becoming reportable.

Sample 4: DTOC timeline (RSH) Shropshire CCG	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 3	Assessment of capacity. Discharge Liaison - “Too early to complete a CHC checklist - when MFFD may regain capacity”. Alcohol liaison review. Mental capacity assessment - requested and completed same day.
Day 8	Physiotherapy requested but recorded that the referral was not appropriate.
Day 9	Physiotherapy assessment completed
Day 14	Discharge Planning Meeting - arranging package of care. Alcohol liaison review

Sample 4: Observations

- Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not despite this being a complex discharge.
- This patient was recorded as MFFD on the day they were added to the F2T list and when the patient became a reportable DToC.
- Discharge communications were limited, with very little in the nursing notes, or those written being buried in the physical health progress notes.
- Current DToC reason (Care package in own home) appears to have been appropriately applied.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 4: DTOC timeline (RSH) Shropshire CCG (continued)	
Day 15 DTOC	MFFD documented in medical notes. Also, 'Awaiting social input'. Entered onto F2T list.
Day 17	Social worker noted that they were exploring available options for social care. MFFD documented.
Sample 5: DTOC timeline (RSH) Powys LHB	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 3	Physiotherapy
Day 4 DTOC	Medical notes record "Planned for Discharge" but do not specify MFFD. Added to F2T list.
Day 5	Medical notes state: "Medically Fit".
Day 5	Physiotherapy.
Day 10	Welshpool looking for rehabilitation placement.
Day 11	Physiotherapist notes that patient may need nursing home.
Day 12	Awaiting package of care in medical notes but awaiting nursing home placement in nursing notes.
Day 16	Reviewed by RAID - stated that EMI placement is appropriate.
Day 19	Nursing home planned for Monday but it was in actual fact a residential home so cancelled.
Day 20	Fall in hospital whilst a DTOC. No harm.
Day 22	Still medically fit - not suitable to return home on assessment.
Day 26	Awaiting nursing home placement.
Sample 6: DTOC timeline (PRH) Telford & Wrekin CCG	
Day 1	Fractured neck of femur pathway documented. Referrals in the discharge planning section of the nursing notes not completed.
Day 8	Social work referral.
Day 9	Physiotherapy and Occupational Therapy requested.
Day 12	Physiotherapy review. "Discharge planning for safe place".

Sample 4: Observations
Sample 5: Observations
• Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not completed despite this being a complex discharge. • This patient was on the F2T list the day before they were recorded as MFFD. • Discharge communications were limited, with very little in the nursing notes or those written being buried in the physical health progress notes. • We note that this patient had a fall in hospital whilst a DTOC, although no harm was recorded. • Current DToC reason (Completion of assessment) appears to have been appropriately applied
Sample 6: Observations
• Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not completed despite this being a complex discharge. • The ward staff sent the occupational therapist away because the patient was not yet medically fit. This demonstrates a lack of understanding as the referral had been requested by the social worker to support complex discharge planning.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 6: DTOC timeline (PRH) Telford & Wrekin CCG (continued)	
Day 13	Safe place discharge planning. Awaiting enablement bed.
Day 17	Mini mental test score.
Day 17	Ward staff sent the Occupational Therapist away saying not appropriate. Physiotherapist recorded that the patient would not be fit to transfer until assessment complete.
Day 18	Mental Test Score. Referred to RAID and for FFA (documented by discharge team).
Day 19 DTOC	Seen by RAID, FFA completed. Notes implied that patient could potentially return home with dementia support -rehabilitation recommended.
Day 20	"Medically stable" documented and for physiotherapy and occupational therapy. Awaiting enablement bed.
Day 21	"Awaiting placement bed".
Day 25	Occupational therapy assessment completed. Social work waiting for night diary.

Sample 6: Observations

- MFFD was not recorded at any stage of this patients stay despite the patient being on the DTOC list for 6 days.
- The discharge journey was documented in detail, split across the medical, nursing and therapy notes. There was, however, a level of confusion between different sets of notes as to whether the intended destination was an enablement bed or rehabilitation support at home.
- Current DToC reason (Completion of assessment) appears to have been appropriately applied.

