SURREY COUNTY COUNCIL

Health Scrutiny Committee
30 May 2014

Progress and Impacts of the Hospital Discharge Rapid Improvement Event (RIE)

Purpose of the report: Scrutiny of Services

The committee will review the progress and impacts of the actions identified in the July 2013 Acute Hospital Rapid Improvement Event

Introduction

1. The Acute Hospital Discharge Rapid Improvement Event (RIE) was held in July 2013. The RIE was set against a background in Surrey of:
    - Growing demand on the health and social care system
    - Delayed transfers of care which are often multi-agency and complex, cost the acute hospitals unnecessary resources and block vital beds to other patients
    - Growing awareness that staying in hospital once medically fit is not good for people's health, independence and wellbeing
    - A positive working relationship between local health and social care partners and a desire to build on previous work to further improve the discharge pathway.
2. The ambition of the RIE was to improve the patient discharge process by working together as partners to ensure that as soon as patients no longer need acute hospital care they are discharged safely.
3. The RIE methodology is about having a joint commitment to improvement, senior leadership and sponsorship, and co-design of solutions by front line staff who really understand the challenges. The event was jointly sponsored by the Strategic Director Adult Social Care and the Chief

Executives of the five acute hospitals in Surrey. A multi-agency group of front line staff from across health and social care providers came together for the week-long RIE workshop in July 2013. An annexe is attached showing the organisations involved. The objective was to create:

- Shared understanding and joint solutions
- Consistent discharge pathways
- Common standards to underpin the discharge pathway
- Performance indicators to track and assess collective performance.

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Progress to date

4. The multi-agency group visited colleagues across the five acute hospitals to diagnose the problems with the existing discharge pathway. The group designed solutions and worked with their colleagues to get feedback and refine these ideas. At the end of the week, the group presented their findings to the sponsors and the seven work streams were agreed. These work streams were then developed further in the following months. The work streams of the RIE are:-

   A. Standard Operating Framework

   B. Proactive Multidisciplinary teams

   C. Read only access to partners IT systems

   D. More transport options home

   E. Poster, leaflet and protocol of choice

   F. Step up step down beds in the community

   G. Assessing collective performance

5. **The Standard Operating Framework** was developed. The aim of this was to agree common standards and for these to be implemented locally at each acute hospital. It provides an overarching framework for discharge planning and describes how to apply clinical standards to help to manage the patient journey through the emergency department, assessment areas and the wards to ensure consistent standards of co-ordinated care. All the acute hospitals are working to incorporate the standards into their local operating frameworks. A personalised 'Going Home Plan' was also designed to provide information for patients to help them to prepare for leaving hospital. Information for the Going Home plan was taken from a comprehensive booklet that Frimley Park Hospital had implemented and therefore they continue to use their patient booklet. The other four acute hospitals are piloting the Going Home Plan.

6. **Proactive multi-disciplinary teams** the aim of these was to help to ensure that all relevant agencies are involved at an early stage to help

prevent admission and to facilitate timely discharge. One of the areas of focus was for the teams to ensure that there was regular communication with the patient and/or their family (where relevant) and the community care provider, so that they could all be kept up to date and for them to be pro-actively engaged in the planning for leaving hospital. The Acute Hospitals are implementing this way of working and have aligned it with local work they have been doing to review and improve multi-disciplinary teams. For example in Ashford & St Peters Hospital this is being rolled out via their Discharge Task Force and in Epsom General Hospital it now forms part of the One Ward One Team programme.

7. **Read only access to partners IT systems**, providing nominated health staff with 'read-only' access to partners information about a patient to help prevent admission and assist with background information that would help with the planning to leave hospital. The first step is to provide access for Acute Hospitals to the Adult Social Care (AIS) records. Organisations can only share information with express consent from an individual and we therefore are currently finalising the information sharing and information governance requirements. In the mean time, named health staff have been nominated and our social care teams are provided training on the Adult Social Care (AIS) database. This work is ongoing and once we have the Information sharing matters finalised then health staff will have access.

