Oxford University Hospitals NHS
NHS Foundation Trust

Trust Board Meeting in Public: Wednesday 14 September 2016

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Title	**Patient Perspective**

Status	For information
History	Patient perspectives are regularly presented to Trust Board and Quality Committee.

Board Lead(s)	**Ms Catherine Stoddart, Deputy CEO and Chief Nurse**			
Key purpose	**Strategy**	Assurance	Policy	Performance

Executive Summary

1. Delays in transferring patients out of hospital have been a well-recognised and long standing issue within Oxfordshire. In autumn 2015, strategic work across the health and social care system led to the implementation of an innovative approach to address delays and improve patient flow and experience.

2. The purpose of this paper is to provide insight into a patient's experience of the new initiative. This aims to reduce delayed transfers of care by providing patients with a more suitable environment for rehabilitation in care homes and nursing homes, rather than remaining in the acute general hospital setting.

3. The impact of the new approach to Delayed Transfers of Care (DTOC) has been measured by the DTOC Control group. The lowest level of DTOC in the Trust's beds in the previous five years was recorded in June 2016.

4. This story provides an important opportunity to recognise the benefits of transferring patients to an environment that is suitable for rehabilitation, for example:

   - Proximity to the patient's home, enabling friends and family to visit regularly.
   - A more therapeutic environment: care home and nursing home teams have more opportunities to develop a personalised relationship with patients, to provide care in an environment with a greater focus on long-term quality of life.
   - Activities organised at care homes and nursing homes promote health and well-being as they encourage social interactions and the residents have an additional incentive to remain active.
   - The food at the nursing home was appetising and Mr L felt this aided his recovery.
   - Mr L found that he recovered quickly once he was at the nursing home, and was able to go home sooner than planned.

5. **Recommendation**

   The Trust Board is asked to reflect on the story.

1. Background

1.1. Delays in transferring patients out of hospital have been a well-recognised and long standing issue within Oxfordshire. In autumn 2015, strategic work across the health and social care system (including the two Oxfordshire NHS Trusts, the Oxfordshire Clinical Commissioning Group and Oxfordshire County Council) led to the implementation of an innovative approach to address these delays, with a view to improve both patient flow and patient experience.

1.2. This innovative approach focused on transferring patients who were delayed in hospital into care homes and nursing homes across Oxfordshire for a short period of time, while they awaited the next stage of their care (mainly home care packages or the organisation of a long term care home or nursing home). This approach had been piloted the previous winter.

1.3. The central aims of the 'Rebalancing the System' initiative were to:

- Ensure that patients, who were medically fit to be discharged from hospital, but awaiting non-acute health and social care support, were cared for in the right environment.
- Linked to this, reduce avoidable patient deterioration caused by delays in bed-based hospital care.
- Reduce the number of patients delayed.
- Enable the shift to ambulatory (as opposed to bed-based care) thereby supporting the management of the expected increase in hospital admissions due to winter illness affecting the elderly and those with chronic conditions on a much smaller scale.

1.4. A multi-agency Liaison Hub was established in December 2015 to coordinate and manage the needs of the patients being transferred to the care homes and nursing homes. The Liaison Hub operates with involvement of the three provider organisations, located at the John Radcliffe Hospital (JRH) and Horton General Hospital (HGH).

1.5. The key functions of the Liaison Hub are:

- identifying appropriate patients to be transferred to the care home and nursing homes;
- ensuring proactive discharge planning for patients who are transferred to the nursing homes;
- arranging and running the multidisciplinary working with nursing homes, social workers, therapists, GPs and hospital clinicians;
- managing the logistics of communication with patients and families, escalating concerns and issues;
- maintaining a tracking system via a virtual ward for all patients who have moved, recording their onward destination;
- providing day-to-day (seven days a week) support to nursing homes to proactively support patient management.

1.6. This project has had a significant impact on the number of patients delayed in beds in Oxford University Hospitals NHS Foundation Trust (OUH) and Oxford Health NHS Foundation Trust (OHFT), and more widely across Oxfordshire. Since the end of March 2016, the number of delayed patients across Oxfordshire has reduced. In June 2016, the lowest level of Delayed Transfers of Care (DTOC) in the Trust's beds in the previous five years was achieved.