Sample 7: DTOC timeline (PRH) Shropshire CCG	
Day 1	Admitted. Occupational therapy and physiotherapy assessments initiated. Referred to Social Worker.
Day 8	MFFD recorded. Re-assessed by Physio and Occupational therapy. Possibility of care package suggested.
Day 9 DTOC	Plan for transfer to community hospital.
Day 11	Transferred to rehabilitation ward as bed needed on current ward.
Day 15	FFA completed for Whitchurch.
Day 16	Ward 16 MDT meeting- to ask wife if can increase care.

Sample 7: Observations

- This admissions booklet had been fully completed, including the discharge section and the discharge referrals which were made on admission.
- The patient was moved to the rehabilitation ward once MFFD to release a bed on the acute ward.
- Discharge communications were limited, with very little in the nursing notes, or those written being buried in the physical health progress notes.
- There was a absence of SW communications.
- There was a 7 day delay between the patient being MFFD and a FFA being completed. This was due to a community bed not being available and a decision being made to transfer to a D2A bed.
- Current DToC reason (Nursing Care Home Placement) does not appear to have been appropriately applied and we would have expected Further non-Acute NHS Care.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 8: DTOC timeline (PRH) Shropshire CCG	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 6	FFA commenced (but not clear when completed).
Day 9	Requested physiotherapy.
Day 16	Noted that the patient needs social assessment for discharge.
Day 19 DTOC	Frail but medically fit. Discharge planning to continue.
Day 20	24hr care discussed with family.
Day 23	Fall, no harm.
Day 23	Discharge Liaison Nurse (DLN) spoke to family about discharge and agreed Whitchurch community hospital. DLN chased Whitchurch hospital.
Day 25	D2A referral.
Day 26	Transferred to rehabilitation ward.
Day 31	Unwell, no longer MFFD.

Sample 8: Observations

- Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not completed despite this being a complex discharge.
- The FFA was started at an early stage but there was a delay in completion.
- This patient was transferred to the rehabilitation ward because a bed was available rather than because they required those services.
- Discharge communications were limited, with very little in the nursing notes or those written being buried in the physical health progress notes. A communications page was used to document nursing updates on the rehabilitation ward, but nothing about social or discharge arrangements.
- We note that this patient had a fall in hospital whilst a DTOC, although no harm was recorded.
- Current DToC reason (Completion of assessment) appears to have been appropriately applied.

Sample 9: DTOC timeline (PRH) Telford & Wrekin CCG	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 3	Physiotherapy referral.
Day 4	Physiotherapy assessment.
Day 12	Occupational therapy assessment.
Day 18 DTOC	RAID input. Occupational therapy records equipment needs.
Day 19	RAID review: capacity assessment requested and further occupational therapy. "Home when physiotherapist and dietitian happy" stated in medical notes.
Day 20	EDD recorded in medical notes, with NHS bed planned and equipment ordered.
Day 21	"For discharge home"

Sample 9: Observations

- Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not despite this being a complex discharge.
- MFFD was never recorded and it was not clear whether the patient was actually fit for discharge with phrases used such as “Home when physio and dietitian happy”, “for discharge home” and “home once stable”.
- On the F2T list the patient was classified as “awaiting equipment,” although the specifics of this were not stated- the ward staff when asked were not clear on what was required and did not fully understand what ‘assistive technology meant’
- Discharge communications were limited with very little in the nursing notes, or those written being buried in the physical health progress notes.

Appendix A: Findings from sample testing

The key findings from our sample testing are summarised on page 8-9. The detailed findings related to each item are described in this appendix.

Sample 9: DTOC timeline (PRH) Telford & Wrekin CCG (continued)	
Day 24	Plan for discharge with new EDD. Occupational therapy review.
Day 25	"Aim for home tomorrow"
Day 26	"Home once stable" Home access visit arranged to fit equipment. Discharge checklist not completed despite discharge due for the next day.
Sample 10: DTOC timeline (PRH) Shropshire CCG	
Day 1	Referrals in the discharge planning section of the nursing notes not completed.
Day 5	Physiotherapy and Occupational Therapy assessments.
Day 6	Discharge planning – "? home today." Social communication about family considering residential care.
Day 7	Continue discharge planning. FFA started.
Day 8	Continue discharge planning - Awaiting placement (not stated where). "Medically safe for discharge."
Day 12 DTOC	MFFD - discharge planning for respite.
Day 14	Fall, no reported harm.
Day 15	MDT- still medically fit. Patient wants to go home but needs 24 observations, discussed possibility of care package at home.
Day 21	Notes make reference to nursing staff not making discharge decisions without speaking to the discharge team who were coordinating D2A.
Day 22	May need Morris care home at D2A. FFA updated and assessment completed. Communications re discharge recorded- family disputing care arrangements. Care package discussed not deliverable by Social Services so will require community hospital as alternative. Family to visit this facility.
Day 26	Discharge to be planned for Bridgnorth - change in status to community hospital recorded. DLN confirmed FFA paperwork complete - D2A Pathway 2.

