Herts Valleys Integrated Hospital Discharge Service
Watford General Hospital Integrated Discharge Team
Scrutiny Report 11/05/2018 and 18/05/2018
01/05/2018

Watford General Hospital Integrated Discharge Team (IDT) is a multi-disciplinary team and is jointly managed by Hertfordshire County Council and West Herts Hospital Trust (WHHT). It is one of a number of teams supported by Adult Care Services (ACS) focussing on hospital discharge and post hospital discharge review.

The attached Watford General Integrated Discharge Team Service Specification details the ambitions, the form, the functions and pathways of the service.

In response to the focus of the Scrutiny Committee:

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*

IDT recognise the importance of early discharge planning and are committed to the ambition of establishing a process with WHHT (as dictated by the 8 High Impact Changes {link below} to manage Delayed Transfers of Care) to support pre admission planning for planned admission. Currently the focus is more around working with WHHT to establish mechanisms by which IDT can be notified earlier about patients that are likely to require complex discharge planning and achieving receipt of referral notification with 48 hours of admission to hospital. This currently sits around 8 days but joint initiatives such as 'Fresh Eyes' is challenging practices and encouraging earlier referral. https://www.local.gov.uk/sites/default/files/documents/Impact%20change%20model%20managing%20transfers%20of%20care%20(1).pdf

IDT has been established to fulfil a number of functions to support rapid assessment and discharge from hospital; this includes a duty function (see attached rota) and a group of workers dedicated to preventing admission from assessment areas onto wards. Referrals are received on a daily basis from the Clinical Navigator Team, with the expectation that there is an hour response to assess and then arrange services. The team will often respond with a range of interventions reliant on universal support through to short term care placement to manage risk once the patient has been confirmed as medically fit to transfer. One recent innovation in Herts Valleys has been the establishment of the 'Front of House' service 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. It can also help bridge gaps in care, whilst awaiting a provider to restart or increase a package of care.

Working with Clinical Navigators to Prevent Admission.

Patient was admitted from a Care Home over night following a fall. Assessed by the medical team as having no underlying injury or illness. Clinical Navigators linked with IDT to escalate that the home were refusing to have the patient back unless a profiling hospital bed was provided. The patient would have been ineligible due to level of independence in mobilising. IDT intervened to understand the concerns of the care home around her high risk of falls but also for them to review their risk assessment and appreciate the demands of the hospital. Through a negotiated approach the patient went home the same day.

Another area of innovation building on the success of the East and North Herts model is the deployment of an Impartial Assessor for Care Homes, that not only supports both IDT in planning complex discharge but will support WHHT and the admitting care home in 'turning around' medically fit patients where there may be concerns around management of their social care. WGH IDT has benefitted from a short period of input from this role over the Winter Period and will have a permanent position from the 8th May 2018.

In addition to this level of support IDT also support attendance at all ward rounds (see attached rota) including the assessment units, this will include Herts Help. This is critical for identifying opportunities to discharge people home early with statutory, voluntary or universal support or identifying complexity of need and early referral for discharge planning.

What processes are in place, across all relevant partners to plan discharges 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)*

Please see attached IDT Service Specification for Watford General Hospital.

The Discharge Planning Process is supported by daily attendance on Board Rounds which track the progression of the patient through their diagnostics, treatment and recovery. These daily meetings include clinical and nursing staff but also the wider team of therapists, social care and voluntary sector staff.

Board Rounds support not only the assessment and discharge planning process but provide the opportunity to exchange patient information, update on progress towards discharge but also escalate and address barriers to transfer, whether that is medical, patient choice, lack of support to enable transfer etc.

The Board Round concept has been developed in recent months with an initiative known as 'Fresh Eyes' where WHHT senior clinical and WHHT management have adopted a weekly board round approach to challenge decision making with the multi-disciplinary team and inject pace into the patient journey. IDT have been fully signed up to this approach, which supports the patient experience and WHHT / IDT patient flow. IDT also support and lead in dedicated MDT initiatives to support flow, these are often work on ECIST's 'Perfect Week' concept which seeks to positively resolve issues that can delay flow across the whole hospital.

