THHFT DELAYED TRANSFER OF CARE (DTOC) INITIATIVES AND IMPROVEMENTS

Relevant Board Member(s)	Shane Degaris, Chief Executive Officer
Organisation	The Hillingdon Hospitals NHS Foundation Trust
Report author	Julie Wright, Director of Integrated Care
Papers with report	Appendix 1 – Red2Green Graphs Appendix 2 – Number of DTOC and medically optimised patients Appendix 3 -. Stranded Patients – Snap Shot Audit

HEADLINE INFORMATION

Summary	This paper provides an outline description and update to the Health and Wellbeing Board on key initiatives and improvements implemented within the Hillingdon Hospitals NHS Foundation Trust to reduce the number of patients experiencing delays in being discharged from an acute bed.
Contribution to plans and strategies	This paper support system wide transformation work described in a number of strategies across organisations.
Financial Cost	N/A
Ward(s) affected	All

RECOMMENDATION

That the Health and Wellbeing Board notes the content of the paper.

Information

This paper provides context behind several schemes and initiatives being set up to reduce delays in discharge for patients able to leave the hospital and provides an outline and progress update on the following schemes:

- Red to Green
- SAFER
- Discharge home to assess
- Stranded patients audit and actions
- Ending PJ paralysis
- Criteria led discharge
- HHCP integrated frailty pathway
- DTOC action plan
- Safer Efficient Hospital Internal Professional Standards

1. Context

During Winter 2016/17 demand for inpatient services exceeded the number of beds available within the hospital. Hillingdon's DTOC position has fluctuated over time and currently is within the nationally agreed target of 2.5%. However the number of medically optimised patients within the hospital remains a challenge and is currently at 9.4% (38 patients on average). The national target is 3%. This is driven by a high number of so-called stranded patients (defined nationally as patients with a length of stay above 7 days) which is currently at 53% of our bed base (215 patients). The national benchmark is 35% to 40% so the Hillingdon system in an outlier in this respect. The combined impact of this will cause additional bed pressures through the 2017/18 winter months if the trend continues resulting in patients in A&E waiting for a bed but unable to be moved out of the department.

A Hillingdon emergency care recovery board has been established which is chaired jointly by the CEO's of the Hospital Trust and the CCG and an extensive programme of system wide work agreed which is being monitored by system regulators. This consists of five main theme programmes – Demand management, A&E processes, Patient Flow and 'SAFER'. The final programme work stream is focussed on integrated discharge - the Executive sponsor is Tony Zaman Director of Adult Children and Young People's Services and the programme group is chaired by Maria O Brien, Board Director Community Services/Deputy COO for CNWL.

As part of a whole system integrated recovery programme there are several distinct schemes underway in the hospital aimed at reducing the length of stay (LOS) and freeing up bed capacity. Equally important is the national evidence highlighting the negative impact on patients who have prolonged length of stay in an acute hospital environment especially the frail and elderly.

This paper details the schemes most relevant to expedite discharge and reduce LOS.

2. Red to Green

Red2Green is a method of ensuring that the care which is planned to take place for a patient on any given day actually does take place. It links to SAFER (see section 3 below) in that the care required for the day is identified at the senior review, and then tracked to ensure it happens through Red2Green. The basic principle of Red2Green is that a day on which everything which should happen for a patient does happen is a Green day. If something should happen, but doesn't, it is a Red day. By focussing staff on moving patients from a Red day to a Green day, and by identifying those things which block any individual patient from having a Green day, the Hospital (and the wider health and social care system) are able to identify processes and systems which are not working, and which need to be improved. In turn, resources can be directed at resolving these blockages, which will mean more patients have Green days in the future. In this way, Red2Green will enable more patients to follow the SAFER patient flow bundle, and help to realise the benefits of a reduced length of stay in hospital.

See Appendix 1 - Red2Green graphs which show a reduction in the average length of stay; an increase in total number of discharges per week and reduction in discharges after 5pm with a gradual increase in discharges before mid-day and 3pm.

