Item 4b- Hospital Patient Flow Topic Group- Background Report

1. Purpose of the report

1.1 To provide members with background information to the issues regarding patient flow within Hertfordshire's two main acute hospital trust, namely East and North Herts Hospital Trust (ENHHT) and West Hertfordshire Hospitals Trust (WHHT).

2. Background

2.1 The scrutiny was agreed by Health Scrutiny Committee in 2016. The objective of this scrutiny is to examine patient flow process at the two Hertfordshire acute trusts to identify good practice, blockages in admission and discharge pathways and recommendations for improvement.

2.2 Members will be seeking information to answer the following questions:

- What management and clinical processes does the Trust have in place prior to hospital admission?
- What processes are in place across all relevant partners to plan discharges once a patient is admitted to a ward?
- What joint oversight and monitoring is in place to ensure timely discharge and to prevent readmittance?

3. Context

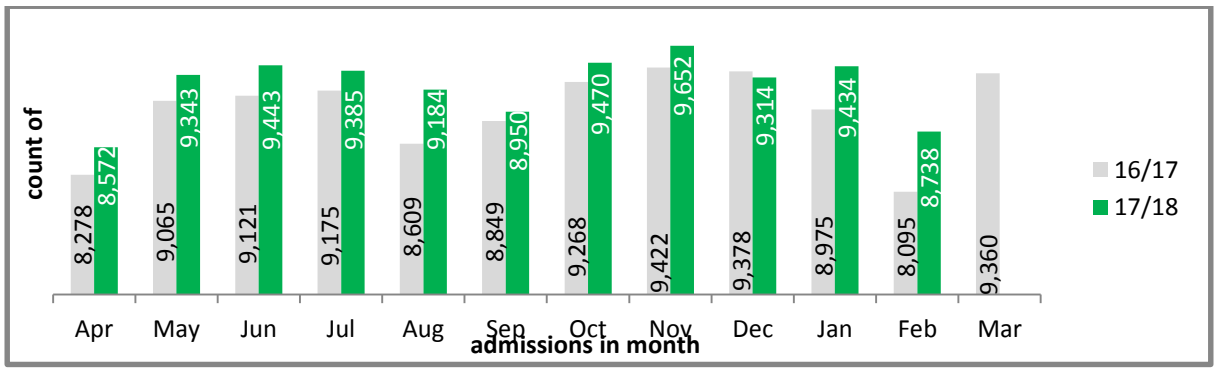
3.1 Patient flow describes the activity and processes that allow individuals to move through the different stages of their care effectively and with minimal delays.

3.2 In an acute hospital Trust this encompasses all the activity concerned with an individual's attendance at hospital, their potential admission and their ultimate discharge from the Trust's care.

3.3 Poor flow can result in a number of pressures on the system, including overcrowding in Emergency Departments, clinical areas being used as waiting areas and patients being admitted to wards that are not best suited to manage their care. Most importantly, national evidence shows that in these circumstances, clinical outcomes are measurably worse, particularly for frail older people, who may decondition due to extended periods in hospital beds reducing their ongoing independence.

3.4 Managing patient flow requires coordinated activity across the health and social care system. There is an increase demand on hospitals nationally. The growing number of emergency admissions and pressure on emergency department means that most hospitals in the county have to run well above optimal levels of bed occupancy.

3.5 In Hertfordshire, there have been 101,484 non elective admissions between April 2017 and February 2018. This is an increase of 3.3% when compared to the same period last year (98,234 in 2016/17). This is further illustrated in the chart below.



3.6 A significant proportion of hospital attendances do not require admission or can be discharged in the same day. However, where a patient is admitted, particularly when they have complex health issues or are frail, there will be a number of procedures, assessments and interventions that need to be coordinated by the trust and other partners to ensure the best patient care. A delay on any one of these elements can lead to a patient waiting unnecessarily.

3.7 Once it is determined clinically and by a multi-disciplinary team that a patient no longer requires hospital interventions and is safe to transfer then they are ready to be discharged. Where this cannot happen immediately then this is classed as a delayed transfer of care (DTOC). There are a number of causes for these delays, although the most common, both nationally and in Hertfordshire is the shortage in homecare capacity to allow patients to return home safely and the pressure on step down and intermediate care beds.