1.7. The metrics that are monitored weekly by the DTOC Control group are presented in Appendix 2.

1.8. As of the 24 August 2016, 476 patients have been transferred to nursing home beds. Of these, 364 have been directly discharged from the nursing homes to the following places:

Table 1: Flow of patients through the hub beds

Placement	Numbers
Permanent nursing home placement	145 (68 private funders, 70 social funding and 7 continuing health care funding)
Supported Hospital Discharge Service or Oxfordshire Re-ablement Service	83 (70 SHDS and 13 ORS)
Home with domiciliary care	70 (11 of these private funders)
Home with no care	18
Died (in hospital or nursing home)	48
Total	**364**

1.9. There are currently 50 patients in care homes and nursing homes awaiting various discharge care packages. Some require further assessment and rehabilitation. Since the system was introduced up to the 16 August, there have been 469 patients transferred to nursing home beds. Of which,

- 55 patients are currently in nursing home beds,
- 353 patients from nursing homes have been discharged home
- 61 were readmitted to hospital and discharged straight to home.

1.10. The length of stay of the patients discharged from care homes are as follows:

Table 2: length of stay

Length of stay	Frequency
0-7 days	52
8-14 days	59
15-21 days	67
22-28 days	39
29-42 days	71
43-56 days	69
>56 days	98

1.11. In April 2016, surveys were sent out to the first 150 patients who had been transferred to hub beds from either the OUHFT or from an OHFT Community Hospital bed. A total of 40 questionnaires were returned (a response rate of 27%). Feedback from patients and their families was largely positive, with the majority of respondents strongly agreeing or agreeing with all ten positive statements (see Appendix 1 for the full responses to each of the statements).

1.12. This patient story supports the largely positive response to the patient survey.

2. Patient perspective

2.1. The purpose of this section is to provide insight into a particular patient's experience of the new initiative. Mr L stayed on an Acute General Medicine ward at the John Radcliffe Hospital for seven days in December 2015, before being transferred to a nursing home, where he stayed for five weeks.

2.2. Mr L was offered a Liaison Hub nursing home bed for up to eight weeks. He was pleased to be placed in a nursing home near his home. It was important to him that he was close to home so that it was easier for friends and family to visit him. He was glad to be involved in decisions about where he would be transferred:

2.2.1. *After a few days in hospital, a lady came to see me, and she said she was trying to get me into a rehab hospital. I said "don't send me to Henley" because that would have been miles away. She said it was a nursing home I knew of, and I said "that's very handy because that's close to me", and the lady who runs the nursing home came to see me and talk about it within 20 minutes. She said she could offer me a space at the nursing home for 8 weeks*

to get me back on my feet, and I was happy with that. I was transferred the next day, a Saturday, in a car organised by the hospital.

2.2.2. The patient survey results support this experience: 78% of patients who responded to the survey agreed that they were involved in the decision to be moved to a care home/nursing home.

2.3. Mr L's overall experience of the service was extremely positive. He cited the staff as one of the main reasons for this. The environment in the nursing home is conducive to forming therapeutic relationships between patients and staff, compared to the fast paced nature of acute general medicine wards:

2.3.1. *My experience of the nursing home was very, very good. The care there was out of this world. I could not fault it. It was the way the staff treated me, nothing was too much trouble. If you wanted something, they brought it straight away. There were two staff in particular who were really brilliant, I think one was Dutch and one was Polish. Everything was done for you with a smile.*

2.4. The food at the nursing home was varied and appetising, which encouraged Mr L to eat well while he was recuperating:

2.4.1. *The food was very good. Before I went into hospital I hadn't been eating properly, but the nursing home helped me to get back on track. At the JR, there were cornflakes at breakfast, and the other food was too mashed, they weren't really solid meals. When I got to the nursing home we had porridge, bacon and eggs at breakfast, and proper hot meals at dinner and the evening meal, and sandwiches always available if you preferred. Then we had Ovaltine, biscuits and cake later on. We ate in the communal area. They would have taken me to the communal area at the JR but I wasn't well enough then.*

2.5. Mr L enjoyed the social environment at the nursing home and this contributed to his recovery:

2.5.1. *I loved the community feel there, and I had some good friends there. There was one lady who I knew from years ago, and another that I made friends with while I was there. I used to sit with them, and I still go back to visit them regularly.*

There is always something going on there, like an activity or a musical show. The entertainment went down well with most people, and it certainly went down well with me.

2.5.2. 83% of patients agreed that their health and social care needs were met during their stay at the care home/nursing home.

2.6. Mr L was able to keep his independence, though the residents' safety was also an important consideration for the staff:

2.6.1. *They helped me look after myself. I was already dressing myself so they didn't need to help me with that. I liked to use the stairs*

instead of the lift. They would have preferred I used the lift, but when I used the stairs anyway they made sure I was ok on them, watching as I went up.

2.6.2. 90% of patients agreed they felt safe while they were in the care home/nursing home.

2.6.3. 73% of patients agreed that the care home/nursing home was a better environment for them while they were waiting for be transferred back home.