Fresh Eyes and the Voluntary Sector Role in Complex Discharge Planning:
It was identified through the Fresh Eyes process on Tudor Ward that an older female patient could potentially return home subject to a discussion around her arrangements to access the property. The midday bed meeting escalated the need to support de-escalation of surge beds on Tudor Ward. IDT immediately engaged the patient who was medically well and desperate to go home two days earlier than expected. Whilst she had access and transport to her property and did not need care support, she was concerned about the lack of food in her house until her cousin visited at the weekend. IDT immediately engaged Age UK who are co-located with the team and supported with an emergency food parcel, they also agreed to follow up post discharge with support around housework and possible relief of isolation.

What joint oversight and monitoring is in place to ensure timely discharge and to prevent re-admittance?

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 in a timely way to prevent delay at a later stage i.e. plotting the timeliness of social care assessments and continuing health care checklists being completed.

This information is then pulled together in a daily SITREP (attached) which is circulated across the wider Herts Valleys Health and Social Care System, this details the volume of discharge activity over the course of the week, the volume of people 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. Estimated Date of Discharge 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; the expectation is that no more that 3.5% of the hospital bed base should be delayed by complex discharge, the proxy figure for this is 22 people. The SITREP attached from 30th April 2018 evidences 27 people delayed.

This performance target and the DTOC challenge forms part of the whole services PMDS process and is a focus of team discussions and 1:1's.

The weekly performance of team is also reported through to central government through the STEISS report; this is supported by a weekly audit and dialogue to agree the number of people delayed and the reasons why. This takes place between the social care and health management within IDT and provides another useful forum to check and challenge on patient progress.

Working with WHHT management and clinical leads we also take a lead in the Length of Stay review, a process by which patients who have been in hospital over 14 days are reviewed, this is proving a useful desktop exercise where external and internal issues to WHHT and IDT can be escalated and challenged.

IDT in recent years has become increasingly visible with clear routes of escalation through to the Head and Deputy Head of Service as well as the social care management team. In addition IDT are represented on a daily system call (inc. weekends) involving HVCCG (inc. Continuing Health Care, WHHT, Hertfordshire Community Health Trust and the East of England Ambulance Service. The meeting is chaired by Herts Valleys CCG and focusses on the previous days / weeks' performance, anticipated activity for the day ahead and the escalation and management of risks to promote patient experience and Accident and Emergency Performance. IDT report an OPEL Score on daily basis (see attached) which contributes to the system score in terms of demand and flow, it also identifies a set of delivery and escalation activities to support consistent and transparent levels of responses to the system pressures.

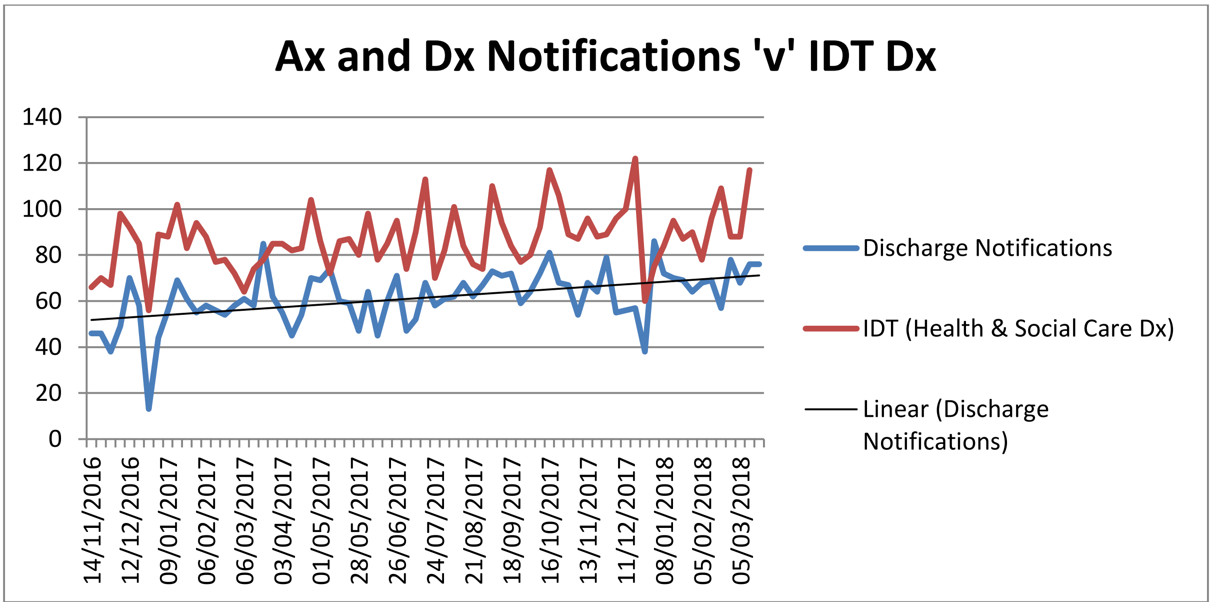
In terms of escalation and contributing to the WHHT daily performance, IDT are located alongside the bed management team and attend the 12:30pm and 3:30pm bed meetings as well as any internal incident response required. This is another useful forum for escalation to support patient flow as well resolving individual patient issues. It has been these environments which have seen some of the most creative work e.g utilisation of HCC day centre transport to resolve critical issues with HVCCG contractual arrangement with patient transport and the development of a WHHT staff circular to improve information in relation to discharge planning.