3. SAFER

SAFER is a patient flow bundle: This consists of five elements. **S** = All patients should have a review every day by a senior doctor. This review should determine what happens next for every patient, and identify the plan for the patient to get better and leave hospital. **A** = All patients should have a planned date of discharge, which everybody involved in their care can work towards; family, hospital staff, social services, community support teams etc. **F** = The movement (flow) of patients in the hospital should start as early as possible. First discharges from the acute wards should be by 10am. **E** = Early discharge - at least a third of patients should go home by midday. **R** = Review of patients who have been in hospital for more than 7 days. Any patient who has been in hospital for more than a week should have an individual plan of what is required to get them home.

Implementation of the SAFER patient flow bundle should significantly speed up patient movement through the hospital, and decrease pressure on the emergency department (ED) and the assessment units. This will provide a better patient experience and reduce the risk of patient harm through deconditioning. It is well known that keeping patients in hospital for longer than necessary can lead to other problems.

All patients will have estimated dates of discharge (EDD) established and reviewed as part of SAFER flow bundle. As an example, ordering of tablets to take out (TTO) 24 hours in advance is also to be embedded as part of SAFER flow bundle. SAFER will be rolled out across the Trust by the end of September.

4. Hillingdon Health Care Partners (HHCP)

The Accountable Care partnership – HHCP - has several clinician led work streams; the 2 examples provided specifically impact positively on improving discharge:

- Frailty Pathway - The frailty pathway is designed to deliver care across the whole system, at the hospital Geriatricians are present in the ED, also offering telephone advice line for health and social care providers inside and out of the hospital. The frailty unit opened in March 2017, and is also having a positive impact on length of stay. The unit is a 10 bedded inpatient unit open 24/7 with a targeted maximum Length of Stay (LOS) of 72hrs. The frailty unit now offers a co-located ambulatory and assessment service which commenced the first week in September.

- Discharge home to assess - Whilst this model is still evolving, the principle of discharge home to assess is to ensure that once a patient deemed medically optimised then all efforts should be made that day or the next to discharge. The standard definition of a medically optimised patient is when the treatment in acute care is completed and the patient is now fit for discharge from a medical perspective. All relevant investigations have been completed and none further are anticipated. The patient may, however, require further therapy or social or nursing care input. This should be provided in an alternative setting.

Since starting this new model, 123 patients have benefitted from being discharged on the day or the day after being classed at medically optimised. More work is required to increase the out of hospital team capacity in order to meet the emerging demand of patients eligible for this service.

5. **Review of 'Stranded patients'** (patients with a length of stay above 7 days)

Appendix 2 details the number of DTOC and medically optimised patients over time and Appendix 3 details findings from the most recent stranded patients review, which was a snapshot audit on several of the hospital wards on a particular day. This audit details the reasons for patient delays that are deemed medically optimised and waiting on hospital processes and also patients delayed waiting for processes external to the hospital.

The following process is in place to identify and manage the stranded patients who may also be medically optimised:

- The discharge co-ordinators will have a freshly generated list every day for their wards with stranded patients including those medically optimised. The discharge co-ordinators will discuss progress and plans with the ward multi-disciplinary team (MDT) ensuring progress which will be used to update the wards, the Red2Green patient champion, the Head of Site and the Director of Operations. Patients suitable for Discharge Home to Assess will be identified on a daily basis.
- The daily Red2Green meetings will take place with the partner agencies at 10:00 to go through all the red and stranded patients presented by the ward leads ensuring support to unblock delays in the patient journey inside and outside the hospital.
- The red and stranded patient task list will be distributed to all the internal and external support teams with feedback on progress by 15:00.
- The discharge team will provide a 7 day service including daily tracking of progress and discharges.
- The Director of Operations will hold a DTOC and medically optimised (MO) conference call every Wednesday at 09:30 with senior system leaders providing escalation of any delays in the hospital to partner agencies.

