Agenda

AGENDA for the meeting of the HOSPITAL PATIENT FLOW TOPIC GROUP in COMMITTEE ROOM B COUNTY HALL, HERTFORD on FRIDAY 18 MAY 2018 at 10.00AM

MEMBERS OF THE TOPIC GROUP (7) - QUORUM (4)
J Birnie *(District Councillor)*; R C Deering; E M Gordon; D J Hewitt; T Howard; R H Smith; C J White *(Chairman)*

AGENDA

The meeting of the Topic Group is open to the public (this includes the press) and attendance is welcomed. However, there may be occasions when the public are excluded from the meeting for particular items of business. Any such items would be taken at the end of the public part of the meeting and listed under "Part Two ('closed') agenda".

The meeting room is fitted with an audio system to assist those with hearing impairment. Anyone who wishes to use this should contact main (front) reception.

Members are reminded that:

(1) if they consider that they have a Disclosable Pecuniary Interest in any matter to be considered at the meeting they must declare that interest and must not participate in or vote on that matter unless a dispensation has been granted by the Standards Committee;

(2) if they consider that they have a Declarable Interest (as defined in paragraph 5.3 of the Code of Conduct for Members) in any matter to be considered at the meeting they must declare the existence and nature of that interest. If a member has a Declarable Interest they should consider whether they should participate in consideration of the matter and vote on it.

PART I (PUBLIC) AGENDA

1. APPOINTMENT OF THE CHAIRMAN

2. WORK OF A TOPIC GROUP
Report of the Head of Scrutiny

3. REMIT OF THE TOPIC GROUP
Report of the Head of Scrutiny

4. HOSPITAL FLOW DISCHARGE TOPIC GROUP
Report of the Head of Scrutiny

This report includes:-
(a) Programme for the scrutiny
(b) Background Report and Appendices A-E

5. CONCLUSIONS AND RECOMMENDATIONS

To agree the conclusions and recommendations of the Topic Group and note the process for taking these forward.

If you require further information about this agenda please contact Elaine Manzi, Democratic Services Officer on telephone no. 01992 588062 or email elaine.manzi@hertfordshire.gov.uk.

Agenda documents are also available on the internet at https://cmis.hertfordshire.gov.uk/hertfordshire/Calendarofcouncilmeetings.aspx.

The Scrutiny Lead Officer for this Topic Group is Charles Lambert, Scrutiny Officer on telephone no. 01438 843630 or email charles.lambert@hertfordshire.gov.uk

KATHRYN PETTITT
CHIEF LEGAL OFFICER

Item 2 - Work of a Topic Group

1. All scrutiny meetings in Hertfordshire are ‘meetings held in public’ (not ‘Public Meetings’)

2. Topic groups in Hertfordshire normally run for one, or occasionally, two days

3. All topic groups work to a pre-prepared scoping document. The scoping document sets out what the topic group is going to do i.e. questions to be answered, any constraints on its work and who will be attending as witnesses. The scope will have been reviewed and agreed by the commissioning committee prior to issuance.

4. There should normally be no more than 4 questions for the scrutiny to address

5. Constraints identify areas that will not be covered by the scrutiny and it is the responsibility of the chairman to ensure that the scrutiny does not digress into areas that are not covered by the scoping document.

6. It is vital to keep the scrutiny focused on the questions (see 4 above). Should members believe a constraint warrants further consideration the topic group report should draw this to the attention of the commissioning committee.

7. The scoping document is drafted by the service lead officer in consultation with the assigned scrutiny officer. The commissioning committee consider the scope and amend, if necessary, and agree the questions (see 3 above).

8. Witnesses can be internal and external to the County Council.

9. Topic group members are appointed by the commissioning committee. Membership can be drawn from the entire council; however, executive members and deputy executive members are excluded from undertaking scrutiny

10. Topic groups usually have 5 members with the exception of Education related items where a schools representative may be included (i.e. parent governor representatives (PGRs) or diocesan representatives) when the topic group will have 7 members. Both Scrutiny Committees have waived political proportionality.

11. Each scrutiny has a designated chairman. The role of the chairman is to ensure that all the questions on the scope are covered. The chairman will ensure that all members are engaged and have the opportunity to raise questions. The chairman will encourage the discussion to move on if he or she believes a point has been addressed or is not relevant to this scrutiny.

