Buckinghamshire Healthcare NHS Trust

Division of Integrated Elderly & Community Care	
Briefing Paper	Moving Care Closer to Home
Dated	April 2016

1. Introduction

Buckinghamshire Healthcare NHS Trust provides a range of services for frail older people of Buckinghamshire and beyond including community, outpatient, day case and inpatient care. In 2015 a new Integrated Elderly and Community Care Division was created within the Trust to ensure that the organisation maximises the opportunities it has to provide and develop integrated care. The national direction is to move care closer to home, where appropriate. With that in mind the divisional team have looked at the services currently available and developed proposals to further invest in expanding community services in order to support more patients closer to home and to reduce the number of delayed discharges and transfers of care. This could be achieved by shifting resources from acute to community services.

2. Improving the quality of care

Currently, services for frail older people are provided from patients own homes (through the adult community healthcare teams), as well as a variety of outpatient, inpatient and day case services offered from Wycombe, Stoke Mandeville, Amersham, Buckingham, Thame, Marlow, and Chalfont hospitals.

The national Five Year Forward View, published in October 2014, stressed the importance of "expanding and strengthening primary and out of hospital care". It cites various examples of successes in managing elderly complex patients in the community and avoiding admissions. There is good evidence that patient satisfaction is higher when people are treated at home rather than in hospital and there is also some evidence that this may be more cost effective. (Purdy,S, 2010)

Moving care into the community and providing streamlined pathways that integrate health and social care are major components of the five year forward view and is designed to ensure resilience and sustainability in the NHS for the future.

Locally, treating as many patients, especially older people, at home is also a top priority for the Trust and local commissioners. The Chiltern CCG's operational plan for 2014 – 16 states two of their outcome ambitions as:

- Reducing the amount of avoidable time people spend in hospital through better and more integrated care in the community.
- Increasing the number of older people living independently at home following a stay in hospital.

A 2016 report by the independent Commission on Improving Urgent Care for Older People states that there needs to be a greater focus on proactive care. The current system often focuses on providing care reactively. The Commission believed the mind-set of the care system needed to change from reacting in a crisis, to proactively planning to avoid one and to react appropriately if someone deteriorates. They stated this would help support hospital services to meet the needs of those who really needed the unique skills, expertise and environment of the acute sector. It also encouraged greater use of multidisciplinary and multiagency teams. Suggesting the teams could operate in both the hospital and the community, bringing together staff from different backgrounds. Where appropriate, they should encourage and support self-management by working with people and carers, which at Buckinghamshire Healthcare we are uniquely placed to deliver.

In the wide-ranging Lord Carter report into hospital productivity and performance, published in February 2016, it highlights that the number of days lost to bed blocking is higher than previously thought: "Nearly all trusts wrestle with the problem of moving those who are medically fit into settings that are more appropriate for the delivery of their care or rehabilitation, and for the families

and carers." Information provided by trusts reveals that on any given day as many as 8,500 beds in acute trusts (across England) are blocked with patients who are medically fit to be transferred. In Buckinghamshire, we report on between 50 and 60 delayed transfers of care per day.

3. Process for developing new model

On average there can be upwards of 50 – 60 patients remaining in Buckinghamshire acute hospital beds that are medically ready for discharge or transfer to their next stage of care, be that a nursing home bed or waiting for a social services long-term package of care at home. It has been identified that these patients could benefit most from greater investment in community support.

These patients are often transferred to ward 5b at Wycombe Hospital, which can constitute another process in their journey, delaying their discharge and adding to their length of stay. Currently on 5b, 100% of the patients are deemed medically fit for discharge.

Ward 5b is a 20 bedded ward which facilitates both male and female patients. The ward primarily cares for older patients who require additional rehabilitation prior to discharge. 5b also accepts admissions from all parts of the Trust for those patients over the age of 75 who require low level rehabilitation or those who are waiting for social care in the community.

In 2015/16 there were 263 people admitted to the ward. The main sources of referral into 5b were from several main areas:

- 65% were from Medicine for Frail Older People (Wards 8 & 9 at Stoke Mandeville and MUDAS at High Wycombe)
- 34% were from Wycombe Stroke and Cardiology Services.
- 1% direct from Assessment & Observation Unit and Short Stay Ward at Stoke Mandeville.

Of those admitted to the ward, 68% were from the Wycombe and Marlow locality and the remaining from Amersham and Aylesbury, with a few additional out-of-area patients.

The average length of stay on the ward was 24 days. It is important to note that this is 24 days beyond their initial treatment episode on the specialist referring ward, as most patients (99%) are referred to 5b following an inpatient stay on another ward within Stoke Mandeville or Wycombe hospitals. At any given time, 75 - 100% of patients on 5b are medically fit for discharge, waiting to be transferred to the next step in their pathway.