In addition to other schemes, the expected outcome of the process described above will be to achieve the NHS target for 92% bed occupancy, 162 to 182 stranded patients by November 17 (40 to 45% of bed base), medically optimised patients below 3% and DTOC consistently less than 2.5%.

Themes from the stranded patient reviews and Red2Green will continue to inform system wide plans for improving timely discharges from the hospital going forward.

6. Ending 'PJ' paralysis

Pyjama of 'PJ' Paralysis is a recognised phenomenon and highlights the detrimental effect on patients of remaining in pyjamas or nightwear and in bed for extended periods while in hospital.

Ten days of bed rest for someone over 65 years old can lead to 10% loss of aerobic capacity and 14% loss of muscle strength. Research shows that patients who stay in nightwear and in bed lose muscle condition, mobility and may be more vulnerable to infection.

Getting dressed is something we do every day, but for hospital patients it can mean the difference between going home to live independently or needing support. Getting patients moving if they are able is proven to reduce hospital stay, aid recovery and accelerate the return home to independent living.

‘End PJ paralysis’ is a national campaign and has now been launched across all medical and Care of the Elderly wards, with Trust staff encouraging patients to get out of bed and to get dressed during the day.

7. Criteria led discharge

Through the implementation of criteria led discharge (CLD) nurses and therapists have been supported to safely discharge patients rather than waiting for medical staff to attend the ward and agree the patient can be discharged. This can help reduce or potentially eliminate acute care delays in the discharge of patients.

On Beaconsfield East the multidisciplinary team (occupational therapists, physiotherapist, nurses, speech and language team and medical staff) agree the criteria that the patient needs to achieve in order to be discharged from acute care. Once the patient has met these criteria the nurse or therapist can discharge the patient without a follow up review from the medical team. This model has received very positive evaluation and roll out to other wards within the Trust is being worked through with ward teams.

8. Whole system DTOC action plan (BCF)

The Trust is working with whole systems health and social care partners to achieve the requirements of the agreed action plan. The actions are tabled under 8 high impact change domains and detailed in the Better Care Fund. Whilst many of the actions are progressing, some of the requirements to make a difference to the delayed transfers of care for both health and social care remain a concern to the Trust, namely care home placement capacity for both patients with and without challenging behaviour and the availability of packages of care in patients homes.

9. Safer efficient hospital Internal professional standards for wards

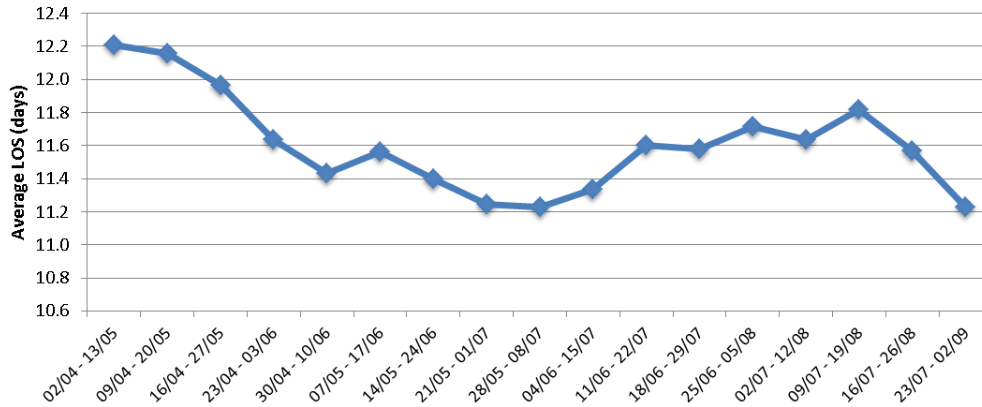
These standards are based on those already successfully used and working at other hospitals and have been developed and agreed by all the Trusts’ senior clinical leads including the medical director at THHFT. The standards represent the Trusts key values and expectations of each other to ensure safe patient care and effective patient flow. Clinical teams adhering to the standards results in teams working better together in ‘high pace areas’ like the Emergency Department and on all the trusts wards.