12. A pre scrutiny briefing is held for the topic group members in advance of the meeting.

13. Topic group members are expected to have read all the papers in advance of the meeting.

14. Topic group members are expected to attend for the duration of the scrutiny.

15. The scrutinies run to the agenda programme and it is the responsibility of the chairman to ensure that the scrutiny keep to the agreed timetable.

16. At the end of the scrutiny the scrutiny officer summarises the conclusions and recommendations in order to obtain broad agreement as to what they should be.

17. A draft report, concentrating on the evidence and recommendations is prepared by the scrutiny officer. The details of the discussion and papers received at the scrutiny are available via Hertfordshire.gov.uk

18. Reports follow a set structure of
    - Introduction
    - Recommendations
    - Evidence
    - Conclusions
    - Members & Witnesses
    - Appendix 1: Scoping Document
    - Appendix 2: Glossary

19. The draft report is produced within 10 working days of the meeting ending. The draft is sent to the lead officer for factual checking; then onto all topic group members for comment. Deadlines are set by the scrutiny officer for receipt of comments from the lead officer and topic group members.

20. The final report is published within 15 working days of the scrutiny.

21. The final report is sent to the executive member and chief officer and copied to all participants in the scrutiny and the commissioning committee chairman and vice chairman/men.

22. It is a statutory requirement that the executive member responds to the report and its recommendations within two calendar months. A template for the executive response is provided to the executive member and lead officer on publication of the final report.

23. The response is returned to the scrutiny officer and then circulated to members of the topic group and the chairman and vice chairmen of the commissioning committee for their information. It is also placed on the next commissioning committee's agenda so all members of the committee are informed of the response.

24. At the point at which the two month executive response form is returned, the lead officer and the chairman of the topic group are given a date, approximately

six months after the scrutiny, to attend the relevant Impact of Scrutiny Sub Committee.

25. The executive member has responsibility for ensuring the template is completed for the relevant Impact of Scrutiny Sub Committee explaining what steps have been taken regarding each and every recommendation.

26. The Impact of Scrutiny Sub Committees have the responsibility for 'signing off' the recommendations as complete and/or agreeing further actions.

27. The lead officer and executive member attend the Impact of Scrutiny Sub Committee to explain what progress has been made in implementing the recommendations.

28. The chairman of the topic group will be invited to the Impact of Scrutiny Sub Committee.

29. The chairman of each Impact of Scrutiny Sub Committee will be invited to attend the next meeting of its parent committee to give comment on its findings

Item 3

SCRUTINY REMIT: As at 24 April 2018
Hospital Patient Flow Topic Group

DATE DUE AT HSC: 9 May 2018
HSC COMMITTEE APPROVED: date…….
WORK PROGRAMME: Q4 2017/8 or Q1 2018/9

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?

Item 3

SCRUTINY REMIT: As at 24 April 2018
Hospital Patient Flow Topic Group

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	
https://improvement.nhs.uk/resources/matthews-story/	EEAST
Lister GP helpline	ACS
PTS (passenger transport service)	ENHT
Princess Alexandra, Harlow Journey	WHHT
Trust discharge policies	CCGs
	HCT

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

Item 3

SCRUTINY REMIT: **As at 24 April 2018**
Hospital Patient Flow Topic Group

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 ✓

Agenda Item no:

4 (a)

HOSPITAL PATIENT FLOW TOPIC GROUP

FRIDAY, 18 MAY 2018 AT 10:00AM

Programme

Time	Item	Officers
10.00	Welcome and introductions Scrutiny objective, questions and constraints.	Chair: Cllr Chris White Charles Lambert, Scrutiny Officer
10.10	Background information and outline of programme	LEAD OFFICERS: Ed Knowles, Assistant Director Integrated Care
10.30	Feedback from visits to Lister Hospital and Watford General Hospital	Charles Lambert – Scrutiny Officer
10.40	Ambulance Transfers • Process for handover • Difference between PTS and emergency transfers • Reporting mechanisms	PRESENTERS: EEAST rep
11.10	**Break**	
11.20	Lister Hospital • Challenges of patient flow/Where the process can falter • Communications with GPs • Oversight and monitoring • Social care responsibilities	PRESENTERS: David Brewer- Head of Engagement ENHT, Heidi Hall, Head of Integrated Discharge (East), Adult Care Services
12.20	**Lunch**	
1.20pm	Summary of the morning's scrutiny	Charles Lambert
1.30	Watford General Hospital • Challenges of patient flow/Where the process can falter • Communications with GPs • Oversight and monitoring • Social care responsibilities	PRESENTERS: Fran Gertler WHHT, Andy Mallabone, Head of Integrated Discharge (West), Adult Care Services
2.30	Community Provision • Communication with Hospitals and involvement in the patient flow • Challenges for the Trust and partnership working.	PRESENTERS: HCT Marion Dunstone – Director of Operations Denis Enright Associate Director of Operations – Adult Services Barbara Harrison