3.8 Over the course of 2017/18, Hertfordshire has seen a significant reduction in the proportion of patients experiencing delayed transfers of care. Recent figures showed that Hertfordshire has achieved a 47% reduction in social care related delays over the course of the year and has the 18th highest rate of improvement in the country (out of 152 local authority areas) with 12.3 days delayed per 100,000 population. Nonetheless, Hertfordshire is still not meeting its mandated target of 2.6 bed days of delay per 100,000 population.

3.9 The issue of delayed transfers of care is more acutely felt in the west of the County and in particular delays caused by a shortage of homecare. Between April 2017 and February 2018, Herts Valleys had 17, 975 days of delay compared to 7,488 for East and North Hertfordshire. The challenges in the local homecare market in West Hertfordshire make it difficult to secure homecare packages to support timely discharges from West Hertfordshire Hospitals Trust and Hertfordshire Community Trust bed-bases. A range of initiatives are in place to try and reduce further the level of DTOC.

3.10 The significant interdependencies between public health, health and social care means that improving patient flow requires integrated activity across health and social care partners.

Both acute trusts, with the County Council, have supported the establishment of Integrated Discharge Teams (IDTs). These are multi-disciplinary teams, jointly managed by the County Council and the respective hospital Trust, designed to undertake a proactive discharge planning process and to enable safe, timely and quality discharges for complex patients who may need the support of more than one organisation.

4. Processes prior to admission

4.1 Both Herts Valleys Clinical Commissioning Group and East and North Hertfordshire Clinical Commissioning Group lead on the system-wide initiatives to reduce attendances at Accident & Emergency Departments and admission to the hospital. These include work to redevelop the pathways and services available for the conditions that most often result in hospital admission, including Respiratory conditions related to Chronic Obstructive Pulmonary Disorder (COPD) and asthma, stroke and diabetes.

4.2 The county-wide 111 service, now known as Integrated Urgent Care, has already resulted in a reduction in ambulance dispatches by supporting people to choose and access more appropriate services outside the hospital setting. Initiatives such as the Early Intervention Vehicle in East and North Hertfordshire and the Emergency Care Practitioner Car in Herts Valleys are equipped to deal with issues in the community which might previously have been dealt with through an ambulance call out and a hospital admission.

4.3 Both Acute Trusts have pathways outlining how a patient should transfer within the Trust from the point of attendance. The Adult Emergency Department Flow Chart (Appendix A) illustrates how this process operates within WHHT.

4.4 A number of initiatives focus on having in place a range of support in the Emergency Departments that support ambulatory patients without the need for ongoing care within the hospital. Both acute trusts have GPs in their Emergency Departments to help manage and divert non-urgent patients. In addition, the IDTs in both Lister and Watford General have invested in front-of-house social care support which can provide very short-term care to enable someone to return home after a conveyance to hospital – providing both personal care and confidence until they can return to their usual level of function.

4.5 Recognising the particular risks of admission, lengthy stays and delayed discharges for patients who are frail, both Trusts have established specialist frailty units which provide a multi-disciplinary assessment (the Comprehensive Geriatric Assessment) allowing an individual's needs to be better understood and the most appropriate support provided. An audit completed in October 2017 showed that the frailty unit in Watford General had increased the percentage of patients discharged on the day of A&E attendance from 23% to 60%. Further information on the frailty units is included as Appendix B and Appendix C.

4.6 Care Homes across the County are supported to ensure they are able to make appropriate referrals to hospital. This includes ensuring that all care homes have easy and timely access to GP support in the community. In the West, the Care Home Improvement Team and Medicines Management Team provides support to those homes with the highest referral

rates. The Complex Care Premium scheme in the East means that more care homes have staff trained and able to manage complex cases appropriately in the community.

4.7 Lister piloted the Impartial Assessor for care homes model. This role not only supports the liaison between the acute trusts and care homes around more complex patients, but also supports both the trusts and the admitting care homes in ensuring medically fit residents who may need additional support but do not need to be admitted. This model will commence in Watford General from 8th May.

4.8 Clinical Navigator services operate from both Trusts and are focused on prevention of admission and same day turnaround from the Acute Admissions Unit (AAU). Experienced Clinical Navigators, with first-hand experience of the wider support available including other NHS services (e.g. Community Mental Health Teams) but also the voluntary and community sector support, can case manage individual cases but also raise the awareness of the these alternative pathways and options to other clinicians and professionals within the Trusts.

