HOSPITAL PATIENT FLOW

To examine patient flow processes at the two Hertfordshire acute hospital trusts to identify good practice and blockages in admission from an ambulance and discharge

Report of the Topic Group

18 MAY 2018

Contents

REPORT OF THE HOSPITAL PATIENT FLOW TOPIC GROUP

1.0 Purpose of Report

1.1 The objective of this scrutiny was to examine the patient flow process at Hertfordshire's two main acute hospital trusts, namely East and North Herts Hospital Trust (ENHT) and West Hertfordshire Hospitals Trust (WHHT) to identify:

a) Good practice,
b) Blockages in admission and discharge pathways, and
c) Recommendations for improvement.

1.2 The Group's report has sought to make recommendations so that good practice and learning has been identified, implemented and shared to improve the patient flow and patient experience.

1.3 The scope and objectives of the scrutiny is referenced in the scoping document attached at **Appendix 1**. The questions addressed by this topic group are found in this appendix.

1.4 Associated papers issued to Members can be found at: LINK

2.0 Recommendations

The Topic Group recommends that:

2.1 WHHT, 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 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)

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)

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. 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.

(4.11)

3.0 Evidence

3.1 In ENHT, EDDs are currently set within the first 48 hours of admission. This is seen to be too long and can be reduced by including all relevant officers, clinicians and pharmacists on board rounds. In doing so, it is expected that setting and communicating the EDDs can be reduced to 24 hours. This would mean that discharge letters can be produced without delay. Plans are in place to complete medication and discharge letters 48 hours prior to patients being discharged at ENHT. To this end pharmacists have recently been piloted on board rounds. This has meant that the medication that patients need is identified, added to the discharge plan and made available when the patient is leaving the acute setting. Delays to prescriptions being administered is an area that both acute trusts are working to reduce. Because ENHT are managing to set these within 48 hours of admission, they are achieving the benefit of a reduced numbers of delayed discharge days compared to WHHT.

3.2 WHHT currently has an average of eight days for the setting and communication of the EDDs. In response to this, they have recently started to include pharmacists on board rounds as part of the Fresh Eyes initiative getting more professionals in one place to discuss discharge planning. As well as this, they are piloting a Computers On Wheels (COWs) system for electronically recording medication requirements and other notes. The pharmacists on board rounds are transcribing pharmacists, so they can prepare prescriptions as rounds proceed. However, with this being such a recent introduction and initially on a small scale, the full benefits have not yet been realised.

3.3 Both ENHT and WHHT have introduced the discharge lounge with success, preparing patients who are being discharged by moving them off wards when they are clinically well in readiness for leaving the hospital. However, having EDDs set earlier after admission will better prepare patients and support services for discharge, such as patient transport from East of England Ambulance Trust (EEAST). Plans are in train so that discussions take place with patients to help them to understand the preparations for them leaving the hospital. These plans will increase the use of the discharge

lounge so that patients are in a prepared state to move on. Communications with ward staff has increased so that they are educated in the benefit of appropriate transfers to the discharge lounge for the benefit of the patient and overall patient flow.

3.4 It is increasingly being seen across both acute hospital trusts that assessments do not need to be performed in the hospital. If it is safe to do so, then a well patient can be discharged, return home or another setting and then can be assessed for their ongoing needs in an alternative setting. This is an approach called Discharge to Assess (D2A). This is working well in both WHHT and ENHT, able to discharge people home or where appropriate to community hospital and short-term residential beds across the county. It is increasingly used to help free up blockages and get well patients out of the acute setting.

3.5 Both trusts have D2A dementia pathways; however there are issues, due to the level of complexity, to support transition to a long term care home. There are also challenges across the sector in meeting the needs of these patients. Discussions are taking place with all partners across the system to get this to work. Having the right workers in a person's home or community Dementia Unit, will provide clinicians with confidence in discharging patients for assessment at a later date. Additionally, another method of assessing patients away from the hospital is increasingly being used, which is through the use of a trusted provider (Care By Us).

3.6 Another blocker that both the acute hospital trusts have to deal with is the different ICT systems used by health and social care officers that do not interface with each other. While the IDTs at both hospital sites are viewed as a single team, irrespective of commissioning authorities, having independent record systems has been identified as a challenge. Neither health nor social care officers are able to input into each other's patient information system. Sharing patient information or discharge progress updates are more challenging for handovers and information sharing for progressing the patient flow and plan for discharges.