		Urgent Care Performance Programme Lead
3.00	**BREAK**	
3.10	Commissioner monitoring	PRESENTERS: Tom Hennessey- Assistant Director Integrated Health ENHCCG & Tracy Foster- Deputy Director of Perfromance & System Resiilience HVCCG
3.40	ACS work • Homecare responsibilities	ACS rep
4.00	Summary and Recommendations	Members & Charles Lambert
4.30pm	Conclusion	

* Times are approximate. Check with the Scrutiny Officer

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

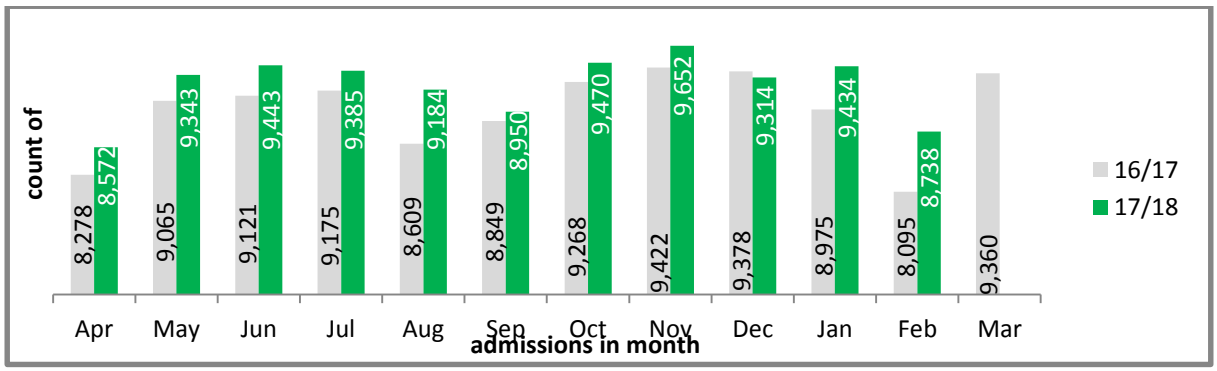
3.1 Patient flow describes the activity and processes that allow individuals to move through the different stages of their care effectively and with minimal delays.

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)