8. **Transport options home**. This workstream enabled us to explore and identify alternative transport home options for patients to use that would be appropriate to their needs. The RIE recognised that there were issues with patient transport, and the purpose of this workstream was to explore if people were fully utilising all options and if we could develop alternative options to the PTS. We have:
    - Developed a checklist of local alternative transport options that can be used on the wards by staff and patients, this is being piloted in Epsom General Hospital and East Surrey Hospital (SASH).
    - Designed a helpful hints, or fact sheet for care providers to help them to put in place the relevant checks and processes in order that they would be able to offer transport support for their customers. Currently we do have some private providers who already provide this so the ambition is to help build on this good practice and support other providers to consider offering this as part of their service.
    - Designed a pilot in Mid Surrey Social Care, linked to Epsom General Hospital for our in house reablement service to offer transport home, We are aiming for a go live on this trial by end of June 2014 and if successful would look to roll out to other areas. This would also have the secondary gain of helping people to settle in following discharge from hospital

9. **Poster, leaflet and protocol of choice** this is to help ensure that patients have an understanding of the discharge process and to encourage them to think about their plans for returning home, including possible transport options. Each acute hospital is liaising with their internal communications

teams to design a poster with their local branding and in conjunction with local patient groups. The 'Going Home Plan' provides personalised information in leaflet form for patients on their estimated date of discharge and helpful tips on local services and what they might need to consider for planning their return home. A multi-agency working group has co-designed a protocol of choice; this is currently being reviewed by Clinical Commissioning Groups, community health providers and acute hospitals. The protocol of choice is an ongoing piece of work and we are aiming that this will be ready to launch in early June 2014.

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10. The aim of creating additional **step up and step down** beds in the community was to provide a resource to help prevent admission and help patients to leave hospitals as they no longer needed acute medical intervention. This was piloted in one of the Surrey County Council, residential care homes. The pilot concluded that a nursing rather than a residential care setting was really what was needed. The development of these resources will now be taken forward as part of the local partnership work through the Surrey Better Care Fund where Adult Social Care are working with local Clinical Commissioning Groups.

11. The **Assessing collective performance** work stream was to ensure that we had a common set of measures with joint health and social care targets. We have agreed Surrey wide measures as part of the Surrey Better Care fund in order to have a whole system approach for measuring performance. The measures include, delayed transfers of care from hospital, admissions to residential and nursing care from hospital, avoidable emergency admissions, 91 day review of outcomes for older people following discharge who received reablement. The intention is to commence reporting to the Surrey Better Care Board and the Surrey Health and Wellbeing Board in Quarter 1 2014/2015. There is a general clause in the Care Bill which references the duty to cooperate and so this will help to continue to support local partnership working.

12. We are planning **to complete an evaluation** of the impact of the RIE. We hosted a session with the Local RIE leads in February 2014, to review progress, share best practice and for initial feedback. The overall feedback at that point was that the RIE had been helpful in bringing together providers of health and social care to act as a catalyst to take forward improvements and that this has helped to build on local collaborative approaches to improving how we work together.

13. The intention going forward would be for us to continue to host a Surrey wide network every six months to share innovation, best practice and help to support and advice on any emerging. We have a commitment from our provider partners to continue with this forum as one that they value.

Conclusions:

14. In summary the Acute Hospital RIE has resulted in initiatives being put in place with the aim of improving the patient discharge process by working together as partners to ensure that as soon as patients no longer need acute hospital care they are discharged safely. The majority of the workstreams have been completed and are now with Local Acute

Hospitals and Social Care staff for piloting and implementing. There are some remaining workstreams that we are continuing to work on. These are the Access to Adult Social Care (AIS) Database, the completion and launching of the protocol of choice and with regards to the transport alternatives, the launching of the Pilot of the Surrey Reablement service to offer transport home from hospital.

15. Early indications are that the RIE provided a platform for collaborative working across Surrey and that colleagues have valued the opportunity to share best practice, and local innovation. We are currently in the process of drawing up a survey for those involved to evaluate the impact the RIE and what the impact has been on local partnership working. The proposal is to continue as a professional network and to meet six monthly to share ideas, innovation and best practice that colleagues could consider to adopt or adapt in their local settings.

Public Health Impacts

16. The early feedback is that Acute Hospital Discharge RIE has had a positive impact on the health outcomes of the population in Surrey by providing tools which help to prevent emergency admissions and ensure that as soon as patients no longer need acute hospital care they are discharged safely. An evaluation of the RIE will be undertaken in July 2014.

Recommendations:

17. That the Health Scrutiny Committee supports the continuation of a Surrey hosted County wide professional network of providers. The proposal is that the Network would meet on a six monthly basis to share ideas, innovation and best practice so that colleagues have an opportunity to hear of other initiatives that they could consider adopting or adapting for their local settings.

18. That following the publication of the RIE evaluation this is shared with all whom contributed to the RIE and to Health & Scrutiny Committee.

Next steps:

19. We are continuing to work on the access to Adult Social Care Records (AIS), the completion and sign off of the protocol of choice transport alternatives. It is expected all of these work streams will be completed by end of June 2014.

20. The Hospital RIE is drawing to a close, with most of the workstreams completed and an evaluation pending. We are planning to undertake an evaluation of the impact of the RIE in July 2014.

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Sources/background papers: Annexe of organisations involved attached

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