The Pennine Acute NHS Trust

Report on Delayed Discharges for Bury and Joint Health Overview & Scrutiny Committees

Introduction

This paper has been produced at the request of the Joint Health Overview & Scrutiny Committee and outlines the operational challenges in managing patient delayed discharges across the Pennine Acute Hospitals Trust footprint. Processes are in place to monitor delays daily in conjunction with key partners. However, there continues to be a number of challenges and opportunities for further reducing the numbers of delays to ensure patients return home, or to other services, at the earliest opportunity to liberate acute beds.

1. Definitions

There are two types of delayed discharge which are monitored and managed closely across the health economies on a daily basis. The first group are the Delayed Transfers of Care (DTOC) which are externally Sitrep reportable to bodies including Trust Development Agency (TDA) and Monitor. The data also contributes to the Better Care Fund (BCF) and AQUA dataset. These are agreed each day by a multi-disciplinary team including acute, community and LA colleagues and there are financial penalties applicable to the Local Authorities. The official definition of a Delayed Transfer of Care is:

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

This group are defined as:

- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or Family choice
- Disputes
- Housing – patients not covered by NHS and Community Care Act

Table 1 below shows the number of reportable delays by site and for the Trust for 2014/15 as compared to other LA's and Greater Manchester Trusts.

Table 1: Sitrep delays 2014/15

Delayed Days Patient Snapshot by Local Authority

	2014/2015											
Local Authority	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Blackburn With Darwen UA	4	19	24	12	11	16	9	13	36	28	11	11
Blackpool UA	12	15	9	8	15	14	18	22	11	18	17	17
Bolton	31	10	16	22	15	11	8	7	8	12	23	14
Bury	14	11	24	15	12	25	18	7	5	7	9	12
Cheshire East	31	21	35	39	35	41	38	39	33	36	41	36
Cheshire West And Chester	18	29	21	21	16	25	20	39	21	20	21	21
Cumbria	38	45	50	47	35	44	48	38	34	41	52	39
Halton UA	14	6	9	4	6	2	5	7	9	11	8	10
Knowsley	3	5	6	12	3	4	10	4	3	7	1	7
Lancashire	81	120	118	98	134	133	140	90	117	135	105	107
Liverpool	39	45	37	32	31	27	31	45	33	34	32	35
Manchester	32	43	35	30	54	54	37	42	41	37	44	48
Oldham	9	6	4	7	7	5	7	11	9	11	5	8
Rochdale	16	8	18	18	10	16	17	13	12	13	13	14
Salford	9	19	20	14	2	6	20	16	23	21	13	10
Sefton	23	18	9	21	12	17	16	11	11	10	14	16
St Helens	4	3	6	5	6	4	0	2	6	9	8	4
Stockport	10	13	9	10	14	22	14	14	16	27	21	11
Tameside	8	5	4	2	5	11	8	8	9	32	31	45
Trafford	15	42	29	34	40	48	30	26	51	39	42	41
Warrington UA	20	27	10	21	22	28	22	9	13	16	30	24
Wigan	28	34	29	20	21	28	17	21	14	14	17	15
Wirral	9	9	4	8	4	8	6	5	8	8	6	8
Regional Neighbours	**468**	**553**	**526**	**500**	**510**	**589**	**539**	**489**	**523**	**586**	**564**	**553**