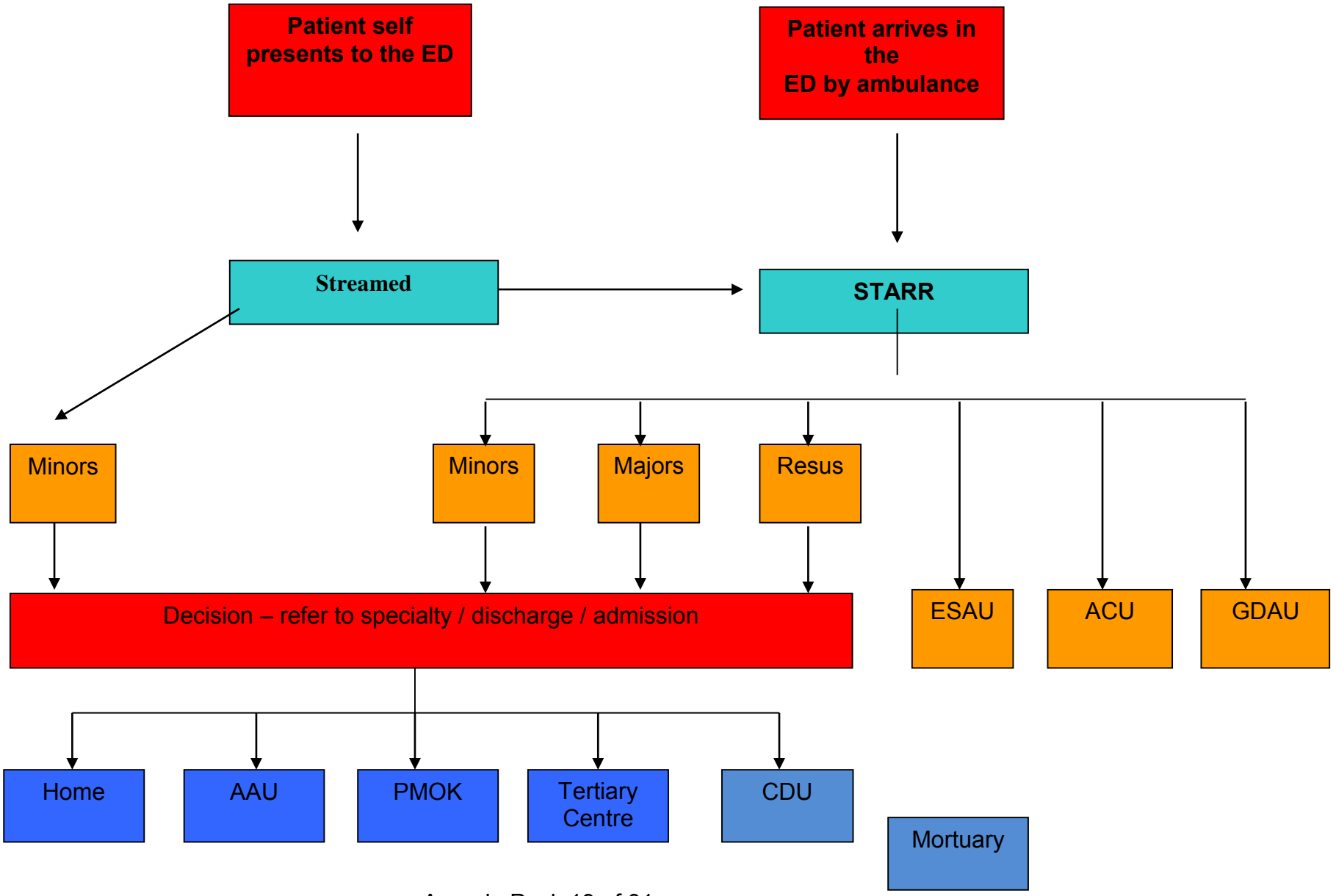
Appendix B – Hospital Flow – Frailty presentation (ENHT)

Appendix C – Frailty Unit information (WHHT)

Appendix D – Red2Green/SAFER information

Appendix E – DTOC Analysis

Appendix A: Adult Patient pathway through the ED



Hospital Flow & Frailty.

Heidi Hall

Head of Hospital & Integration teams

Frailty Patients in A&E

- Patient is brought in to A&E
- Referred by clinician/nurse to front door team (Clin Nav/ Social care/ Age Uk)
- Parallel AX completed by clinicians and above team
- Team have direct access to all pathways/ services
- Parallel planning enables quick DX

ENH Discharge Pathways

Pathway One

atient needs can safely be met at home

- Age UK – Hospital support
- Specialist Care at Home
- Home care
- Supported Discharge (NH only)
- Discharge Home to assess (3 Localities)
- Early Supported discharge - Stroke
- Front of the house service
- CHC (Care at home)
- Homefirst

Pathway Two

Unable to return home – patient requires further rehabilitation/ reablement

- Community hospital intermediate care beds
- Non Weight Bearing beds
- Neuro Beds
- D2A beds
- Intermediate care beds- Private sector
- Step down beds
- Discharge (enablement) flats
- Short stay beds