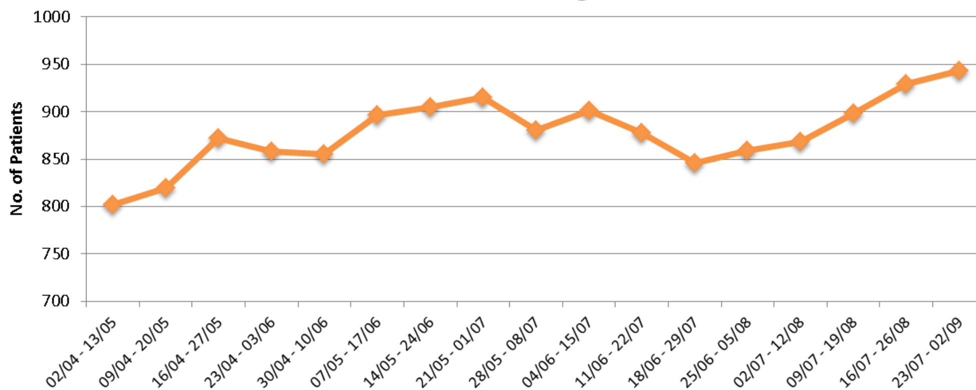
Appendix 1

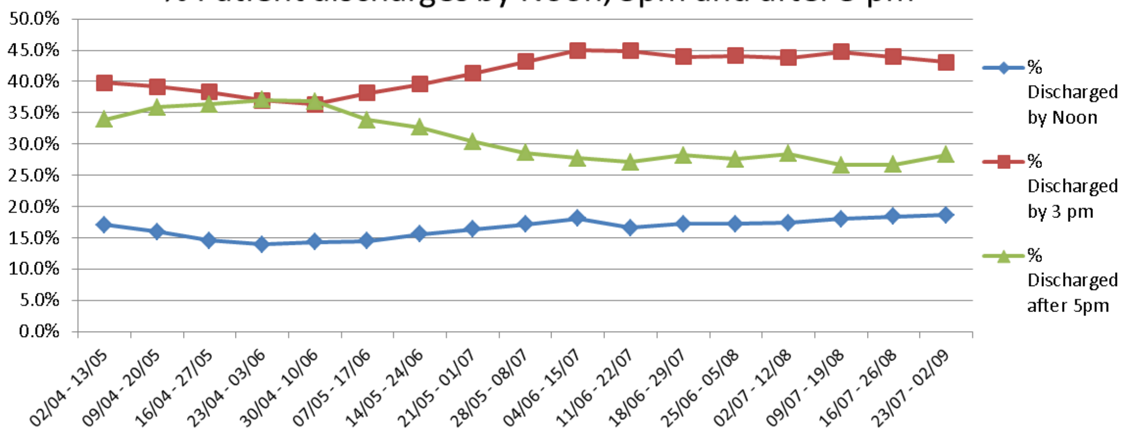
The Hillingdon Hospital NHS
NHS Trust

All Ages

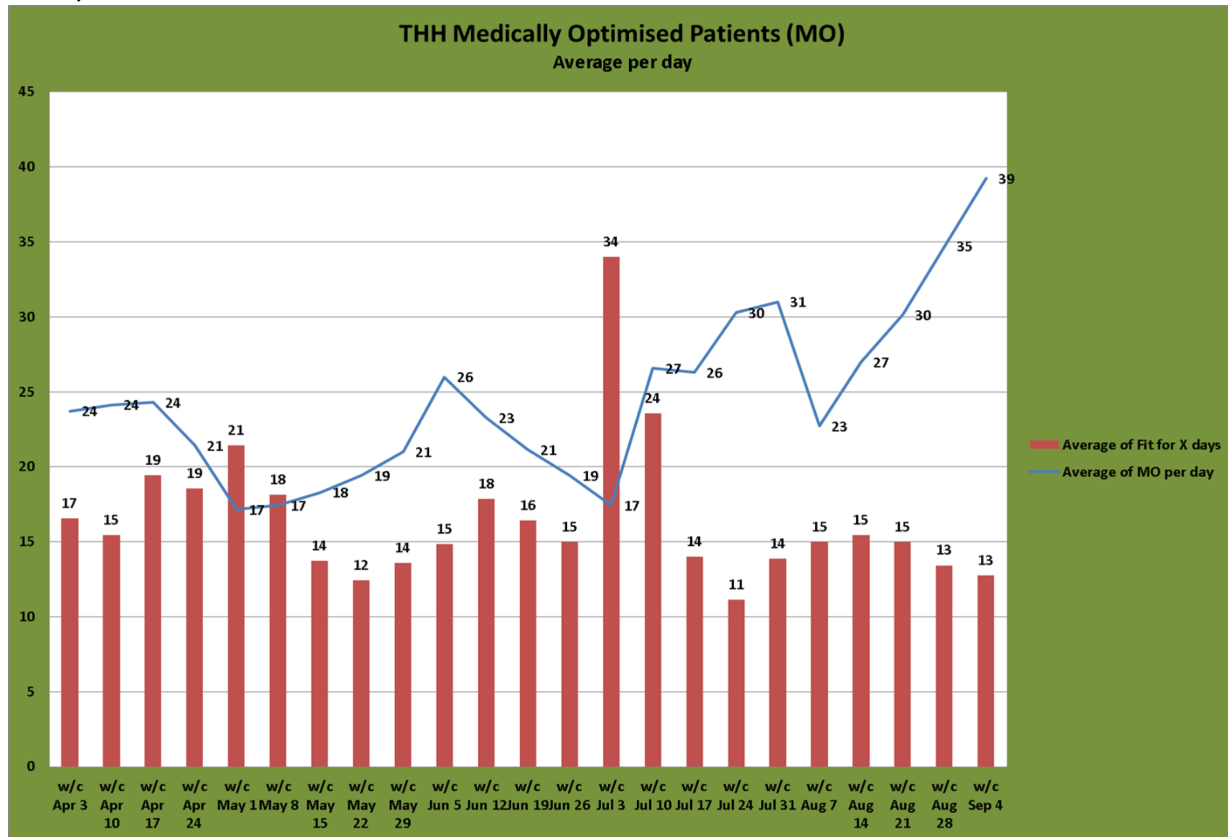
Red2Green Graphs

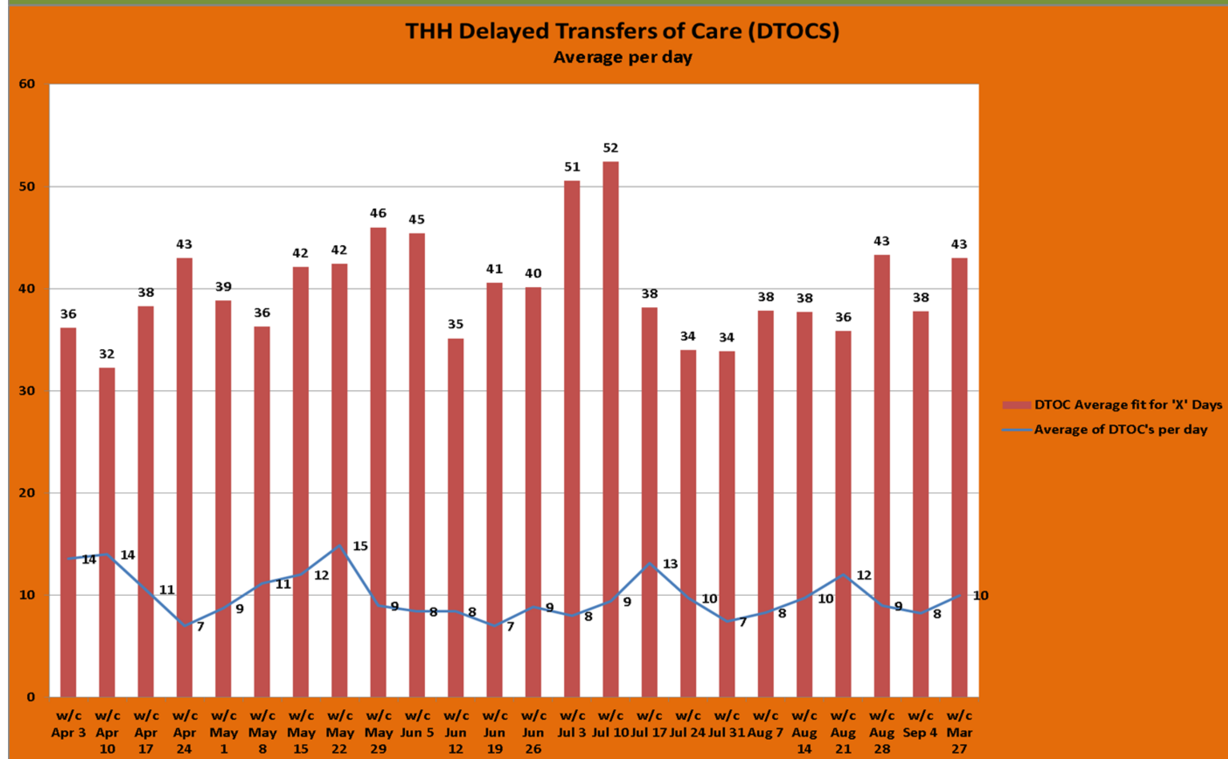






DTOC, MO Patients

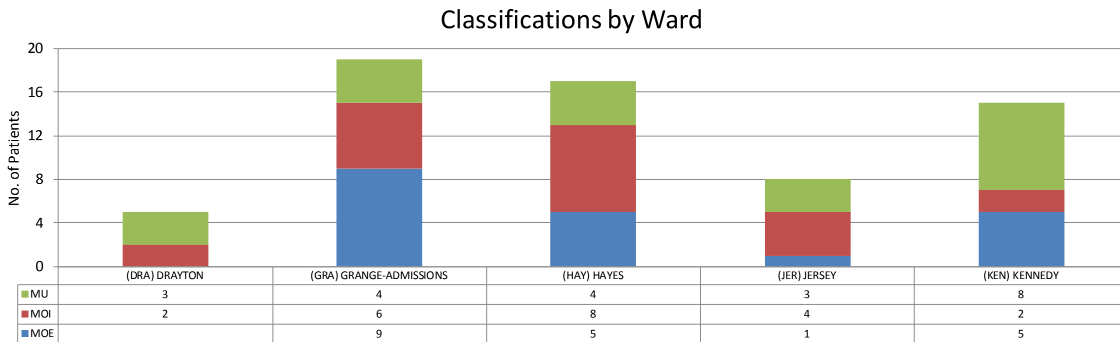




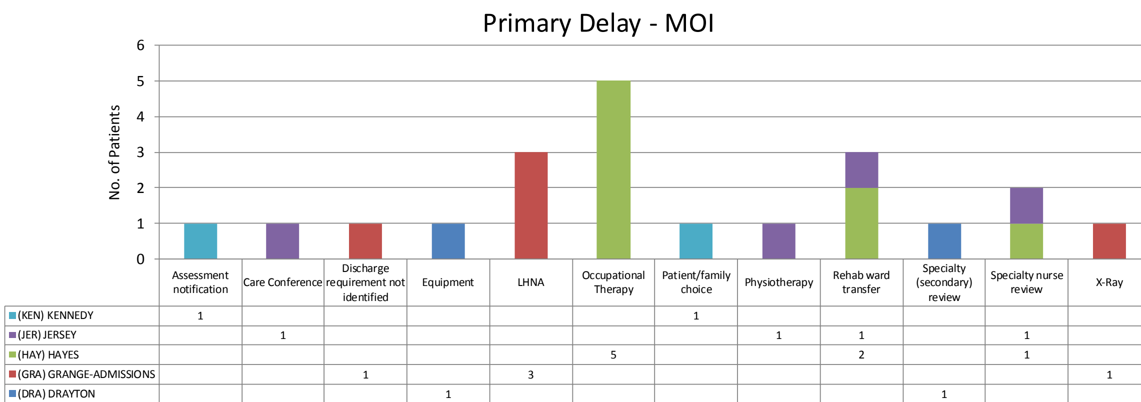
