Appendix D

Embedding the principles of Red2Green/SAFER at West Hertfordshire Hospital Trust to optimise patient flow, reduce delays to discharge and improve patient safety and experience

'Red and Green Bed Days' are visual management system to assist in identification of wasted time in a patient's journey in order to optimise patient flow. A Red day is when a patient receives little, or no value adding acute care. Red days fail to contribute to a patient's discharge from hospital. A Green day is when a patient receives care that can only be in an acute hospital bed and everything that has been planned or requested is achieved. Green days ensure that a patient receives an intervention which supports their care pathway out of hospital and into the best setting for their needs. The Red and Green process focusses on a multi-disciplinary board round.

The SAFER patient bundle is linked to the Red and Green day process and blends five elements of best practice to achieve cumulative benefits. It is a practical tool designed to reduce delays to discharge in adult inpatient wards (excluding maternity), reduce length of stay, optimise patient flow and improve patient experience and safety.

West Hertfordshire Hospital Trust **(**WHHT) has committed to implementing and embedding Red2Green/SAFER in all acute adult inpatient areas across the trust. In February 2018 the SAFER Implementation Manager (SIM) was appointed to drive the initiative forward. The trust welcomed the support of the Emergency Care Improvement Programme (ECIP) team to embed the principles and challenges of Red2Green/SAFER. The trust initially selected 3 pilot wards to work intensively with. The wards were each sponsored by a member of the executive team. WHHT has taken the learning from this process and is currently rolling it out across the trust to improve patient flow and reduce delays to discharge in acute inpatient areas.

Red2Green predominantly focusses on the board round to identify what care or intervention a patient needs to move their care closer to discharge with a 'home first' if not, 'why not' approach to minimise risk adverse behaviour. The trust is working towards all wards having one multi-disciplinary team (MDT) board round, a safety huddle or an abridged board round in the morning to highlight any concerns, i.e. sick patients, potential discharges and required actions; and another one later in the day to follow up actions and to highlight potential discharges for the following day. The board rounds are held at set time and attended by

members of the Integrated Discharge Team (IDT), nursing, therapies medical teams. Each patient's care and management plan is discussed in turn, and decisions around discharge are made.

The Deputy Head of the Integrated Discharge Team (IDT) will be providing ongoing training for consultants, doctors, matrons, nurses, therapists, hospital social workers and members of IDT around Continuing Health Care (CHC) assessment, advice on completing fast track referrals and the Decision Support Tool (DST) to support discharge planning.

Ward staff are encouraged to identify and proactively manage any constraint or block at the board round, which contributes to a delay in discharging a patient from hospital. Those constraints that cannot be managed locally are escalated to the ward matron to be raised at the bed meetings for action. Ward staff are also electronically capturing the root causes of delays which fail to contribute to moving a patient's care closer to discharge. The trust is producing Pareto charts for the 3 pilot wards to analyse the frequency of constraints, in order to better identify issues which negatively impact on patient flow.

The SIM is working with the wards to improve discharge planning starting from the point of admission. One of the three pilot wards is trialing giving patients the 'Patient Discharge' letter soon after arrival on the ward to set expectations around discharge. The letter informs the patient of their provisional date of discharge assuming ideal recovery and no delays. This letter can be downloaded and printed directly from the intranet and edited to suit individual ward areas. The information pack that a patient is given on admission to a ward is also being reviewed by a sub-committee of the Discharge Quality Working Group, which is chaired by the Clinical Director for Care of the Elderly. It will include information expectations around discharge and information about the Patients' Lounge.

The Deputy Head of Nursing has been working closely to promote the Patients' Lounge. There has been increase in the number of patients admitted to the Patients' Lounge. Ward staff are encouraged to the notify Patients' Lounge staff of planned admissions the day before discharge. Electronic communication has recently gone out to all staff raising the profile of the Patients' Lounge to improve daily admission numbers.

The trust is aiming to achieve earlier in the day discharges and improve patient flow from emergency assessment areas through better discharge planning. Wards are encouraged to proactively identify patients ready for discharge in advance of their date of departure to reduce delays at discharge. Statistical process control (SPC) charts are produced for the 3 pilot wards on weekly basis to capture the number of patients discharged by midday, the

number of stranded, super- stranded patients and median length of stay (LOS). These charts are sent directly to the ward leads so that they can take ownership of the information. Visual data representing key metrics will also be produced for other wards as the timetable for embedding Red2Green/SAFER is rolled out.

Doctors and pharmacists are working smarter to prescribe take home medication (TTAs) as soon as a discharge date is indicated. The trust is also increasing its number of on-ward non-medical prescribing pharmacists.

Therapies are moving away from the expression ‘back to baseline.’ They have implemented a “Functional Clinical Criteria for Discharge” worksheet to enable therapists to identify the minimum a patient needs to be able to do in order to be ready to leave the hospital. Therapists are also engaging sooner with patients during their admission rather than when they are deemed medically stable for transfer in order to reduce unnecessary delays to the discharge process. Therapies are planning interactive workshops to enable a culture change around SAFER and discharge risk assessment.

The ‘Nurse/Criteria Led Discharge’ group is currently being established as a sub-committee of the Discharge Quality Working Group. The physiological aspect for setting the ‘clinical criteria for discharge’ (CCD) is being progressed to support nursing autonomy around discharges in order to reduce delays and optimise patient flow

The Head of IDT, the Divisional Manager of Medicine, the SAFER implementation Manager, the Associate Divisional Director and a senior member of the therapy team meet weekly to discuss management plans that for stranded and super-stranded patients to move their care closer to discharge and improve patient flow. The group is proactively working towards having no patients with a LOS >100 days by July and early identification of patients with very complex discharge planning needs.

The Discharge Process Work Group, chaired by the Director of Performance meets on alternate weeks to the Discharge Quality Working Group, which is chaired by the Clinical Director for Care of the Elderly with the objective of optimising patient flow, reducing delays to discharge, improving patient safety and experience.

A Red2Green Workshop has been planned for 2/7/18, which will be supported by ECIP. Doctors, matrons, ward managers, senior nurses, therapies and IDT will be invited to share learning around the embedding process.