2.7. The only issue that Mr L encountered was a delay in receiving medicines for a cold.

2.7.1. *There was only one thing that could have been better - when I had a cold, they sent for the doctor to prescribe me some medicines, but it had to be the doctor from the JR, and that meant waiting 'til 8pm. I said I could have walked over the road to see the GP there and then I could have got the medicines from the pharmacy nearby. But they said I needed to see the doctor from the JR and the medicines needed to come from a pharmacy in Headington – because of how they are registered.*

2.7.2. The medical cover from some of the nursing homes came from the JR and HGH as it was not possible to have GP cover for all the nursing home beds.

2.8. Mr L found that he felt better very quickly, and this was something that his visitors remarked on:

2.8.1. *I had up to five visitors per day, and they commented on how much better I looked when I got to the nursing home. I came there for respite, and I felt better in myself, but I also learnt a lesson; not to let myself get ill like that again and make sure I look after myself properly in future. I'm eating much better now.*

2.9. Mr L was offered support when he was moving back home:

2.9.1. *In the end, I was only there for 5 weeks. I thought I might as well let someone who needs it have the bed instead of me, because I didn't need to be there anymore. They asked me if I wanted some help when I got home, but I didn't, I've got a son and a daughter who do a lot for me and I can manage the rest.*

2.9.2. 95% of patients agreed that they were supported and informed about the move back home.

2.10. The Liaison Hub is staffed by Sisters and Discharge and Therapy Coordinators who are very experienced in complex discharge planning and are able to work autonomously. The Liaison Hub team is very proud to have been part of this innovative project which has been received so positively by patients and their families. Seeking, evaluating and sharing feedback is vital to ensure that the service can continue to grow. It has been a dynamic process and feedback is reflected upon in order to improve practice.

3. Recommendation

3.1. The Trust Board is asked to reflect on the patient story.

Presented by:

Catherine Stoddart, Deputy CEO and Chief Nurse

Authors:

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Appendix 1: Results of the Patient Survey

Table 3

Statements	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total responses to question (out of 40 returned)
1. I was involved in the decision to be moved to a care home	11	20	5	1	3	40
	28%	50%	13%	3%	8%	100%
2. I had sufficient information that I needed about my transfer and the support I would receive once in the care home	8	23	3	4	1	39
	21%	59%	8%	10%	3%	100%
3. My family (or carer) was involved as much as I wanted them to be in decisions about my care and support	12	22	3	1	1	39
	31%	56%	8%	3%	3%	100%
4. I was treated with dignity and respect at all times when being transferred from hospital to the care home.	17	20	1	1	1	40
	43%	50%	3%	3%	3%	100%
5. My health and social care needs were met during my stay at the care home.	17	16	1	2	2	38
	45%	42%	3%	5%	5%	100%
6. Any medication I was on was reviewed and I was informed about any changes	10	22	5	3		40
	25%	55%	13%	8%	0%	100%
7. I felt safe while I was in the care home	21	14	1	1	2	39
	54%	36%	3%	3%	5%	100%
8. The care home was a better environment for me while I was waiting for be transferred back home	19	10	7	1	3	40
	48%	25%	18%	3%	8%	100%

Statements	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Total responses to question (out of 40 returned)
9. I was well supported and informed about the move back home (23 returned)	13	8	1			22
	59%	36%	5%	0%	0%	100%
10. The move to my permanent care home was well managed (17 returned)	2	10	1	1		14
	14%	71%	7%	7%	0%	100%

Appendix 2

Table 4: Key Performance Indicators

Quality Measure	Metric	Data Source	Target/ benchmark
Access in	Total new admissions to Intermediate care beds	Virtual ward report	35-40 week
Access out	Total Discharges from Intermediate care beds	Virtual ward report	35-40 week
Access	% of patients discharged to long term care home	Hub patient tracker	32-37%
Access	% of patients discharged home with long term care	Hub patient tracker	27-33%
Access	% of patients discharged home with no support	Hub patient tracker	
Access	% of patients transferred home from ICB with re-ablement support	SHD/ORS report	
LOS	Av LOS from admission to discharge from ICBs	Virtual ward report	
Access	Total readmissions to hospital (add narrative for performance report)	Virtual ward report	
Mortality	Total deaths as a % of all admissions to ICBs	Virtual ward report	13-20%
LOS	Av LOS from admission to discharge from ICBs	Virtual ward report	< 28 days
LOS	% of patients with LOS greater than ICB greater than 8 weeks	Virtual ward report	
LOS	Number of weekly DTOC at Snapshot - Sitrep (commencing 17/12/15)	Sitrep DTOC report	
Flow	Number of Bed days delayed (Jan - March 16) compared to Jan - March 15	Sitrep DTOC report	
Flow	Total homes contracted with	Virtual ward report	
Flow	Total beds utilised	Virtual ward report	
Workforce	Additional staff recruited/ redeployed to support initiative	HR report	