Appendix 3

Stranded Patients – Snap Shot Audit

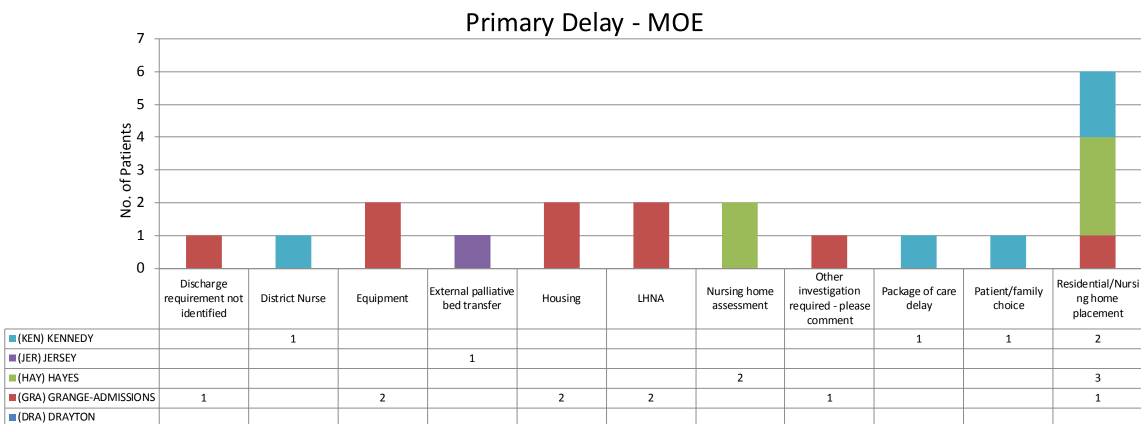
Review of Patients with Length of Stay over 7 Days



	(DRA) DRAYTON	(GRA) GRANGE-ADMISSIONS	(HAY) HAYES	(JER) JERSEY	(KEN) KENNEDY
MU	3	4	4	3	8
MOI	2	6	8	4	2
MOE		9	5	1	5



	Assessment notification	Care Conference	Discharge requirement not identified	Equipment	LHNA	Occupational Therapy	Patient/family choice	Physiotherapy	Rehab ward transfer	Specialty (secondary) review	Specialty nurse review	X-Ray
(KEN) KENNEDY	1						1					
(JER) JERSEY		1						1	1		1	
(HAY) HAYES						5			2		1	
(GRA) GRANGE-ADMISSIONS			1		3							1
(DRA) DRAYTON				1						1		



	Discharge requirement not identified	District Nurse	Equipment	External palliative bed transfer	Housing	LHNA	Nursing home assessment	Other investigation required - please comment	Package of care delay	Patient/family choice	Residential/Nursing home placement
(KEN) KENNEDY		1							1	1	2
(JER) JERSEY				1							
(HAY) HAYES							2				3
(GRA) GRANGE-ADMISSIONS	1		2		2	2		1			1
(DRA) DRAYTON											