Pathway Three

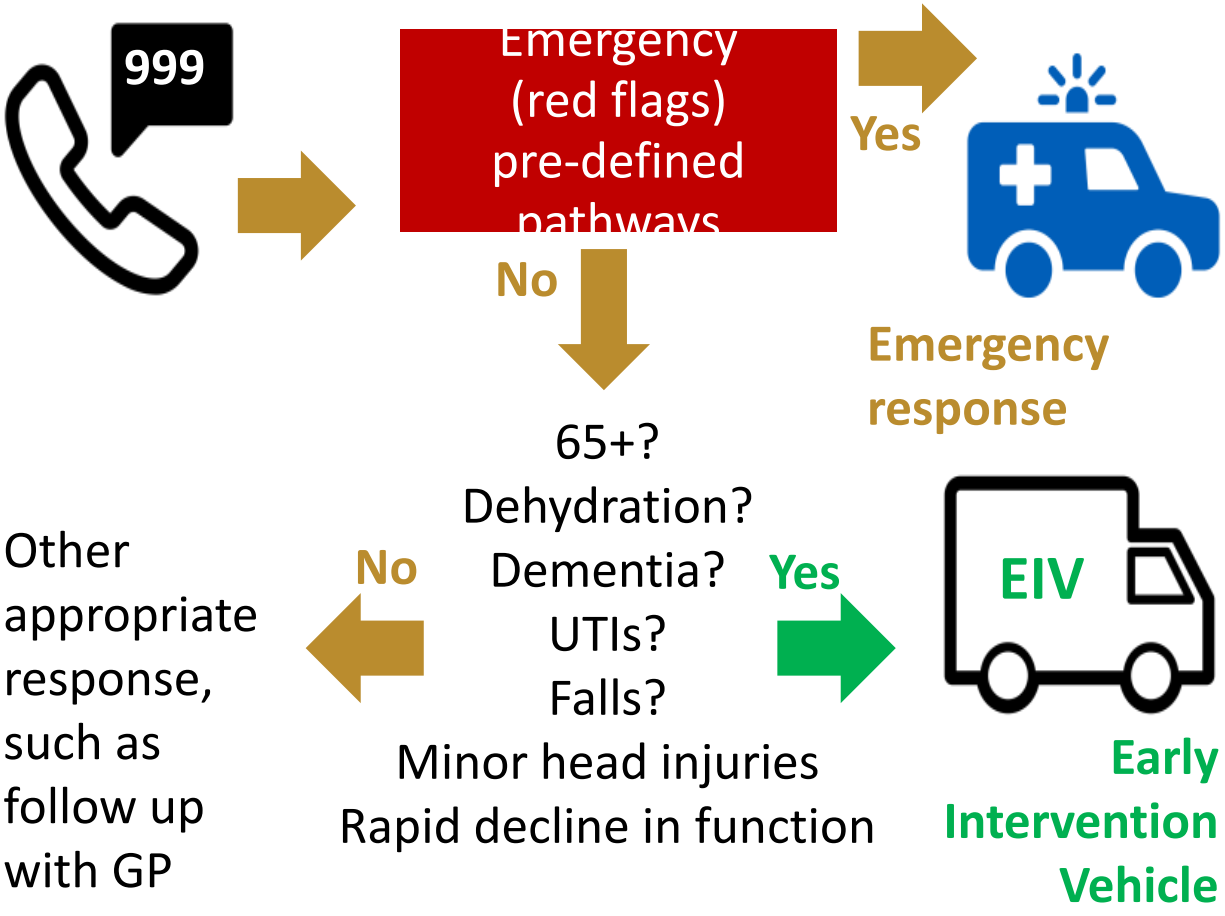
Unable to return home- patient has very complex are needs and may need continuing care

- Residential beds
- Nursing home beds
- CHC- D2A bed
- Return to residential/nursing home/ upgrade
- Funding without prejudice

Frailty Beds Ashwell

- Daily Board meetings
- Early identification and EDD setting (LOS-72 hours- 5 days)
- Prioritisation
- Shared roles/ Professional relationships/ respect/ trust
- Open and regular communication/ Direct mobile access
- 7 day services
- Escalation

EIV Process


999
Emergency (red flags) pre-defined pathways
Yes
Emergency response
No
65+?
Dehydration?
Dementia?
UTIs?
Falls?
Minor head injuries
Rapid decline in function
No
Other appropriate response, such as follow up with GP
Yes
EIV
Early Intervention Vehicle

Early Intervention Vehicle

- Direct access to frailty advise line/ outpatients clinic
- Escalation to A&E front door team following initial Ax at home if requires attendance
- Heads up on care/ equipment supplied or needed on DX once clinical Ax undertaken
- Early identification of patients and their needs following holistic AX

Case study

- Older lady had a fall at home, brought to A&E for an X ray. EIV attended and supplied equipment for DX. Forwarded assessment detail to A&E team, following X ray and plaster, supported to go home with FOH POC.
- Gentleman having recurring falls, diagnosed with UTI and attended via routine ambulance. Confused on admission and supported to have a short stay on DX, before returning home with ongoing POC.

Appendix C – Frailty Unit information

Frailty is a clinically recognised state of increased vulnerability that results from aging, associated with a decrease in the physical and psychological reserves (BGS definition). It is associated with increased morbidity, mortality, hospital admissions, and (once admitted) length of stay. Frail patients often have complex needs, which require complex answers. About 10% of people over 65 years old live with frailty, and between a quarter and a half of those aged over 85 years.

