NHS CHIEF EXECUTIVE AND EXECUTIVE MEMBER RESPONSE	
NAME OF TOPIC GROUP: HOSPITAL FLOW	
CHAIRMAN: CHRIS WHITE	**DATE OF SCRUTINY: 18/05/2018**
SCRUTINY OFFICER: CHARLES LAMBERT	**DATE REPORT PUBLISHED: 02/06/2018**
LEAD OFFICER: ED KNOWLES	**DATE RESPONSE DUE: 02/09/2018**
EXECUTIVE MEMBER: COLETTE WYATT-LOWE	**DATE RESPONSE RETURNED:**
NHS CHIEF EXECUTIVE: HELEN BROWN *Acting* (WHHT), NICK CARVER (ENHT), DEBORAH FIELDING (STP), KATHRYN MAGSON (HVCCG), BEVERLEY FLOWERS (ENHCCG)	

Recommendations:	**Executive Response:** *e.g. To carry out the survey in xxxxxx (month/year)* *(Note: All abbreviations used must be set out in full the first time they are used)*
2.1 West Hertfordshire Hospitals Trust (WHHT), East & North Herts Trust (ENHT) and Hertfordshire County Council (HCC) work together to standardise the discharge process and introduce consistent practice across the county. This should be facilitated by: a) Planning for discharge by establishing estimated discharge dates (EDD) within the 24 hours of	WHHT, ENHT and Hertfordshire County Council will continue to work together to standardise the discharge process and introduce consistent practice across the county. **a) EDD work** In WHHT the national initiatives, Red2Green[1] and the SAFER[2] patient flow bundle will continue to be used to optimise patient

[1] 'Red2Green looks 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.

admission b) Improved use of community therapy following patient discharge c) Routine inclusion of pharmacists on board rounds. d) Implementation of Computers On Wheels (COWs) initiative A target of December 2018 should be set for implementation of these actions. (4.4, 4.6, 4.8)	flow, reduce delays to discharge and length of hospital stay, and improve patient safety and experience. SAFER blends five elements of best practice to achieve cumulative benefits including a focus on ensuring every patient has an estimated discharge date (EDD). The Discharge Working Group is also looking at methods to audit those patients that are discharged before or after their EDD. If achieved, this will enable further learning that could be integrated across services. The SAFER Implementation Manager continues to work with ward staff to ensure principles are consolidated and embedded within the working culture. WHHT highlight that the important element for discharge, is the Integrated Discharge Team (IDT) knowing the EDD within 48hours of admission. The trust addresses this through twice weekly length of stay (LoS) meetings for all inpatients with stays of 7 days or more. There is also ongoing work with the Fresh Eyes consultant board rounds where the attending discharge coordinators prompt early referral. The Trust is committed to continual improvement in this area, and achieving best practice levels. Within ENHT, the Integrated Discharge Team (IDT) currently support a multi-disciplinary team (MDT) board round on weekdays where all patients are discussed and estimated discharge dates (EDD) are set and agreed. EDDs are set based on medically optimised criteria by a doctor and the rest of the MDT (therapists, nurses, social workers) work together to ensure that a patient's discharge actually takes place on the EDD. After every board round the IDT member feed back the updates

[2] S – Senior review, A – All patients will have an expected discharge date, F – Flow of patients will commence at the earliest opportunity, E – Early discharge, R – Review by an MDT. (LINK)

	to a central administrator, and in particular, any changes to EDDs. All this information is held on the 'con call' database and is discussed daily on a system call with internal and external partners to challenge any blockages and so ensure a safe and timely discharge as well as monitor length-of-stays. Working in this way has reduced the need for paper referrals which caused delayed discharges for patients. This way of working has also reduced the need for formal escalation as blockages are transparent through these working arrangements and so dealt with straight away. b) **Use of Community Therapy** In WHHT, assessment by physiotherapist and / or an occupational therapist as appropriate is a core component of a complex patients discharge and is in place across WHHT wards. A physiotherapist is also part of the above mentioned twice weekly length of stay meeting where they input advice on appropriate forward referral to community therapy. WHHT highlight therapist capacity in the community as a challenge. However, the availability of some health discharge to assess service supports an integrated approach to therapy and homecare by enabling patients to reduce their long term care needs. ENHT already operate a discharge to assess model for appropriate discharges with an enabling occupational therapist (OT) and active links with all locality community teams. The IDT continues to work closely with a range of therapy services managed by Hertfordshire Community Trust (HCT) to enable early discharge and ensuring patients get a timely and appropriate service.