3.7 Work is being done with both acute hospital trusts in accessing and discharging to community health services. Both trusts have a community pathway that they plan for. The community service was seen to be widely under-utilised across the county. Some concerns were raised around ability to access these services and holding sufficient numbers of beds for the demand, however, officers made assurances that there are sufficient bed numbers and that establishing early EDD and an increased use of community bed assessments will improve hospital flow.

3.8 HCC provided social care still has a large part to play in timely discharges. There is an historical pattern of there being fewer care homes in the east and so as a result the proportion of care in residential settings in the west is slightly higher. There are still waiting lists for homecare across the county which impacts on both trusts' ability to discharge patients.

3.9 To further the goal of reducing delayed transfers of care, increasing the amount of timely discharges and improving patient flow through the hospitals, the Sustainability and Transformation Partnership (STP) has commissioned external support to evaluate system pressures, the volume of activity flowing through different interventions and where improvements could be made. The work commences in July with initial feedback expected around September.

3.10 The Clinical Commissioning Groups (CCG) hold daily discussions and weekly recaps around issues or blocks in the system. If there are notable concerns, they will follow these up with relevant trusts. These meetings look to reduce the continued challenge around communication between all system organisations, with particular emphasis on the hospital patient flow.

3.11 East and North Hertfordshire CCG were given the opportunity by NHS England to trial a vanguard programme within their geographic area of responsibility. The programme was wide reaching, but also included reducing delayed transfers of care (DTOC's) and improving hospital flow. As a result various initiatives were tried and tested with ENHT such as the Early Intervention Vehicle (EIV), management of their own intermediate beds and increased work on D2A. These have all shown effective reductions in DTOCs, however some initiatives such as owning residences for intermediate care provision did not prove effective in reducing delays and was very costly. Both WHHT and ENHT stated access to Hertfordshire intermediate beds was not seen as an issue. However, the Trusts confirmed that it was necessary to constantly monitor what those beds were being used for and make sure that they were flexible to accommodate patients with differing conditions, rather than have a fixed use.

3.12 CCGs have increased responsibilities around the commissioning of GP services in their areas. However, while CCGs hold greater influence, GPs are constantly being asked to do more with their time. As a result, GPs are more likely to use acute pathways because they know their patient will be seen and provided with additional, necessary time than sometimes GPs themselves are able to provide with the pressures they are under to see more patients. The types of referrals being made are not analysed fully and therefore more work is needed to support practices so that patients are referred to the most appropriate service, which might not always be the hospital.

3.13 Members questioned how referrals are tracked, officers made assurances that this data is captured for every referral and that demand management monitoring is underway in both CCGs to identify trends for referrals. However, this is not as developed as it could be. Members believed tracking the problem to identify it, then address if there is any need for education or addressing particular issues around why referrals are being made. This would thereby relieve any unnecessary pressures on the hospital patient flow.

3.14 The Ambulance Service works to prevent admissions prior to patients presenting at Emergency Departments (ED). East of England Ambulance Service Trust (EEAST) has introduced an initiative called “See and Treat”, which works to direct patients to other pathways such as GP referral rather than straight to the ED. EEAST also supports ENHT with provision of the EIV which attends a patients home where the reason for calling 999 is not life threatening and is within a certain criteria, such as falls, urinary tract infections, dehydration and dementia. Sending out an EIV rather than an emergency response vehicle has worked to prevent unnecessary admissions to acute hospitals. In the west of the county the EIV has not been introduced, and instead they have an Emergency Care Practitioner (ECP) Car that will attend Care Homes to reduce ED admissions from there but does not go into the community. The EIV has attended a significant amount of call outs over the last year, which has reduced the number of unnecessary attendances at ED.

4.0 Conclusions

4.1 Throughout all the witness evidence heard, it was identified that what is required is a culture shift at all levels of people involved in the hospital flow. Relationships need to be maintained and continually developed between social and health care professionals. Co-location was seen as a key driver to help adopt this change. Members heard that when all professionals consider joint working and joint budget planning, improvements will be made. Additionally, Members acknowledged that readmission rates impacted on blockages related to hospital patient flow and believed that all suggested actions would work towards reducing this pressure.

4.2 EEAST shared the outcomes of the recent risk summit held by NHS England. The resulting actions from this have demonstrated a noticeable change in handovers into and out of the hospitals. Officers shared their optimism at how this change had been adopted so well and believed the commitment to these actions would continue when the winter holiday period returns. Members supported the continued use of these actions.

4.3 Members were pleased that EEAST had taken on the Patient Transport Service (PTS) as previous reports highlighted concerns around how that service was provided. Since taking it over, EEAST has had to implement plans for making the most effective use of the PTS in relation to improving hospital flow. Future plans, which Members were supportive of, include bringing the PTS more in line with the emergency response team protocols to maintain standards.