4.9 There is evidence that early discharge planning minimises the likelihood of delays, by allowing the appropriate interventions to be identified and mobilised at an earlier point and by helping to ensure that all the relevant information is captured early on. The IDT in Watford General is working to establish better mechanism so that it can be notified earlier about patients that are likely to require complex discharge planning. The aim is to receive all relevant referral notifications within 48 hours of admission to hospital. At present the average notification can be 8 days, so the hospital trust and the IDT are prioritising initiatives that challenge existing practice and encourage earlier referrals.

4.10 In Lister Hospital, process are in place so that as soon as a patient arrives at the hospital, either via ambulance or as an elective admission, the IDT is made aware of their name ward and Estimated Discharge Date (EDD). The Hospital Acute Liaison Officer (HALO) will identify potentially complex patients as soon as they arrive to start gathering the relevant information to discharge. This reduced the need for additional assessments and so speeds up the discharge process.

5. Planning and effective discharge from hospital

5.1 For less complex patients who have been admitted, discharge does not typically involve the IDT.

5.2 A Hospital and Community Navigation service, funded through the Improved Better Care Fund and operating county-wide, is supporting a greater number of patients to leave hospital. The service draws on the expertise and networks of voluntary and community sector organisations and works on the principle that many people can benefit from non-clinical, non-statutory support (for example, main sure an individual comes home to food in their house). Since it commenced in October 2017, the service has already received over 2,000 referrals.

5.3 More complex patients may require a number of interventions whilst in the care of the Trust, sometimes from different departments and different specialisms – in many cases these interventions need to be carried out in a specific sequence and are therefore

dependent on other information or results being available. The more of these 'handovers' required the greater the need for coordination and management to maintain patient flow and reduce an individual's length of stay.

5.4 Red2Green and SAFER are two national tools that aim to minimise delays and length of stay within acute Trusts and empower hospital staff to improve 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. Both Trusts have committed to implementing Red2Green / SAFER in all acute adult inpatient and embedding the methodology and practice across their staff. Further information on how the initiative is being implemented in WHHT is provided in Appendix D.

5.5 The IDTs in both acute trusts play an active part in these initiatives and in encouraging proactive discharge planning. Both IDTs attend daily Board rounds which track patients through their diagnostics, treatment and recovery and include, alongside clinical and nursing staff, the wider team of therapists, social care and voluntary sector staff. Board Rounds allow for discussions on the current status of patients and how this might impact upon their Expected Discharge Date. It also allows potential barriers to discharge to be highlighted, whether this is medical, related to patient choice about the ongoing support they wish to receive, or is related to a lack of support to enable transfer.

5.6 The IDTs work closely with both medical and surgical wards to manage length-of-stay (LOS). Longer-staying patients are reviewed by IDT and discharge plans are amended as and when appropriate. IDT also contributes to a multi-disciplinary review of EDD and discharge plans for longer-staying / complex patients. There is a care choice facilitator working in the East and North IDT who works with self-funding patients to support their discharge from start to finish. Watford General Hospital has also introduced a care choice facilitator through a 6 month pilot which started in February 2018. These services mean that patients and their families have a single point-of-contact they can use to gain financial and care home advice.

5.7 The earlier identification of an individual's discharge date and the proactive involvement of the IDT in establishing the need for ongoing support, reduces the likelihood of delayed discharge.

5.8 There are a number of reasons which contribute to a discharge not taking place when expected. The most prevalent is the shortage in home care capacity, meaning that people are unable to be discharged because the appropriate package of care is not yet available to be provided within the community. Other reasons include delays in assessment (both social care assessment and CHC assessments) and situations where patients choose not to leave the hospital. Comprehensive information on the number and cause of delays accompanies this report as Appendix D.

5.9 System-wide activity has been focussed on reducing DTOC to support patient flow. Both Trusts are developing interventions in line with NHS England 8 High Impact Changes model

which focuses upon the initiatives and key areas focus for all systems looking to improve their performance. This includes:

- activity to embed 7 day working arrangements across all partners, to avoid increased delays over the weekend – both IDTs are now able to provide 7 day staffing cover
- the implementation of Discharge to Assess models, where people are able to leave hospital once they are medically optimised and receive their ongoing assessments at home or in another setting. Discharge Home to Assess models are now operating across the County and enabling more people to leave hospital at an earlier point. An example of ENHHT's Discharge pathways is included in Appendix B.
- investing in systems to monitor patient flow – as part of the STP Hertfordshire will be investing in a new urgent care system that will allow for real time reporting on hospital pressures and patient flow.