Delayed Days Patient Snapshot by Trust

	2014/2015											
Trust	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Bolton NHS Foundation Trust	24	6	13	18	10	8	2	6	6	10	21	11
Bridgewater Community Healthcare NHS Trust	2	0	1	0	1	3	0	0	0	0	1	1
Central Manchester University Hospitals NHS Foundation Trust	6	10	9	11	28	33	10	29	29	21	31	38
Greater Manchester West Mental Health NHS Foundation Trust	7	3	3	4	2	1	1	5	4	2	5	3
Manchester Mental Health And Social Care Trust	13	10	7	6	10	9	1	14	12	8	7	9
Pennine Acute Hospitals NHS Trust	33	27	44	38	34	45	9	24	16	21	17	27
Pennine Care NHS Foundation Trust	15	8	8	9	9	16	2	14	18	12	27	24
Salford Royal NHS Foundation Trust	12	27	22	22	12	12	0	18	27	35	25	21
Stockport NHS Foundation Trust	10	14	10	6	14	19	0	12	11	20	19	13
Tameside Hospital NHS Foundation Trust	3	2	2	0	2	0	3	3	3	27	14	27
The Christie NHS Foundation Trust	0	0	0	0	1	0	0	0	0	0	1	1
University Hospital Of South Manchester NHS Foundation Trust	21	50	40	34	41	55	16	19	48	43	40	30
Wrightington, Wigan And Leigh NHS Foundation Trust	24	32	22	16	11	20	0	16	6	6	2	0
Greater Manchester Area Team	**170**	**189**	**181**	**164**	**175**	**221**	**44**	**160**	**180**	**205**	**210**	**205**

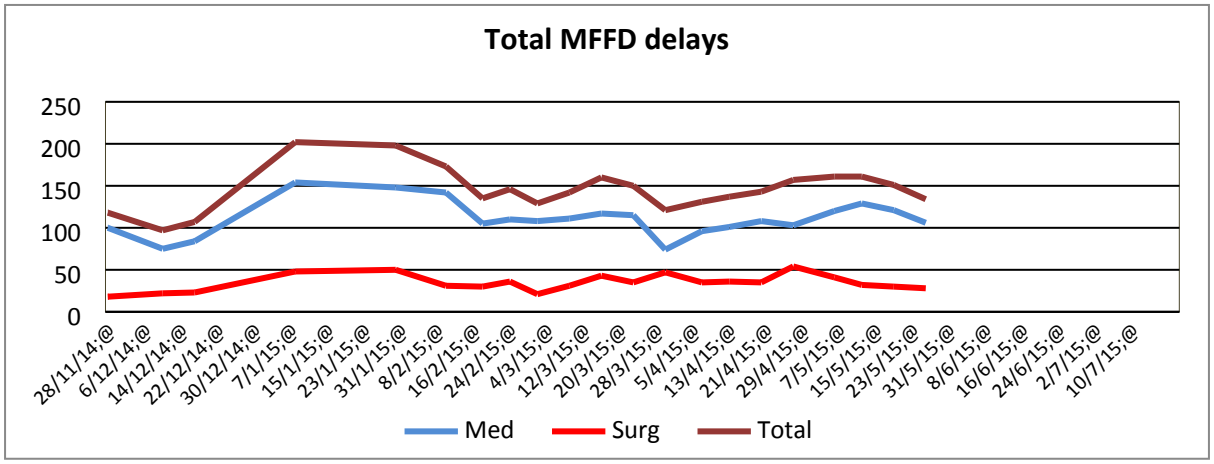
The second group of delays are those defined as Medically Fit For Discharge (MFFD) which is a much larger group than those which are externally reportable. The Trust Development Authority's (TDA) definition for medically fit patients is:

A patient that is medically fit for discharge is where a clinical decision has been made that the patient is ready to transfer. This is from a medical perspective only (usually the consultant or team that the patient is under). The patient therefore has not had a MDT decision at this point, and the patient may require further therapy or social care input prior to an MDT agreement and therefore not a reportable Delayed Transfer of Care delay. (TDA, 2015)

The Trust monitors the MFFD data on a daily basis and it is shared with partner organisations and commissioners 3 times per week. On average, across all hospital sites including Rochdale Infirmary, there are between 120 and 150 MFFD patients in the hospital at any time representing around 20% of the bed stock. Within this figure, approximately 80% are medical patients and 20% surgical patients. The medical patient delays are generally the most complex to resolve as are frail elderly patients with complex morbidities and care needs. It should be noted that the figure does not reflect those patients who are medically fit but have simple needs that do not require additional assessment.