	In both the east and west of the county, pilot Discharge Home to Assess schemes are in operation. Both schemes have focused on supporting patients to leave the Trust as soon as they are 'medically optimised' i.e. they can no longer benefit from hospital interventions. Both schemes have trialled closer integration between the County Council's enablement service and the therapeutic interventions available from HCT, so that patients receive coordinated care rapidly once they are home. This supports their recovery and by actively enabling the individual reduces their level of ongoing dependency. Both scheme are now moving towards a similar operating model across the east and the west, so that the process and experience for the patient in consistent. It is expected that models will contribute to relieve winter pressure and will be fully implemented across the county and embedded in the system for 2019/20. **c) Pharmacists on Board Rounds** WHHT have already introduced some prescribing pharmacists as part of the 'E' of SAFER for early discharge. This is an extension to the core role of the pharmacists and the Trust is training and growing its own team. Where clinically appropriate, pharmacists are already part of the board rounds but this has to be balanced with maintaining enough capacity in their role as dispensers of medication in a timely way to support discharge. However, the Trust is actively seeking to address this as outlined in the next paragraph. The Carter Hospital Pharmacy Transformation Programme (HPTP) aims to increase the percentage of pharmacy staff utilised on wards to more than 80% by 2019/20 for direct patient facing medicines optimisation activities. WHHT achieved its target of

	65% in 2017/18 and aim to achieve 75% in 2018/19. The pharmacy department is currently restructuring its services to allow more pharmacy staff on the wards. The pilot wards illustrated the benefits of the pharmacy team being involved in the board rounds ensuring that the medicines management for the patients is improved, and To Take Outs (Medication) are targeted to be completed on wards. Currently the ward pharmacists make themselves available when a board round takes place and the adoption of the HPTP will allow greater integration of pharmacy into the multidisciplinary ward team. **d) Computers on Wheels (COW)** At ENHT each ward currently has two-to-three COWs in place and the Emergency Department (ED) has six. A further 30 are being built ready for additional deployment to wards. All COWs in stock will be rolled-out by the end of September 2018. The COW deployment is supplemented by a trial that has just started using iPODs on two wards for eObservations by both doctor and nursing staff. The trial will be evaluated by the end of 2018 potentially leading to full deployment if successful. These initiatives should improve the efficiency with which we manage patients resulting in better outcomes for patients including timely discharge. In WHHT, COWs are operational across three wards with imminent plans for a fourth. The next steps for WHHT involve the roll out of hand held devices to support future plans for electronic patient records rather than more COWs. The Trust plan is for mobilisation of the electronic patient record plan from December 2018. This is a programme of significant work.

2.2	The Clinical Commissioning Groups (CCG) support primary care to address unnecessary direct referrals. This should be done through mapping the type and locations of admission referrals. The data generated should inform subsequent communication with and development of professionals to reduce pressure on hospital patient flow. A target of December 2018 should be set for implementation of this action. (4.10)	Within Herts Valley Clinical Commissioning Group (HVCCG) there is a significant variance in secondary care activity between the 68 member GP practices. HVCCG have undertaken mapping and analysis which shows that if all practices in each locality worked to reduce this variation across A&E, outpatients and admissions, the CCG could achieve considerable reductions of demand for acute hospitals. This is in addition to improving patient experience by ensuring that patients are seen in the right place at the right time. The GP Practices in the Herts Valleys area are all participating in an Effective Resource Management programme through 2018-19 which aims to: • Reduce avoidable acute referrals into outpatient services. • Increase referrals into commissioned community services and maximise the use of newly commissioned pathways. • Reduce A&E attendances that presently result in not requiring diagnostic tests or treatment. • Reducing non–elective admissions that should be avoidable. • Reviewing how direct access diagnostics services are used. The 2018-19 Effective Resource Management scheme builds on the work and progress already achieved by the GP Localities from the inaugural scheme in 2017-18. The Localities have formed transformation teams with health and social care partners to support and enable practices to make changes were the opportunities lie. The programme is further supported by comprehensive business intelligence support including being underpinned by a GP Practice level activity dashboard and reporting system.