Sample 9: Observations

- At the time of testing, the discharge checklist had not been completed, despite the patient being due for discharge.
- Current DToC reason (Patient or family choice) appears to have been appropriately applied (self funded care package causing delay although not documented in notes).

Sample 10: Observations

- Whilst the discharge planning section of the admission booklet had been completed, the referrals section was not completed despite this being a complex discharge.
- The D2A referral was completed 15 days after the original request and could have been completed at an earlier stage.
- "? home today" and "MSFD" were recorded rather than "MFFD".
- There was a lack of clarity regarding the initial discharge destination of this patient. Discharge communications were limited, with very little in the nursing notes or those written being buried in the physical health progress notes.
- We note that this patient had a fall in hospital whilst a DTOC, although no harm was recorded.
- Current DToC reason (further non-acute NHS Care) appears to have been appropriately applied.

Appendix B: Information Reviewed and Interviews

	Evidence	Date
1	Discharge Policy	May 2015
2	Choice Letter Audit Results	August 2015
3	Trial welcome leaflet for D2A wards	August 2015
4	DTOC daily position	August 2015
5	fit to transfer list	August 2015
6	Situation Report (SitRep) DTOC guidance	v1.08

Interview	Role
Debbie Kadum	Chief Operating Officer
Ian Donnelly	Assistant Chief Operating Officer, Unscheduled Care
Andy Aldridge	Head of Capacity (Princess Royal Hospital)
Grainne Buggy Rachel Roebuck	Head of Capacity (Royal Shrewsbury Hospital)
Amanda Walshaw	Head of Occupational Therapy
Jill Dale	Head of Physiotherapy
Louise Gill	Head of Nursing
Mark Cheetham	Care Group Medical Director
Kerrie Allward	Shropshire Social Work
Rachael Brown	Appropriate representative from Shropshire Community Trust
Gemma McIver	Shropshire CCG
Diane Beasley	Telford And Wrekin CCG
	Matrons, Ward Managers and members of the MDT and Discharge Liaison Team

Appendix C: Definitions of Assurance Levels

Definition of Assurance Levels

We have five categories by which we classify internal audit assurance over the systems we examine – Full, Substantial, Moderate, Limited or no assurance which are defined as follows:

Assurance Level		Evaluation and Testing Conclusion
Full		The controls tested are being consistently applied. There is a sound system of internal control designed to achieve the system objectives.
Substantial		There is evidence that the level of non-compliance with some of the controls may put some of the system objectives at risk. While there is a basically sound system of internal control, there are weaknesses, which put some of the system objectives at risk.
Moderate		The level of non-compliance puts some system objectives at risk. There is a basically sound system of internal control for other system objectives.
Limited		The level of non-compliance puts the systems objectives at risk. Weaknesses in the system of internal controls are such as to put the system objectives at risk
Nil		Significant non-compliance with basic controls leaves the system open to error or abuse. Control is generally weak leaving the system open to significant error or abuse.

Grading of Recommendations

In order to assist management in using our reports, we categorise our recommendations according to their level of priority.

Assurance Level		Evaluation and Testing Conclusion
High		Recommendations which are fundamental to the system and upon which the organisation should take immediate action.
Medium		Recommendations which, although not fundamental to the system, provide scope for improvements to be made.
Low		Recommendations concerning issues which are considered to be of a minor nature, but which nevertheless needs to be addressed.

The assurance gradings provided here are not comparable with the International Standard on Assurance Engagements (ISAE 3000) issued by the International Audit and Assurance Standards Board and as such the grading 'Full Assurance' does not imply that there are no risks to the stated control objectives.