Graph 1 below shows the most recent information since November 2014 covering the last 6 month period. It can be seen that at its peak over the extremely busy Christmas and New year period, the MFFD numbers rose to around 200 patients.

Graph 1: Summary MFFD patients last 6 months



2. MFFD Detail

The MFFD delays are collected daily in a total of 17 categories but for ease are summarised into 8 which largely follows the organisational splits. For the period Nov 2014 – May 2015 the distribution of delays is shown in Graph 2 and summarised as a proportion of total delays in Table 2 across the four PAHT sites.

Graph 2: Trend of MFFD delays by type

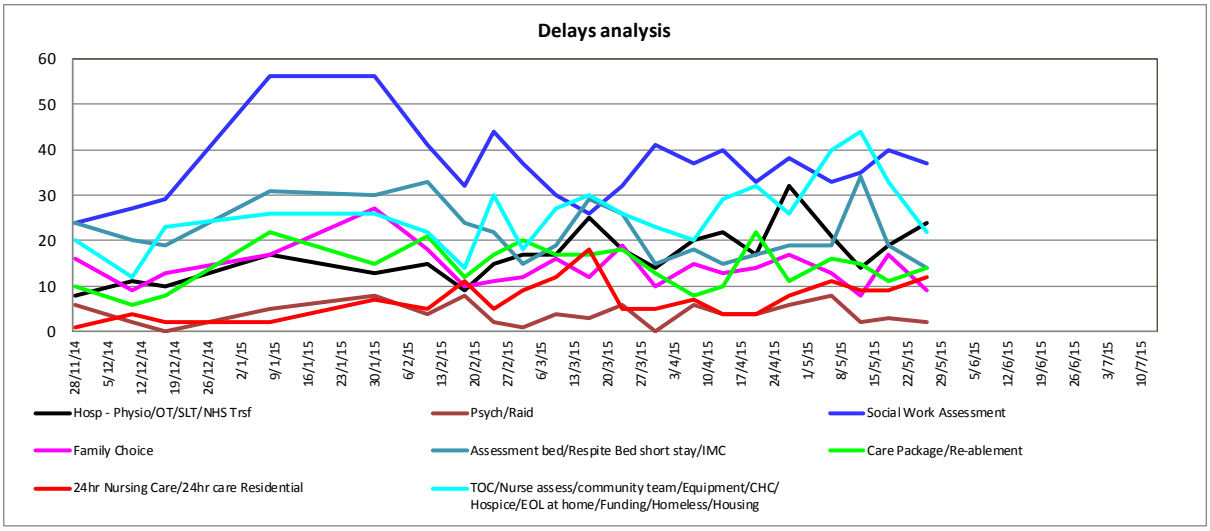


Table 2: Types of delays and proportion of patients delayed across all hospital sites

Delay Category	% of Patients Delayed
Social Work Assessment	26%
Long Term Health Services in Community	18%
Community Bed	16%
Therapy Assessments	12%
Family Choice	10%
Care Package/Re-ablement Service	10%
24hr Nursing Care/24hr care Residential	5%
Mental Health Services	3%
Total	**100%**

This data illustrates that patients awaiting a social work assessment is the most common reason for medically fit patients continuing to occupy an acute bed. However what must be considered as part of that process are patient's capacity to consent to assessment and ongoing care. This is a statutory requirement of the Mental Capacity Act 2005, in addition some of the delays are from LA's outside of the NE sector. It should also be noted that once an assessment has been completed the patient is likely to then need a service on discharge such as a care package or residential placement, which may lead to further delays should best interest meetings be needed.

It should also be noted that the number of days that a patient may occupy an acute hospital bed whilst medically fit is not collected daily. For some patients the delay can be relatively short and others much longer e.g. a patient requiring a therapy assessment is generally likely to be resolved faster than a patient requiring a nursing home placement.

