Health and Wellbeing SUFFOLK

Suffolk Health and Wellbeing Board

A committee of Suffolk County Council

Report Title:	Update on A&E and Delayed Transfers of Care (DToC) System Task Forces
Meeting Date:	26 January 2017
Chairman:	Councillor Tony Goldson
Board Member Lead(s):	Ed Garratt, Accountable Officer, Ipswich and East Suffolk and West Suffolk Clinical Commissioning Groups (CCGs)
Author:	Richard Watson, Chief Redesign Officer, Ipswich and East Suffolk and West Suffolk CCGs

What is the role of the Health and Wellbeing Board in relation to this paper?

1. To outline to the Board the excellent system wide 'task force' approach being taken to address challenges in urgent care in Ipswich and East and West Suffolk.

Key questions for discussion:

2. The key questions for discussion are:

    a) How this approach can be scaled up to support other system challenges in Suffolk.

    b) How can it be used to develop the 'alliances' developing in Ipswich and East and West Suffolk.

What actions or decisions is the Board being asked to take?

3.	The Board is asked:
a)	To note the content of this report.
b)	To ensure that work undertaken supports the Board's priority that people in Suffolk live long, fulfilling and healthy lives and to see a narrowing of the health inequalities between our affluent and poorer areas.
c)	To suggest areas for further development pertaining to the A&E and Delayed Transfer of Care (DToC) System Taskforce Groups.

Brief summary of report

4. This report summarises the approach and achievements to date in relation to the A&E Taskforce in place for West Suffolk Hospital and the Delayed Transfer of Care (DToC) Taskforce for Ipswich Hospital.

Main body of report

A&E Taskforce for West Suffolk Hospital (WSFT)

Background

5. Historically WSFT has been a strong performer on the A&E four-hour standard but have struggled since the introduction of e-Care in May 2016.

6. The focus on the A&E department throughout the Summer and Autumn of 2016 has seen changes to staffing and leadership resulting in an improved model of delivery but not is not yet reflected in the A&E performance indicating that the patient pathway through the hospital (flow) needed to be a priority focus with a Taskforce put together to provide renewed focus on this area.

Approach

7. The main approach has been three fold:

   1. Diagnostic assessment of baseline: we needed to understand the issues impacting on flow through the hospital.

   2. Implementation of the national guidance on SAFER patient flow bundle and 'Red to Green Days' which is seen as good practice

   3. Dashboard development linking into E-care to inform the trusts live patient bed management system

8. In terms of SAFER this stands for:

   - **S**enior Review – a consultant review of all patients by midday every day

   - **A**ll patients will have a Planned Date for Discharge (PDD) and Clinical Criteria for Discharge (CCD)

   - **F**low of patients to commence at the earliest opportunity from the assessment wards with the first patients arriving on the ward by 10am

   - **E**arly Discharge – 33% of patients will be discharged before midday

   - **R**eview – a Multi-Disciplinary Team (MDT|) review of all patients with an extended length of stay greater than 7 days (also known as stranded patients) with a home first mind set

9. A multidisciplinary team was formed from WSFT and the CCG to dedicate time to the design and supporting ward staff in the implementation. Our aim is to get all acute wards operating the essential standards of SAFER and Red to Green by the end of February 2017 which in turn supports recovery against the A&E four hour standard.

Achievements to date

10. The diagnostic assessment element was completed on 11 December highlighting a number of common themes:

    a) Variation in practice: there was no consistent approach to SAFER principles across the ward areas and also across professional groups leading to ineffective review and decision making.

    b) Engagement and shared understanding from clinical leadership on what needs to be done to improve flow.

    c) Limited understanding of challenges across health and care – lack of shared ownership.

d) Good at crisis management but needed to focus capacity at getting better at planning and proactive management of flow.

e) Need for professional standards at ward level relating to diagnostics and discharge planning to reduce variation between wards.

f) Patient transport was repeatedly an issue impacting discharge and needed exploring further.

11. The SAFER patient bundle was then launched on 16 December across WSFT supported by the national expert body Emergency Care Improvement Programme.

12. All fourteen adult inpatient wards commenced implementation of essential SAFER bundle principles on 3 January 2017 which include:

a) 8.30am Monday to Friday consultant led board round with ward manager and other members of ward team including social work and pharmacy support as required

b) All wards using electronic whiteboards to record red to green status of each patient – in essence what needs to be done that day for the patient to ensure they progressed along their pathway to be discharged

c) All wards to ensure every patient has a Planned Date for Discharge and Clinical Criteria for Discharge so everyone is clear what needs to be done to enable discharge to take place

d) 2.30pm Monday to Friday check and challenge board meeting on actions from 8.30am board round within each ward

13. Also starting on 3 January there was a re-launch of daily system MDT reviews of patients who have not been discharged who could be with the aim of identifying external solutions to expedite discharge.

Next steps and sustainable change

14. The next steps are:

1. Support ward staff to embed essential standards of SAFER by end February so it becomes 'business as usual'

2. Daily ward based red to green check and challenge by the Taskforce until end February to ensure the processes are embedded in all wards

3. Development of ward based professional standards for diagnostics and specialist referrals by March

4. Further development of multidisciplinary Clinical Criteria for Discharge supported by integrated community pathways and home first principles to enable discharges to happen

5. Implementation of system thinking changes to discharge pathways, access to transport and integrated patient choice policy developed

6. Medium term development with the emerging Alliance of partners of pooled funding to support more timely discharges

Delayed Transfer of Care (DToC) Taskforce for Ipswich Hospital

Background

15. We are a national outlier for extremely high numbers of patient 'Delayed Transfers of Care' (DToC) at Ipswich Hospital. On 7 November 2016 there were 80 DToCs which is equivalent to 15.4% of the bed base with a national target for no more than 3.5%.

