# **Case Study:** Establishing long stay patient reviews as standard work
## Shrewsbury and Telford Hospital NHS Trust

### What were you aiming to achieve/what was the problem you were trying to solve/what was your goal?

- The aim was to ensure that every day a patient is in hospital is a value adding day
- The problem was that too many frail complex patients were potentially becoming unnecessarily 'stranded' resulting in poor patient outcomes and experience
- The goal was to ensure that patients are given every opportunity to discharge to their own home and that any decisions about long term care are made in a more therapeutic setting and whilst independence is protected where ever possible

### What was the solution/what interventions took place?

- Case management of all 20+ length of stay patients to progress actions 5 days a week as this cohort reduced so did the threshold to case manage this now sits at 14 days
- A referral process is in place to discharge sisters so that as soon as a patient is deemed to require complex discharge planning this commences at the earliest possible point to prevent delay
- MDT review at long stay Wednesday to support case manager with actions outside their scope and fresh perspectives
- Weekly escalation meeting every Friday afternoon (executives present) to escalate themes and specific challenges at executive level
- Check Chase Challenge every day on all wards to promote a red to green philosophy for every patient (zero tolerance for non value adding days)

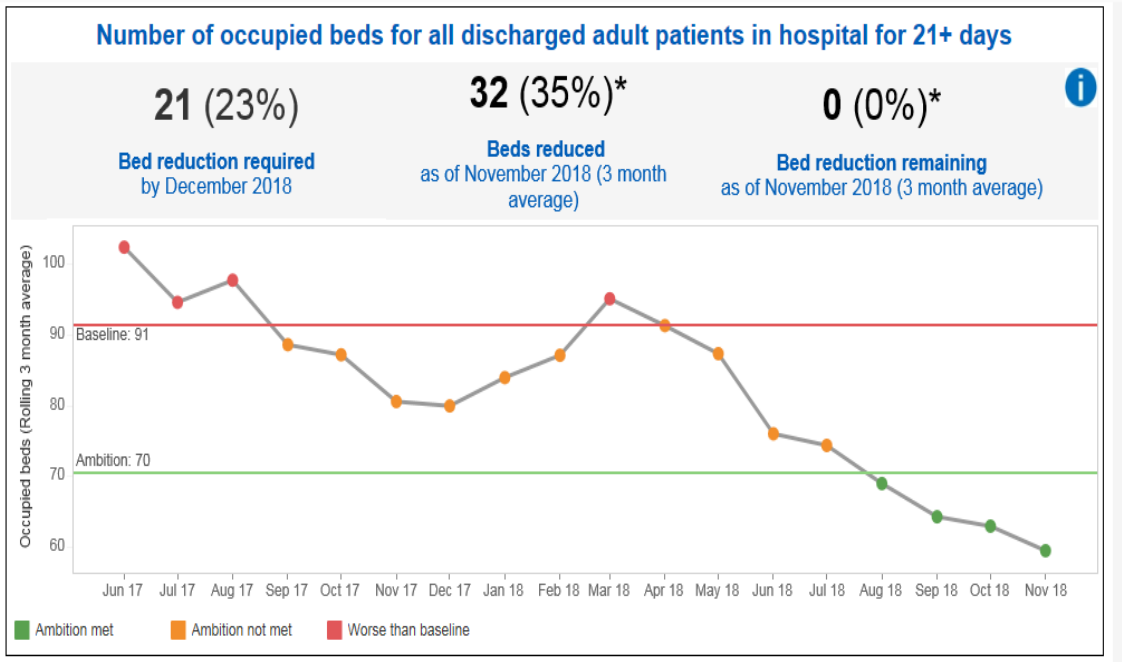
### What were the learning points? What worked well/less well and why? What else did you observe? Were there any unintended consequences?

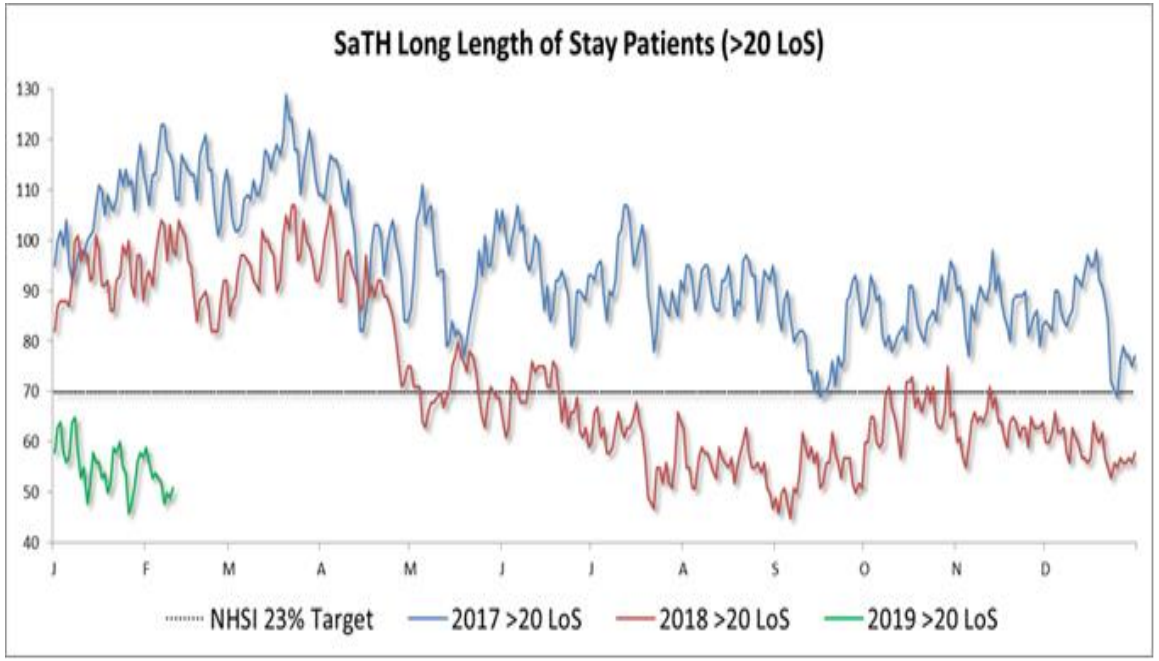
- Case managers taking ownership for completing outstanding actions and overview of clinical delays and social care delays ensured a holistic discharge plan supporting EDD's
- Working with the frailty team to develop a joint health and social care criteria for discharge ensured that as patients enter the bed base the discharge plan is already set for those most likely to become stranded
- Weekly commitment from system partners is essential for delivery of an effective long stay Wednesday approach
- Celebrating success and positive patient outcomes maintained the improvements and engagement both internally and externally particularly at ward level

### Describe the measured results/ What was the impact on your aim or goal?

- Consistent and sustained reduction in long stay patients across the trust 44% reduction from base line
- Increased number of patients discharging to pathway 1
- Reduction in DTOC
- Overall reduction in LOS (for medical patients) 13 days in February 18 – 9 days February 19

# Findings and Impact:




# Next steps:

- AEP audits to support clinical engagement also to revisit findings from 17/18 AEP audit and scope changes
- MADE events every Friday to support with Weekend discharges
- Patient stories to support and strengthen the data and case for change

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