IDT acknowledge that supporting transfer of people who are vulnerable and have recently suffered an acute hospital admission is challenging and risk of re-admission is high. As part of the Herts Valleys Integrated Hospital Discharge Service, the Post Hospital Review Team has been established to support people transferring home with short term enablement home care (Specialist Care at Home),. People transferring on this pathway are reviewed by our care providers within 72 hours of return home and are then supported with ongoing assessment and care planning by a social care professional until their longer term care plan can be established (within a 4 week time period). Workers support people moving through other social care resources are expected to monitor people upon transfer and review their situations with 6 weeks. This alongside the work of WHHT in providing discharge summaries to GP and Community Healthcare, is critical in managing transfer. Future developments in achieving aspirations around place based care and the establishment of multidisciplinary community teams will further minimise the risk of readmission.

<u>Discharge Home To Assess – Preventing Re-admission</u>
One place where we can already see that starting to take shape is in central Watford, where the Discharge Home to Assess pathway which enable people to return home on or prior to their Estimated Date Of Discharge is now supported by nursing and therapy staff from WHHT and Herts Community Health Trust respectively, providing clinical oversight of the discharge and a level of risk mitigation and rehabilitation upon return home.

<u>Performance</u>

<u>Referrals and Discharges</u>

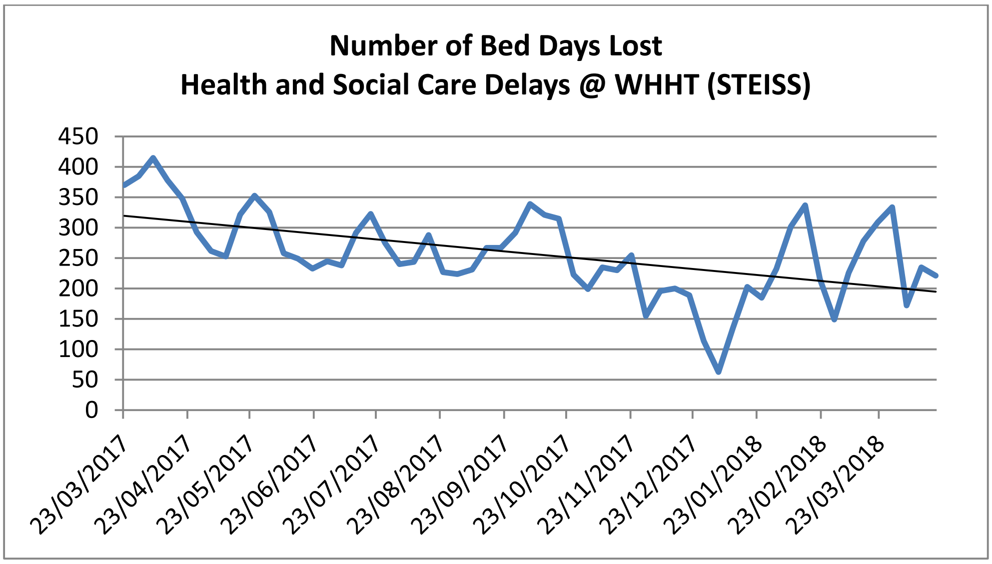


Whilst data below indicates the DTOC challenge, this should be in the context of an increase in referral rate over the last 18months and a significant increase in discharge activity which can be better evidenced by the information below.