Appendix D: Choice Letters

Choice Letters

The Trust's Choice Policy requires that upon completion of assessment and after the patient has been informed clearly by Medical Staff, Social worker/Complex Discharge Nurse, (MDT) that they are ready to leave hospital and said discussion documented in patient notes, Choice letter 2 (a) to be given for local authority funded patients / or patients waiting for housing , Choice letter 2(b) for self-funded patients (usually a minimum of five working days from first letter and/or services' have been declined) by the senior discharge coordinator or discharge liaison nurse (DLN).

Choice Letter 2a: Funded patient

Re: Leaving Hospital

We are pleased that you are now medically ready to leave Shrewsbury and Telford Hospital. Your discharge assessment has been completed and the nurses, doctors, physiotherapist, occupational therapist and social care worker should have discussed with you what your needs will be when you are discharged.

You have been advised that you are no longer in need of acute care and future needs would be best met in another environment. Your Discharge Liaison Nurse and Social Worker will now help you to find a suitable place that meets your needs.

Due to the demand for hospital beds and to ensure the safety of patients who need beds in A&E, we would ask that you consider the options made available to you for discharge and agree the transfer as soon as possible. Social Services are given a timescale of 3 days to make an assessment and offer of services. If your first choice of placement or services on discharge is unavailable within this timescale, a suitable temporary placement will be made available to you. Please be aware that you should accept the temporary placement, as you cannot continue to occupy a bed in this hospital once you are ready for discharge and a suitable place has been offered.

Please note that because of the heavy demand for hospital beds, you may be required at any stage in the process to transfer at short notice to a temporary placement. Please be assured that wherever this is the case, the placement offered to you will fully meet your needs. We recognise that this letter may cause some anxieties and if you would like to talk to someone who can help and support you, please contact a member of staff looking after you.

Choice Letter 2b: Self funded patient

Re: Leaving Hospital

We are pleased that you are now ready to leave hospital. Your discharge assessment has been completed and the nurses, doctors, physiotherapist, occupational therapist and social worker should have discussed with you what your needs will be when you are discharged. You will be aware that the discharge assessments have shown that you are no longer in need of acute care and future needs would be best met in another environment.

We understand that your capital resources and/or income are such that you will be required to pay the full cost of your care (if you are unsure whether or not you should be paying the full cost, please ask your social worker for a financial assessment). A social worker will be able to assist you to identify an appropriate residential/nursing home whether or not you choose to have an assessment of your social care needs (this assessment is optional for people who pay the full cost of their care).

Due to the demand for hospital beds and to ensure the safety of patients who need beds in A&E, the hospital requests that within 1 day of you being informed that a suitable placement is available, you should accept this placement at least on a temporary basis, even if the home identified is not your first choice. Please be aware that you should accept the temporary placement, as you cannot continue to occupy a bed in this hospital once you are ready for discharge and a suitable place has been offered.

Please note that because of the heavy demand for hospital beds, you may be required at any stage in the process to transfer at short notice to a temporary placement. Please be assured that wherever this is the case, the placement offered to you will fully meet your needs. We recognise that this letter may cause some anxieties and if you would like to talk to someone who can help and support you, please contact a member of staff looking after you.

Appendix E: Statement of responsibility

We take responsibility for this report which is prepared on the basis of the limitations set out below.

The matters raised in this report are only those which come to our attention during the course of our internal audit work and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Recommendations for improvements should be assessed by you for their full impact before they are implemented. The performance of internal audit work is not and should not be taken as a substitute for management's responsibilities for the application of sound management practices. We emphasise that the responsibility for a sound system of internal controls and the prevention and detection of fraud and other irregularities rests with management and work performed by internal audit should not be relied upon to identify all strengths and weaknesses in internal controls, nor relied upon to identify all circumstances of fraud or irregularity. Auditors, in conducting their work, are required to have regards to the possibility of fraud or irregularities. Even sound systems of internal control can only provide reasonable and not absolute assurance and may not be proof against collusive fraud. Internal audit procedures are designed to focus on areas as identified by management as being of greatest risk and significance and as such we rely on management to provide us full access to their accounting records and transactions for the purposes of our audit work and to ensure the authenticity of these documents. Effective and timely implementation of our recommendations by management is important for the maintenance of a reliable internal control system.

Deloitte LLP
Birmingham
27 November 2015

Deloitte.