Delayed Transfer of Care April 2016 to February 2019

Service Descriptor: ABMU Health Board provides inpatient care across multiple inpatient sites. The care system actively manages individual patients with weekly review of complex delays and the DTOC validation process is reviewed monthly. The process is fully interagency and multidisciplinary in nature.

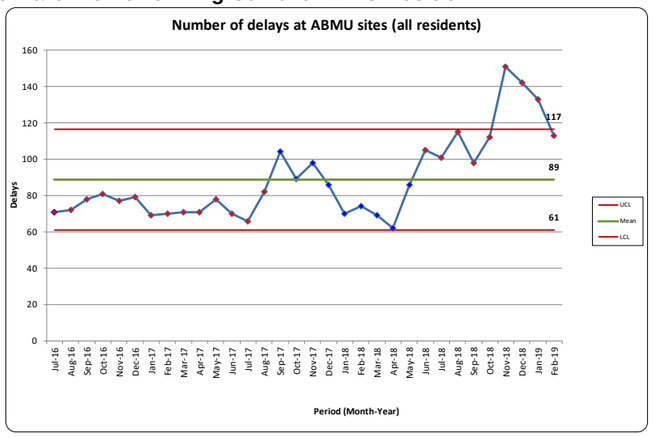
Data Development Agenda:
1)% receipt of correct and timely information
2)%of team feel confidence in data usage to develop / review care
3)%of patients who have experiende hospital acquired harms during delay

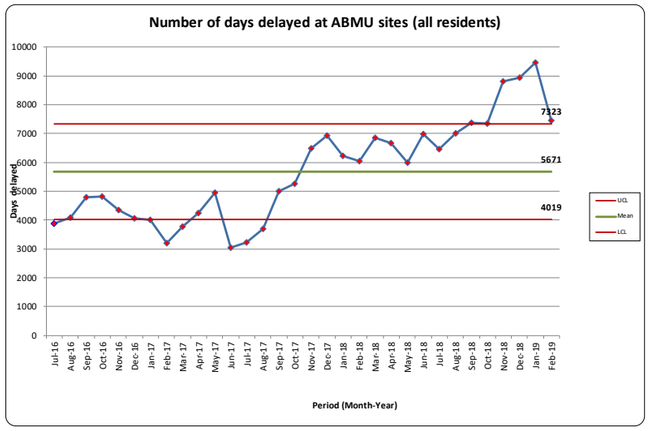
Stakeholders: All ABMU Units, Information Team, GP Clusters, Swansea City Council, Neath Port Talbot Borough Council, Bridgend County Council.

Defined Service Users: ABMU Inpatients who are at risk of or have become a DTOC.

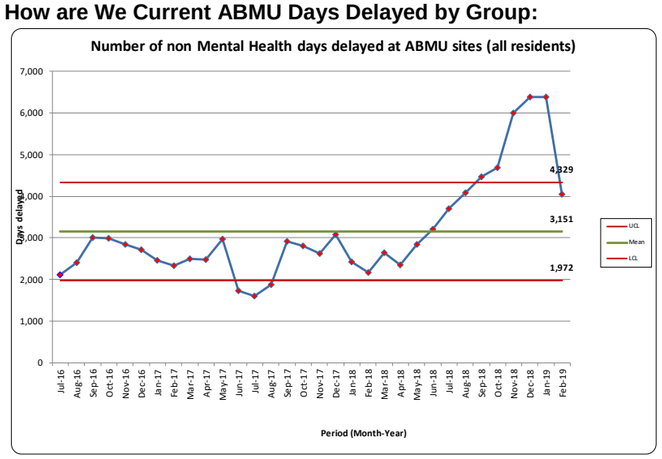
Head Line Performance: 1. To reduce number of patients who are Delayed Transfers of Care to below 50 patients on a rolling monthly basis by March 2020.
2. To reduce number of days delayed to below 4000 days on a rolling monthly basis by March 2020.
3. Aim to meet IMTP performance Trajectory 70 April 2019, April 70, May 65, June 65, July 60, August 60, September 55, Oct 50, Nov 50, December 50, Jan 60, Feb 50, Mar 50
4. Measurement of harm to patients during delayed periods

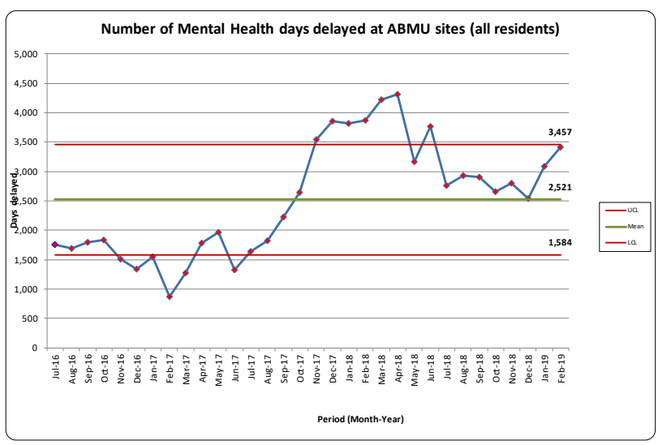
How are We Performing Current ABMU Position:





How are We Current ABMU Days Delayed by Group:





Climate:
- Although there is a general post winter reduction in DTOCs the lack of domiciliary and care home placement is beginning to impact hospital DTOCS
- Limited EMI beds provision
- Different Discharge Team Models across each LA area in Western Bay region
- Number of Social Workers, DLN and Therapy roles is not consistent across the bed base
- Trusted Assessor model not fully established.
- Reablement capacity impacted by lack of domiciliary care
- Out of hospital capacity is not aligned to meet needs

Story behind the baseline:
- Increase in co morbidity and frailty in ABMU Inpatients
- Increased complexity in discharge
- Assessment process not commencing until patient transferred to local units
- No clear link role for communication and liaison between organisations
- 'Bed Based' model of rehabilitation and long term care
- Barriers to seamless discharge / transfer pathway
- Use of correct trend data

What we propose to do to improve performance
- Standardise approach taken across all Units to weekly stranded patient meetings
- Undertake centralised monthly DTOC validation scrutiny meeting
- Undertake Monthly DTOC debrief meeting
- Improve and quicken the assessment process between organisations
- Provide improve communication and Liaison between organisations
- Implement new pathways of care to support discharge, eg home from hospital models.
- Continue investment in additional community capacity to reduce admissions
- Document all cases on the DTOC system
- Measure and reduce hospital acquired harm during delayed period.
- Provide regular patient lists to key LA colleagues.

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How are We Performing Future Projection Comparison:
Assuming that ABMU will continue to take responsibility for Learning Disabilities at Cardiff & Vale and Cwm Taf.