4.4 Members heard that a 24 hour target for setting EDDs is achievable because of the increasing involvement of all relevant professionals on board rounds. This will result in a greater ability to be prepared for discharging patients at the appropriate time. Having officers sharing that information more widely and having all necessary paperwork, medication and assessments planned or in place in time with the EDD improves patient flow. Members believe that the reduction in time from current levels of 48-74

hours is therefore achievable and would benefit all professionals in preparing patients to be discharged safely, much sooner. (2.1)

4.5 Plaudits were given for the Ambulatory Care Units (ACU) at both hospital sites and Members saw any expansion of this service as a benefit to improving hospital flow. The ACU in both hospitals has seen significant increases in referrals, reducing pressures on the ED. This service focuses on providing care to patients who do not need to be admitted to a bed. They are able to be treated and discharged rapidly to their home, community or care home setting. Members were pleased with the increased use of this unit as limited time in hospital reduces the possibility of negative effects from long term hospital stays. GPs are becoming more aware of the ability to refer directly into this service across the county. Members had some concerns that this should not be over-used by direct referrals from primary care.

4.6 Another particularly effective practice that's use was encouraged by Members was the D2A model. Members raised some concerns about this being used at the appropriate times and challenged officers on how isolation is prevented and to make sure patients were eating before being discharged to assess later. Reassurances were given that work is ongoing with Age UK and other voluntary organisations so that patients, if known, will not go home without food or support. (2.1)

4.7 Considering the whole issue, Members raised that while all efforts should be looking to improve flow through the hospital this could not be achieved without also looking at how health and social care teams can prevent unnecessary admissions in the first place. Whether this was through increased community therapy provision, reducing avoidable GP referrals or increased social care support.

4.8 When considering pharmacy delays, the inclusion of pharmacists on board rounds was viewed positively by Members. However, it was believed that more could be done to adopt e-prescribing across both trusts. The Computers on Wheels (COWs) service used in WHHT was showing a real benefit, entering information onto the system as board rounds proceeded. Members wanted the use of this to be expanded in WHHT as it was heard that there were only 3 COWs and a similar system adopted in ENHT as they did not use any like this at all. (2.1)

4.9 Members encouraged the continued public communications around the use of 111 Out Of Hours Service before attending ED or even a visiting a GP. Members saw that the use of this service was yet another method of reducing pressures on hospital flow. Since Herts Urgent Care has managed this service (over the last 5 years) it has continually had a greater impact on reducing pressures on other services.

4.10 Members challenged how direct referrals from GPs can create blockages in the system. As a result of the growing demand, the CCG medical director works with local medical committees to help with any concerns they may

have. Feedback that has been received from GPs is that individuals can be too complex for the services they are going to. This results in questions about:

a) Were the referrals appropriate?
b) Do we have the quality of care available?
c) Are there enough beds and are we using them in the right way?
d) Are we putting the most appropriate person in the appropriate bed?

Members believed this needed to be clear with all partners and that the mapping exercise combined with the work of the consultant that has been commissioned by the STP will go some way to answering these questions. (2.2)

4.11 Members were particularly impressed with the EIV model being used in the East, and whilst in the West there is the ECP service that goes out to care homes only, Members were disappointed to hear that a similar service does not operate in the West and encouraged the further exploration of the EIV. Therefore, they believed that discussions needed to take place at an STP level on spreading EIV to West for an equitable service. Members saw the STP as the ideal level for monitoring the introduction of all beneficial models of care such as the EIV and vanguard programme models. (2.3)

5.0 Members and Witnesses

Members of the Topic Group
Bob Deering
Chris White (Chairman)
Dave Hewitt
Dreda Gordon
John Birnie (District)
Richard Smith
Tina Howard

Other Members in Attendance

David Andrews
Fiona Thomson (District)

Witnesses

Andy Mallabone	Head of Integrated Discharge (West), Adult Care Services
Barbara Harrison	Urgent Care Performance Programme Lead, HCT
David Brewer	Head of Engagement, ENHT
Debbie Foster	Director of Operations, Emergency Medicine, WHHT
Denis Enright	Associate Director of Operations (Adult Services), HCT

Ed Knowles	Assistant Director Integrated Health (West), HCC/HVCCG
Fran Gertler	Director of Integrated Discharge, WHHT
Heidi Hall	Head of Integrated Discharge (East), Adult Care Services
Iain MacBeath	Director of Adult Care Services, HCC
Isabel Cockayne	Director of Communications and Engagement, EEAST
Marion Dunstone	Director of Operations, HCT
Sally Tucker	Chief Operations Officer, WHHT
Simon King	Sector Head
Steve Davey	Senior Locality Manager
Tom Hennessey	Assistant Director Integrated Health (East), HCC/ENHCCG
Tracy Foster	Deputy Director of Performance and System Resilience, HVCCG