Frail and elderly patients need a holistic, person centred approach, with input from multiple disciplines. This is termed a "Comprehensive Geriatric Assessment" (CGA). This assessment looks at the person as a whole, and focuses on the "5 Ms": mobility, mind (cognition and mood), multi-morbidity (multiple different disease processes or long term conditions), medications, and matters most (what is most important to the person for a good quality of life).

The frailty unit at Watford General Hospital aims to provide this multi-disciplinary assessment, avoid unnecessary hospital admissions, and keep people as independent as possible for as long as possible. We have close links with community teams, and can organise further assessments if required in the community. For the patients that do require admission, an early CGA has been shown to decrease deconditioning and length of stay.

We see people referred from A&E, and hope to increase our scope of referrals to GPs and community therapy and nursing teams. Our team complete CGAs in our unit located in Ambulatory Care, and as an "outreach" team assessing in A&E if our spaces are already full. Our team consists of a Consultant Geriatrician, junior doctors, specialist nurses, and specialist senior therapists (Physiotherapists and Occupational Therapists). If appropriate, we can also refer for dietetic advice, speech and language therapy assessments, and social worker assessment.

An audit completed in October 2017 showed that we increased the percentage of patients discharged on the day of A&E attendance from 23% to 60% by completing a timely CGA.

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.

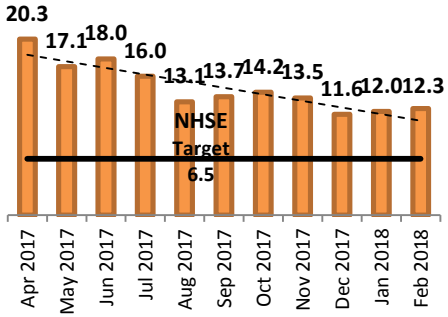
APPENDIX E

Hertfordshire Delayed Transfers of Care Analysis (Quarter 4 2017-18)

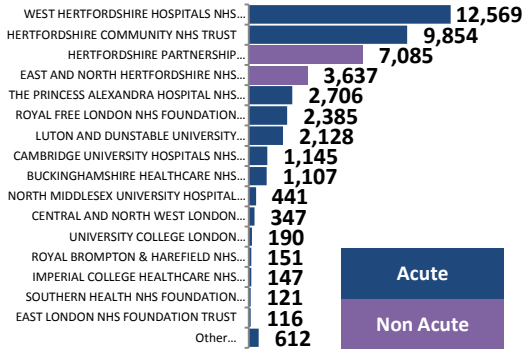
This publication is based on UNIFY published data up to the end of February 2018. This analysis has been produced to support Hertfordshire's quarterly delayed transfers of care performance for 2017-18.

Total Delays

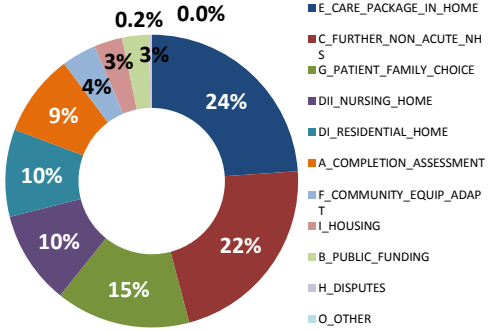
Total Delays Per 100k Monthly Trend Vs NHSE Target



Total Delays Split by Trust (actual delayed days) for the year to date



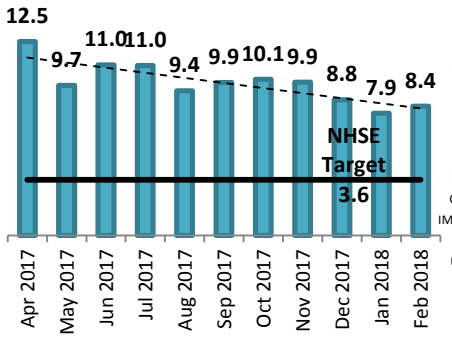
Total Delays Split By Reason (Actual Delayed Days) for the year to Date