Time Period	Average Social Care Assessment Notices/ Week	Average Social Care Discharge Notices / Week	Average IDT Discharges / Week (Health and Social Care
14/11/2016 to end of 2016	45	61.4	71
2017	70.2	73	83.5
2018 to date	76	87.3	91.5

IDT Social Care Referral Rate has increased and the total amount of IDT discharges has kept pace averaging in 2018 91 discharges per week compared to 71 in the final few weeks of 2016.

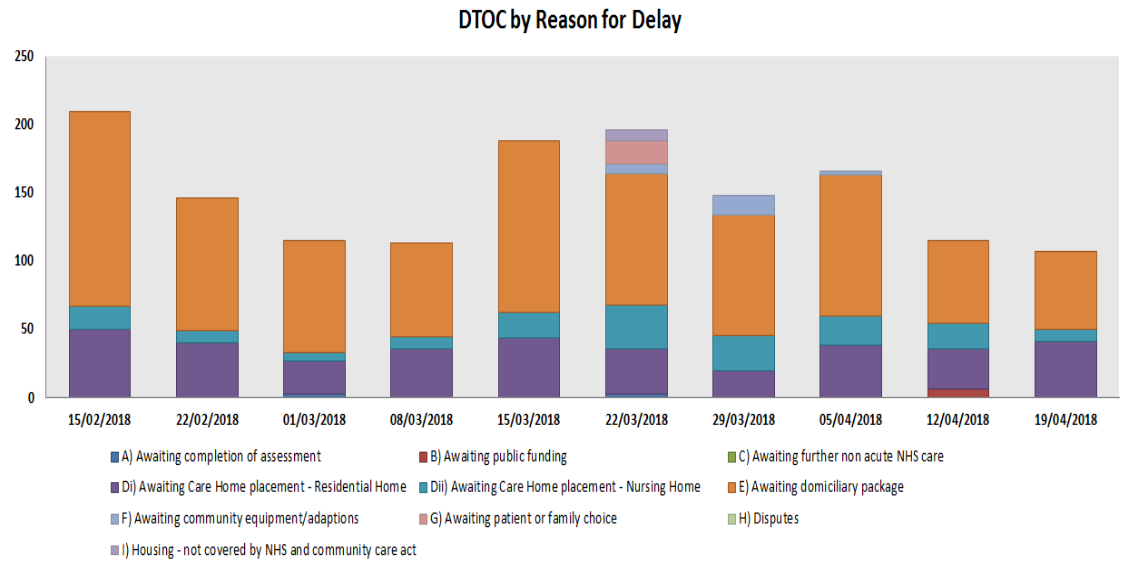
<u>Bed Days Lost at Watford General Hospital due to complex Health and Social Care (STEISS data)</u>



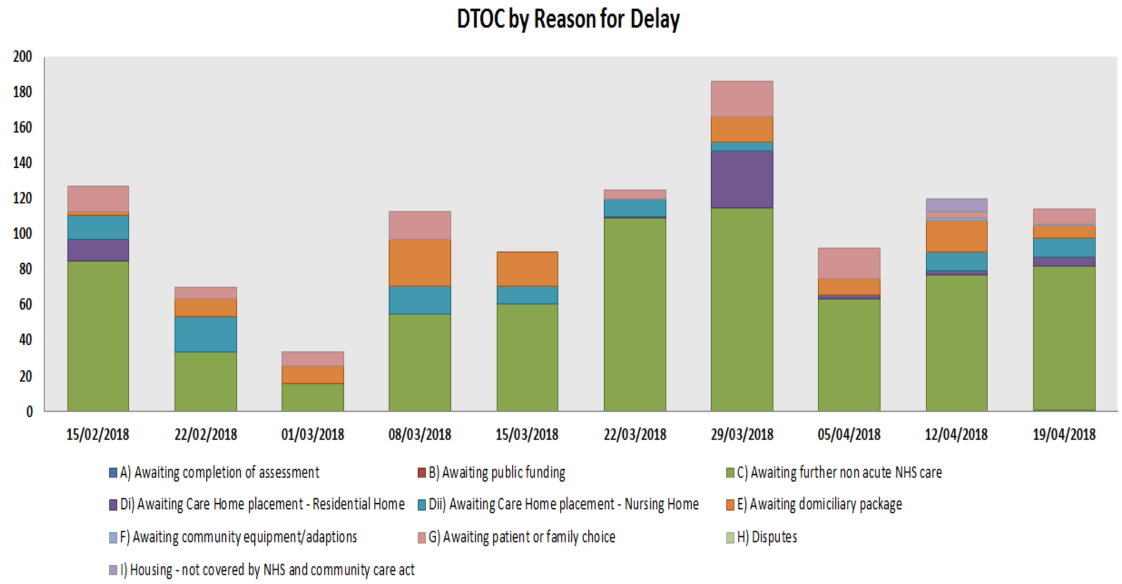
Highlights that IDT's delay activity across both health and social care in the last year have dramatically improved, demonstrating that there were over 400 bed days lost in March 2017 down to approximately 200 days in the same period for March 2018. The data below identifies the core areas of service resource that impact upon delay activities:

- Awaiting Home Care Provision
- Awaiting Residential and Nursing Care Placement, although not evidenced this is often for people with complex needs related to dementia.
- People delayed awaiting intermediate care provision – rehabilitation, with particularly reference to people who need complex support following a stroke.

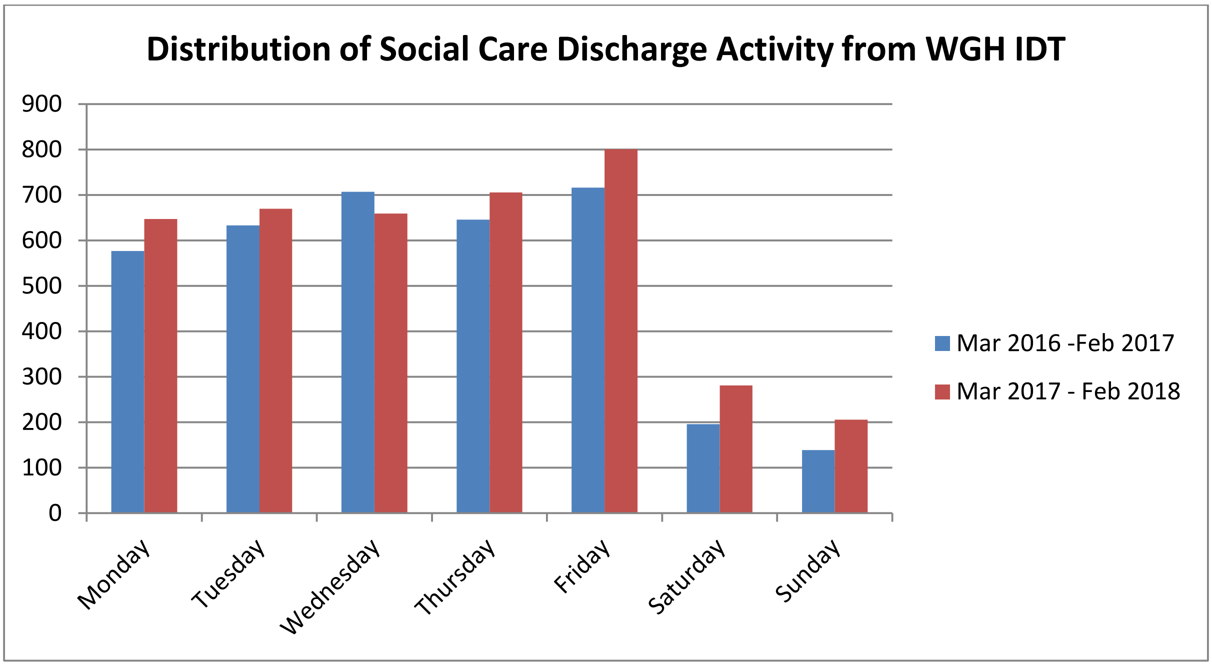
Reasons for Delay - Social Care at Watford General Hospital



Reasons for Delay - Health Care at Watford General Hospital



Weekend Working



10% increase in IDT social care discharge activity, and since the introduction of mandated weekend working in February 2017, there has been at least a 43% increase in discharge activity on the weekends.

End