Officers

Elaine Manzi	Democratic Services Officer
Charles Lambert	Scrutiny Officer

APPENDIX 1

OBJECTIVES:
To examine patient flow processes at the two Hertfordshire acute trusts to identify good practice and blockages in admission from an ambulance and discharge

BACKGROUND:
Both East & North Hospital Trust (ENHT) and West Herts Hospital Trust (WHHT) face increasing challenges to deliver their A&E target to achieve timely discharge. However the issue is more acute at WHHT and it appears that it may be a more systemic issue in the west of the county.

Points to consider

- Non-elective admissions
- Length of stay (elective and non-elective)
- Time taken at different stages in the patient journey including the time taken to refer patients to Integrated Discharge Teams
- The reasons behind Delayed Transfers of Care, e.g. Social care capacity, further NHS non-acute care, assessment delays etc.
- The rate and cause of failed discharges
- Readmission rates

QUESTIONS TO BE ADDRESSED:

1. What management and clinical processes does the Trust have in place prior to hospital admission including
   - planned admission
   - hospital social care team liaison
   - care home liaison
   - ambulance admission
   - referral by GP or social worker
   - front of house arrangements
2. What processes are in place, across all relevant partners to plan discharge once a patient is admitted to a ward? This to include
   - discharges requiring no other agencies for support
   - liaison with integrated discharge support for more complex discharges (e.g. HILS, social care, HCT)
3. What joint oversight and monitoring is in place to ensure timely discharge and to prevent re admittance?

OUTCOMES: That good practice and learning has been identified and is implemented to improve patient flow and the patient experience.

CONSTRAINTS: What are the topics that are irrelevant to the objective or that do not

answer the questions?

- It will not include MH issues
- It will only address WHHT and ENHT
- No individual cases

RISK & MITIGATION AFFECTING THIS SCRUTINY: i.e. how confident are members that the department/organisation has identified risks, impact to services, the budget proposals and has mitigation in place.
RISK/S: pressures places on other services and organisations;
MITIGATION: *e.g. what mitigation does the department/organisation have in place if a partner pulls out?* What is in place to manage at times increased pressure e.g. winter, major incident

EVIDENCE	
PTS (passenger transport service)	EEAST
Trust discharge policies	ACS
CCGs	ENHT
HCT	WHHT

METHOD: 1 day Topic Group **DATE:** 18 May 2018

SITE VISITS: Prior to the Topic Group

Half day seminar at the Watford (WHHT clinical colleagues, A&E practitioners, social worker team) **WATFORD – 11 May**

Half day seminar at the Lister (ENHT clinical colleagues, A&E practitioners, social worker team) **LISTER – 15 May**

MEMBERSHIP: Bob Deering, Richard Smith, Dave Hewitt, Dreda Gordon, John Birnie (Dis), Tina Howard, Chris White (Chairman)

SUPPORT:
Scrutiny Officer: Charles Lambert
Lead Officer: Ed Knowles Assistant Director: Integrated Health
Democratic Services Officer: Elaine Manzi

HCC Priorities for Action: how this item helps deliver the Priorities *delete as appropriate*
1. Opportunity To Thrive ✓
2. Opportunity To Prosper ✓
3. Opportunity To Be Healthy And Safe ✓
4. Opportunity To Take Part

CfPS ACCOUNTABILITY OBJECTIVES: *delete as appropriate*
1. Transparent – opening up data, information and governance ✓
2. Inclusive – listening, understanding and changing ✓
3. Accountable – demonstrating credibility ✓

Appendix 2
Glossary

ACS	Adult Care Services
ACU	Ambulatory Care Unit
D2A	Discharge to Assess
ECP	Emergency Care Practitioner
ED	Emergency Department
EDD	Estimated Discharge Date
EEAST	East of England Ambulance Trust
EIV	Emergency Intervention Vehicle
ENHCCG	East and North Herts Clinical Commissioning Group
ENHT	East and North Herts Trust
HCC	Hertfordshire County Council
HCT	Hertfordshire Community Trust
HVCCG	Herts Valleys Clinical Commissioning Group
IDT	Integrated Discharge Team
Primary Care	Health care provided in the community through a general practitioner or clinic for advice or treatment
WHHT	West Herts Hospitals Trust