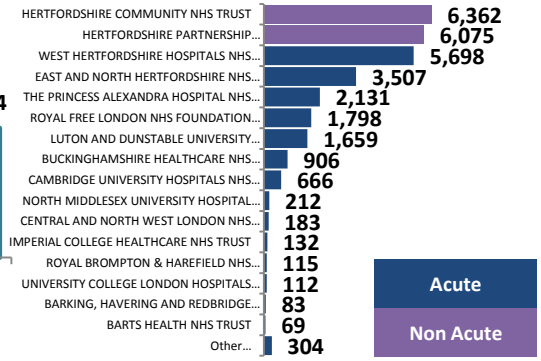
	Hertfordshire National Ranking (Out of 151)	Hertfordshire CIPFA Ranking (Out of 15)	Hertfordshire Eastern Ranking (Out of 11)
April	137	11	11
May	129	9	11
June	128	9	11
July	121	7	10
August	95	5	8
September	102	5	8
October	110	7	8
November	109	8	8
December	104	5	8
January	102	5	8
February	104	5	8
Year to Date	**114**	**6**	**10**

NHS Delays (67% of all Delays)

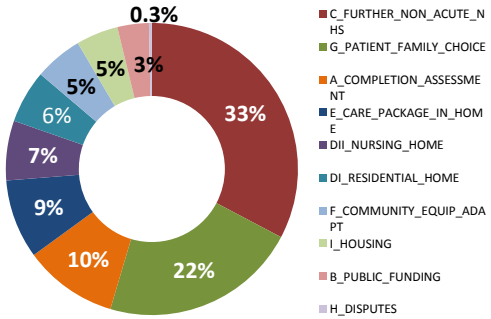
NHS Delays Per 100k Monthly Trend Vs NHSE Target



NHS Delays Split by Trust (actual delayed days) for the year to date



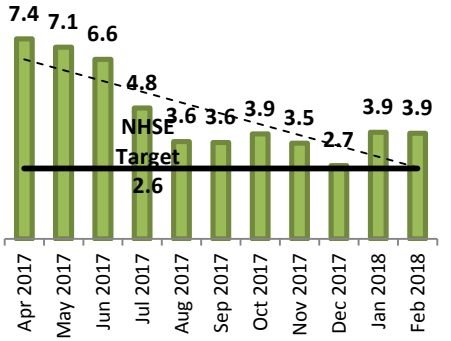
NHS Delays Split By Reason (Actual Delayed Days) for the year to Date



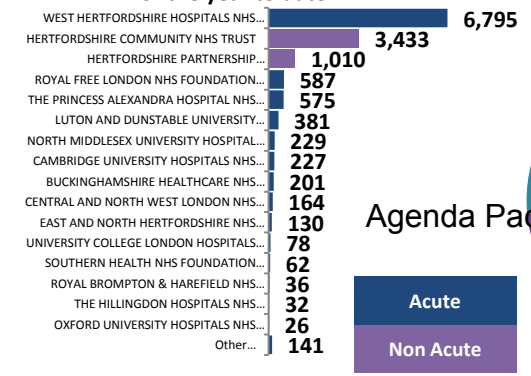
	Hertfordshire National Ranking (Out of 151)	Hertfordshire CIPFA Ranking (Out of 15)	Hertfordshire Eastern Ranking (Out of 11)
April	140	12	10
May	126	11	10
June	129	13	10
July	129	11	10
August	119	10	9
September	122	11	8
October	127	12	10
November	131	10	9
December	127	11	8
January	112	9	9
February	119	10	8
Year to Date	**123**	**10**	**9**

Social Care (31% of all Delays)

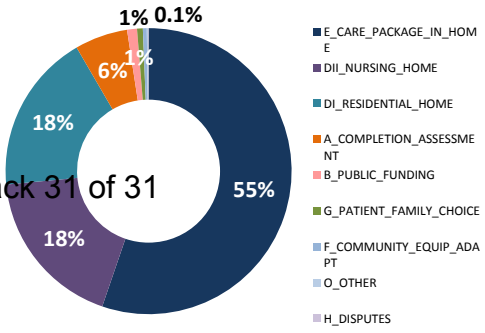
Social Care Delays Per 100k Monthly Trend Vs NHSE Target



Social Care Delays Split by Trust (actual delayed days) for the year to date



Social Care Delays Split By Reason (Actual Delayed Days) for the year to Date



	Hertfordshire National Ranking (Out of 151)	Hertfordshire CIPFA Ranking (Out of 15)	Hertfordshire Eastern Ranking (Out of 11)
April	122	10	11
May	129	11	11
June	116	9	11
July	99	5	7
August	77	2	7
September	84	3	8
October	94	7	8
November	94	5	7
December	85	6	7
January	110	8	8
February	105	9	8
Year to Date	**108**	**7**	**8**