	The East and North Herts Clinical Commissioning Group (ENHCCG) has a strong track record in managing patient flow in partnership with the acute trust and other health and social care partners. It achieves this through targeted commissioning of services to prevent admissions and support integrated health and social care services. Patient flow is also monitored through daily and weekly conference calls to understand issues as they occur and respond swiftly. Issues are escalated through a clear governance structure so that the necessary decisions can be made without delay. ENHCCG works closely with social care to map and provide the necessary type and capacity of community beds and works with the acute and health partners to manage and monitor the discharge referral process. ENHCCG is launching a new community frailty service in September 2018 alongside HCT and Hertfordshire Partnership Foundation Trust (HPFT) with an aim to deliver a range of community based services to support vulnerable people in their own homes, preventing the need for acute attendances. Discussions regarding this new model have included all six GP localities within ENHCCG and it has been agreed by the ENHCCG Governing Body. It is acknowledged there will always be occasions when a patient is referred to a community setting (either a care home, nursing home or an individual's home) which may require further or ongoing medical cover or indeed a return to an acute setting. However, readmission rates from the CCG's integrated discharge to assess pathways remain low. Clearly more can be done and improvements are constantly being sought within the budget constraints faced by the system along

	with increasing demand. ENHCCG has piloted a successful Discharge Home to Assess with HCC and HCT to target those patients likely to most benefit from targeted specialist care and therapy re-ablement services. Discussions are ongoing to embed this successful pilot with HCC's Specialist Care at Home Service to further enhance the utility of existing capacity of care available. This will be developed before the end of the year to support winter pressures and will be embedded within the system by 2019/20. HVCCG, ENHCCG, West Essex CCG and HCC have also jointly commissioned consultants Newton Europe to undertake a detailed review of all processes, decision making, culture and leadership associated with patient flow. This review is data-led and places significant emphasis on the importance of gathering and analysing data to drive improvements. The results of Newton's in-depth review will be available in September 2018 which provides a timely opportunity to implement improvements to how patient flow is managed during the winter of 2018/19.
2.3 The Sustainability Transformation Partnership (STP) should oversee the development of programmes across the Hertfordshire and West Essex footprint and should review, monitor and advise on the continued sharing of good practice between the two main acute hospital trusts in Hertfordshire. Examples of good practice to be shared and implemented include: a) The vanguard programme and the successful initiatives it piloted in East and North Hertfordshire. b) Introducing the Early Intervention Vehicle (EIV) model to the west of the county.	The STP has established a number of 'footprint'-wide workstreams which look to ensure that best practice is shared and implemented across Hertfordshire and west Essex. These workstreams include one dedicated to urgent and emergency care which specifically focuses on practice across and within the major acute hospital trusts. In addition, the Frailty workstream has developed, and in many cases secured, multi-agency agreement on key clinical and social care pathways, including frailty assessments and falls. This ensures that all organisations working with individuals on these pathways are clear as to their roles and responsibilities and their interdependencies with other organisations.

(4.11)	The success of the projects within the national Care Home Vanguard programme (implemented in ENHCCG) highlighted the excellent combined efforts of health and social care partners through new initiatives and workforce training. All projects within the Vanguard are now 'business as usual' within ENHCCG and continue to improve the quality and effectiveness of care to individuals in Care Homes to prevent admissions into hospital and reduce delayed transfers of care. The learning from the Vanguard is now being shared across the STP. The model of the Early Intervention Vehicle is currently being considered by NHS commissioners in the West of the County for mobilisation before the Winter period.

Any other comments on the report or this scrutiny?

Paragraph 3.8 in the report comments on how HCC social care has a large part to play in timely discharges and so it would be interesting to investigate how long term homecare capacity can be addressed to support both hospital and community patient flow by HCC and CCGs