5.10 There are also instances an expected discharge can fail on the day. This can be for a variety of reasons including the patient suddenly referring additional medical intervention, a failure in patient transport meaning that the individual cannot return to their place of residence, the provision of the appropriate medicines for the individual to take home. The number and cause of failed discharges are regularly reviewed and the appropriate multi-agency action taken to resolve.

5.11 Patient flow is not entirely restricted to the hospital trusts. Where patients require rehabilitation and intermediate care they will transfer from the hospital trust to this alternative community health provision. This bed capacity can, in turn, experience delays when people have finished benefitting from the bed-based intervention but are unable to move on. This has a direct impact on flow within the hospital as those patients who require intermediate care are unable to leave the hospital until an appropriate community bed is available.

6. Oversight and monitoring

6.1 Within both hospital trusts there is clear oversight and reporting to manage the issue of patient flow.

6.2 Within East Hertfordshire, a system-wide teleconference call is held daily covering all Hertfordshire patients who have an Estimated Discharge Date for that day. Contributors to the conference call typically include IDT, the Clinical Commissioning Group, Hertfordshire Partnership Foundation Trust, Hertfordshire Community Trust and Continuing Health Care. The call also includes forward planning for patients with an EDD of up to five days. The call is structured to differentiate between patients who are clinically assessed as no longer needing acute care and those patients who have been assessed by other professionals, social workers or therapists and are awaiting support and / or equipment before they can be safely discharged.

6.3 The East and North Herts IDT is managed by the Deputy Chief Operating Officer at the Trust and links in with our operations cell (responsible for managing hospital beds and patient flows through the hospital) daily. The IDT has access to rapid escalation within the Trust's

operations cell processes including direct access to managers and heads of service as required.

6.4 The IDT works closely with both medical and surgical wards to manage length-of-stay (LOS). Longer-staying patients are reviewed by IDT and discharge plans are amended as and when appropriate. IDT also contributes to a multi-disciplinary review of EDD and discharge plans for longer-staying / complex patients – this review always updates the patients for discussion on daily con call. For patients with estimated LOS over 33 days a report is run from nerve centre and patients reviewed and monitored weekly.

6.5 In the west, internally to IDT and HCC, two databases are maintained that track the patient journey through the hospital and highlight any delays in transfer. Reports supporting these tools are run on a daily basis and used to inform discussion across IDT and WHHT to minimise the risk of people becoming delayed awaiting transfer of care but also to ensure that other activities are carried out on a timely way to prevent delay at a later stage i.e. plotting the timeliness of social care and continuing health care checklists being completed.

6.6 This information is then pulled together in a daily SITREP which is circulated across the wider Herts Valleys Health and Social Care System, and details the volume of discharge activity over the course of the week, the volume of patients delayed, the reasons why and the impact on the number of bed days lost. It also details other key information such as people who are 'system waits' (people who are medically fit for discharge but are not currently a formal delay (e.g. EDD has not been passed, awaiting an activity to take place external to IDT). It is this SITREP that provides the daily metrics that indicate the demand on IDT.

6.7 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.

6.8 Activity and performance on both the East and the West of the County is scrutinised and challenged by the wider health and social care system, through the respective multi-agency System Resilience Groups (SRGs) and the two Local A&E Delivery Boards. The latter brings together the Chief Executives of the local NHS Trusts along with the Director of Adult Care Services to consider and A&E performance and improvement. There are national targets around Non-Elective activity, Delayed Transfers of Care readmissions within 91 day which are incorporated within Hertforshire's Better Care Fund Plan and reported against on a quarterly basis to system partners and to the Health and Wellbeing Board.

Background information

Good Practice Guide – Focus on improving patient flow

https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf

Appendix A – Emergency Department Flow Chart (WHHT)

Appendix B – Hospital Flow – Frailty presentation (ENHT)

Appendix C – Frailty Unit information (WHHT)

Appendix D – Red2Green/SAFER information

Appendix E – DTOC Analysis