The data is also captured by site and by Local Authority. This can of course change daily, however a snap-shot analysis of the most recent information from 3rd June 2015 shows the distribution as follows:

Table 3: Number of medical MFFD by site

Site	No. of medically fit patients	% of beds occupied by med fit patients	Proportion of total delays
ROH	33	16%	29%
NMGH	26	15%	23%
FGH	50	28%	43%
RI	6	33%	5%
Total	**115**	**20%**	**100%**

Table 4: Distribution of medical MFFD by local authority area and hospital site

Site	No. of medically fit patients	Proportion of total delays
Manch	8	7%
Bury	39	34%
Rochdale	35	30%
Oldham	29	25%
Other	4	3%
Total	**115**	**100%**

This data suggests a positive correlation between the number of delays in total and the distribution of patients across the four hospitals sites. The area with the lowest number of delayed discharges is Manchester with only 16 % of delayed discharges residing in the Manchester locality. It is also clear on a daily basis that delays are extended for those patients who are not on their local site.

There are some factors relating to the surgical and medical activities that differ across the Trust sites which may contribute to differences in delays e.g. All Acute and Stroke rehabilitation services area now centralised at FGH.

3. Current position

The reasons for the delays across all the sites are multi-factorial and community and LA partner organisations are working with the Trust to develop and implement solutions. Each site has a local economy action plan to improve A&E access performance and flow of

patients through the hospital beds and within the plans there are a variety of actions relating to this specific issue.

There are examples of very good collaborative working across the PAHT footprint to reduce the delay. The Assistant Director of Social Care for Bury Local Authority chairs an economy-wide Discharge Group which has senior representation from all organisations. This group has recently been re-energised and re-focused with commitment from all partners. At NMGH all staff involved in the discharge process from acute, community and local authority work as an integrated team based on the site and line-managed on a daily basis by one Trust manager. The much lower number of delays for Manchester LA and fewer delays in total for the NMGH site reflect this.

Staff are co-located on the FGH site, and soon completion of IT works will mean better access for staff to wireless to enable hot desking.

The Delayed Discharges Act made it a requirement that where the delay is attributed to a local Authority the Acute Trust could fine that Authority. This has not been consistently applied across the country. The Care Act 2014 provides flexibility in the discharge arrangement in that it makes it possible to not fine the LA but consider how to invest monies/ resources differently to support better discharge planning.

There remain however a number of challenges and areas for improvement including:

a) Acute Trust

- Accurate and consistent completion of referral forms to other organisations at ward level; this includes improving understanding of the multiple pathways available for patients on discharge
- Improvement of internal communications and escalation where progress has not been made
- Robust use of ambulatory care pathways to increase emergency admission avoidance
- Setting discharge dates on admission consistently

b) Local Authority partners

- Issues regarding resources and availability of social work staff to attend each site every day
- Care Provider capacity for intermediate care and reablement and different admission criteria across the NE sector
- Working towards a discharge to assess model
- Working on single site discharge
- One single trusted assessor documentation
- Consistent 7-day working
- Cross boundary cover for social workers

c) Community partners

- Capacity of Transfer of Care team to assess patients for Intermediate Care in addition to urgent Fast Track Continuing Health cases
- Capacity for delivery of IV antibiotics and fluids in care homes and community to prevent admission
- Capacity to discharge to assess rather than assess to discharge
- Cross boundary cover for nurse assessors

d) CCG's

- IV therapy services
- CHC funding without prejudice

4. Future partner working

Partners across the Pennine Acute footprint are continuing to work together on solutions to address the delays including:

- Working towards the one single site discharge (based on a recent pilot in UHSM). This will be driven through NE Sector discharge group.
- Working towards 7 day working for local authority
- Wider provision of reablement slots and packages of care
- Joint working agreement signed by all partners for CHC screened patients

The Health Scrutiny committee is asked to note this report.

June 2015