Of those patient admitted in 2015/16:

- 24% were discharged to nursing or residential care.
- 67% were discharged home.
- 9% other discharge destinations.

The division has identified that by increasing investment and capacity in earlier packages of care for people in their own homes would support us to discharge people to the right setting when they are medically fit to leave hospital, reducing their length of stay in the acute hospital. There is strong evidence that a long length of inpatient stay in a hospital setting can lead to sub-optimal care as older patients decompensate and lose confidence as well as increase their risk of hospital acquired infections. (British Geriatric Society; RCGPs; Age UK Report: 2014)

4. Proposed new model of care

Investing in more support in the community will help older people to be cared for in an environment that is most appropriate for their needs and wishes.

We want people to receive the right care at the right time in the right place. Therefore the division wants to transfer some of its resources from acute care to invest in better community provision. This will help to prevent avoidable admissions where possible and ensure that older people are supported with their discharge home to remain as independent as possible for as long as possible. As ward 5b currently cares for patients who are medically ready for discharge or transfer to their next stage of care (be that a nursing home bed or waiting for social services long-term package of care at home) it is proposed to transfer the investment from this ward into expanded community provision. It is proposed that this is piloted for a six month period in order to assess impact and effectiveness.

What we will do
Put packages of care (domiciliary care) in place for older people within their own homes without the need to wait in an acute hospital bed until this can be organised.
Increase access to rapid support in a crisis; to enable people to get back to their own homes from hospital and regain their independence quickly.
Offer enhanced physiotherapy and occupational therapy for stroke patients to aid rehabilitation in the treatment wards at Wycombe. Thus not requiring the need to transfer to another ward to receive this rehabilitation.
Increase capacity to therapy within the Adult Community Health Teams
Enhance the single point of access, making it easier for GPs and other healthcare providers to access health or social care support, supporting admission avoidance and to ensure we have early supported discharge.

Total shift in investment that is being proposed is: £1,000,000
We estimate that up to 90% of those patients admitted to 5b last year could have benefited with access to this community provision and as a consequence could have had a reduced length of stay in the acute environment. However for those patients still requiring inpatient treatment then their care and treatment will not be affected by this change – they would remain on their specialist ward, but with the benefit of easier access/support to be directly discharged from that ward when medically fit, instead of being transferred to 5b whilst awaiting final packages.

5. Benefits

We believe the benefits of this shift of investment would include:

- Older people being cared for in the right environment.
- Reduction in projected length of stay for older people, as we have an average length of stay of 24 days on 5b.
- Better experience for the patient as they receive the right care at the right time, in the right place.
- Seamless pathways of care for older people, with patients not being transferred between wards and sites whilst waiting discharge home or packages of care in the community.
- Reduction in avoidable admissions for older people.
- Relocation of permanent skilled ward nurses to the stroke and cardiology services at Wycombe. There are vacancies on these specialist wards which are currently covered by agency and bank staff, which can reduce continuity of care to patients. Staff on 5b have the relevant specialist skills and will therefore be offered the opportunity to work on these wards.
- As this is a pilot, staff will have the opportunity to explore different working environments, which best utilises their skills. After the pilot concludes we will commence a formal consultation process to ascertain whether staff wish to stay where they are or whether they wish to look for different opportunities, which we will support them with.

6. Proposed next steps

Phased investment has already commenced in expanding community care, which has enabled the team to reduce bed capacity on the ward. The intention is not to transfer new patients onto 5b once all current inpatients are discharged or transferred to the right community setting (there are currently five patients on the ward). Community care – as outlined above – will be directly accessible to the relevant medicine for older people services and specialist wards. Patients requiring specialist care will continue to receive this across the medically frail older people wards, stroke wards and cardiology wards – this remains unchanged from the current provision.

We are commencing a consultation with staff on changes to their working patterns during this pilot.

We will review again in six months' time, alongside overall Trust capacity planning, to establish that there is no longer a requirement to re-provide this inpatient setting.

We will monitor the following:

- Average length of stay for older people
- Number of pre-paid packages of care provided
- Discharge destination for older people
- Patient related outcome measures & patient related experience measures.
- Number of admission avoidance delivered by REACT & the community healthcare teams.
- Focus group with the redeployed staff to see if they feel they have been well supported, what went well and what we could improve on.

References

NHS England October 2014. Five Year Forward View

Kings Fund Purdy. S December 2010 Avoiding Hospital Admissions. What does the research evidence say?

NHS Confederation: Independent Commission Sharing New ways of supporting older people.

Doh Lord Carter review 2016.

British Geriatric Society; RCGPs; Age UK Report: Fit for Frailty- consensus best practice guide for the care of older people living with frailty in the community and outpatient settings (2014)