Approach

16. This has been a longstanding problem for which a multi-agency task force approach was used to identify the reasons for the situation, to agree an action plan with daily actions and a focus for the work required. This multi-agency team was formed, with individual members being released from their organisation to take a pragmatic approach to solving the problem. The aim was to breakdown organisational barriers through a collaborative approach with all stakeholders (including the care market) with an aim of achieving zero DToCs by March 2017.

17. There were three areas of focus for the taskforce's work: front door (A&E), hospital teams – inpatient ward areas and discharge.

Achievements to date

18. The overall headline is that DToC have reduced from a high of 80 on 7 November 2016 when the Taskforce commenced to 39 on 2 December 2016 and thus halving from 15.4% of the bed base to 7.3%. This figure has improved further and is at 25 as of 10 January 2017. Specific achievements which have supported this figure are:

   1. Front door:

   - A multi-agency emergency assessment team was formed to provide 'post take' (admission) wrap around support.

   - Improved management of patient and family expectations right from outset so all are clear on reasons for admission and what will be happening to support the patient being discharged – 'discharge by default, admit by exception'.

   - A new clinical '1,2,3' professional standard introduced to justify why a patient is not being discharged at the post take ward round and has to stay in.

   - 'Ticket Home' has been implemented to help set expectations for self-funder patients.

   - A 'traffic light' system has been introduced which immediately identifies the Estimated Date of Discharge (EDD) and patients' care needs with coloured stickers to be applied to each patient record - early identification of case worker for 'red' sticker patients (those who are more complex). Missed opportunity examples to avoid admissions in the first place are shared with system partners including care homes and ambulance teams.

2. **Hospital teams – inpatient ward areas**

- Clinically led 'peer to peer' challenge has been introduced across all ward areas. Communication and education have been improved.

- Section 5's (social care assessment) have been suspended for every patient who subsequently becomes medically unfit until such time as they become medically optimised and ready for such an assessment.

- A new initiative has been launched 'get up for breakfast', with nursing teams so that all patients where possible are supported to be up and out of bed.

- Best practice ward is now used to promote great discharge planning.

3. **Discharge**

- Weekly system-wide multi-agency/disciplinary team DToC deep dive meetings have been introduced with representation from all system partners and care home providers to jointly work through delayed patients and put in place necessary support to enable discharges of more complex patients to happen.

- Twice weekly sharing of our delayed patient requirement lists has been introduced, via the Chair of the Suffolk Association of Independent Providers (SAICP) – inviting those with 'appropriate' capacity to join the meeting or dial in.

- The process and policy for admission to community beds has been redesigned, opening to 'non-weight bearing patients', streamlining process between teams.

- Negotiation has commenced with providers for potential block booking for management of suitable 'delirium' patients outside of the acute trust.

- Legal advice has been sought regarding what is a 'reasonable offer' for patient choice by Adult Community Services.

- One integrated team to work together to resolve complex issues has been formed.

Next steps and sustaining change

19. Next steps are:

1. Improved communication and change of culture right from the front door (emergency department), with clarity on reasons for admission with admission by exception.

2. Multi-disciplinary team working, to set clear Estimated Discharge Dates, Clinical Criteria for Discharge and 'wraparound' to front door post take ward rounds with clearly identified, consistent reasons for further admission.

3. System-wide 'Emergency Assessment Team' at the front, with all system representatives pulling together daily for the same aim.

4. Early identification of patients requiring discharge support (i.e. amber / red flagged patients from post take ward round) with case workers assigned early on.

5. Regular 'Peer to Peer' support and challenge across all ward areas to reduce stranded patient metrics on length of stay.

6. Obtain true clarity of numbers of delirium patients and design/implement 'delirium specific' pathway to support these patients out of hospital.

7. Discharge to assess identification early on at point of admission.

8. Avoidance of any over-prescription of care.

9. Embed improved process between health/social care and care home providers.

Overall Actions/decisions recommended

20. Overall actions/decisions recommended are:

a) To embrace the concept of a true joint system working approach for other 'wicked' system issues.

b) To support the long term strategy and commitment from partners to ring fence resources to carry out work undertaken using this approach on a task and finish basis.

Why this action/decision is recommended

21. The work underway on the two taskforces described in this paper has demonstrated that joint system task and finish working to 'wicked' system issues is an effective approach. It requires the full support of those partner organisations involved and also the ability for their representatives to be empowered to take decisions including those of a budgetary nature.

Alternative options (if appropriate)

22. Existing ways to tackle the A&E and DToC issues have shown to have been ineffective, particularly where partners have worked in silos and attempted to tackle issues on their own and in competition.

Who will be affected by this action/decision?

23. All partner organisations related to a 'wicked issue' that is chosen with the adoption of the taskforce approach.

Sources of further information

a) NHS Emergency Care Improvement Programme Rapid Improvement Guide to: The SAFER Patient Flow Bundle: 5 Key elements:

http://www.ecip.nhs.uk/uploads/files/1/RapidImprovementGuides/the-safer-patient-flow-bundle.pdf

b) NHS Emergency Care Improvement Programme Rapid Improvement Guide to: Red and Green Bed Days

http://www.ecip.nhs.uk/uploads/files/1/RapidImprovementGuides/red-and-green-bed-days.pdf

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