Buckinghamshire Healthcare NHS
NHS Trust

Report to the Health Adult and Social Care Committee

Pilot of Moving Care Closer to Home

Ward 5B, Wycombe Hospital

May – October 2016

November 2016

Contents

1. Introduction

Buckinghamshire Healthcare NHS Trust provides a range of services for frail older people of Buckinghamshire and beyond including inpatient, day cases and outpatient care. Following the national direction of providing care closer to people's own homes, the clinical team reviewed the provision of ward services which led to 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.

A pilot transferring care from 5b at High Wycombe into community services was commenced in May 2016. A briefing was provided to the Health and Adult Social Care Select Committee at that time.

The pilot was undertaken to explore the impacts of developing alternative models of care. The purpose of this report is to provide the committee with an update on the outcome of those changes and make conclusions about these results and outline the next steps.

2. Context for change

The national direction is to move care closer to home, where appropriate, and is well supported by evidence that frail older patients recover more effectively at home (BGS. 2010). There is strong evidence that long lengths of in-patient stays can lead to sub-optimal care as older patients decompensate and lose confidence as well as being at risk of hospital acquired infections. British Geriatric Society; RCGPs; Age UK Report: (2014).

Moving care into the community and providing streamlined pathways that integrate health and social care are major components of the National Five Year Forward view, (published in October 2014)

It stresses the importance of "expanding and strengthening primary and out of hospital care" and 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).

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 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 national report into hospital productivity and performance, published in February 2016, it highlights that the number of days lost to patient delays in transferring from an acute bed 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.", such as discharge to assess settings. 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 between 50 and 60 delayed transfers of care per day.

This discharge to assess model offers people who are medically fit and do not require an acute hospital bed an assessment for longer-term care and support needs in the most appropriate setting and at the right time for the person. The benefits of such a model is:

- People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.
- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years.
- Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding.
- Improves system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in the wrong place.
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.

Treating as many patients, especially older people, at home is 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.

3. New Model of Care

At the commencement of this proposal on average there was upwards of 15 frail older patients remaining in Buckinghamshire acute inpatient beds that were 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. These patients were often transferred to ward 5b at Wycombe Hospital, which constituted another process in their journey adding to their length of stay. At the time, 100% of the patients on 5b were deemed medically fit for discharge.

In 2015/16 there were 263 people admitted to the ward. The main sources of referral into 5b were from several key 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 the Short Stay Ward at Stoke Mandeville.

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

The average length of stay on the ward was 24 days; however this was an additional 24 days beyond their initial treatment episode on the referring ward, as most patients (99%) were referred to 5b following an in-patient stay on another ward within Stoke Mandeville Hospital or High Wycombe . Therefore up to 99% of admissions had a projected length of stay within the acute environment as they were waiting for their onward care.

Of those patients admitted in 2015/16:-

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

As a 100% of the patients were medically fit to leave hospital, it was proposed to pilot a transfer of care from the ward to support people in the right setting, be that in a nursing home bed, or a package of care in their own home.

This new model of community care would help older people live in an environment that was most appropriate for their needs and wishes. However if an older person needed hospital or other healthcare they would and were able to access it still.

This message was echoed by the community who attended the BHT engagement events during April and May 2016.

The plans that were identified at the beginning of the pilot stage were:-

1.	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.
2.	Undertake assessment for social care in a care home setting rather than have to remain in an acute bed in hospital.
3.	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.
4.	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.
5.	Increase capacity to therapy within the Adult Community Health Teams
6.	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.

We believed the benefits of this pilot would include:

a) Older people being cared for in the right environment.
b) Reduction in projected length of stay for older people. Ward 5b had an average length of stay of 24 days in addition to their main ward stay.
c) Better experience for the patient as they receive the right care at the right time, in the right place.
d) 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.

e) Reduction in avoidable admissions for older people.
f) Relocation of permanent skilled ward nurses to the stroke and cardiology services at Wycombe. There were vacancies on these specialist wards which were currently covered by agency and bank staff, which can reduce continuity of care to patients. Staff on 5b have the relevant specialist skills and were offered the opportunity to work on these wards.
g) Staff would have the opportunity of the pilot to explore different working environments that best utilised their skills. After the pilot concludes we will commence a formal consultation process to ascertain whether staff wish to stay where they are.

4. Progress to Date.

The pilot commenced in May 2016 and a review of the effectiveness after the six months concluded:

	The plans that were identified at the beginning of the pilot stage were	What we did
1.	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.	We are providing interim services enabling patient transfer back into the community rather than remain in an acute in-patient bed. This has allowed allow patients to either return home with the right support or be offered an interim bed in a care home providing space to recover and to consider the next stage of care. We have provided 42 packages of care and have provided up to 11 care home beds.
2.	Undertake assessment for social care in a care home setting rather than have to remain in an acute bed in hospital.	
3.	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.	We are working in very close partnership with primary, social care as well as the care home market to develop community teams that highlight our most vulnerable and at risk patients in order to anticipate any crisis and reduce the need of emergency admission. This is in the recruitment phases and will be fully operational from April 2017.
4.	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.	Increased therapy support was offered to the Stroke Ward to ensure that patients continued to have rehabilitation to ensure that their independence was maximised.
5.	Increase capacity to therapy within the Adult Community Health Teams	The development of the Community Rapid Response and Intermediate Care Team is nearing completion and will be fully operational from April 2017.
6.	Enhance the single point of access, making it easier for GPs and other healthcare providers	The development of the community single point of assessment is nearing

	to access health or social care support, supporting admission avoidance and to ensure we have early supported discharge.	completion supported by increases in the capacity of our community teams to deliver a rapid response to meet patient needs. In the community we currently provide up to 50,000 face to face contacts a month.

The workforce from ward 5b were temporarily relocated to alternative clinical areas giving each staff member an opportunity to indicate their preferred clinical speciality, which enabled staff to explore different working environments, which best utilised their skills.

5. Monitoring the Impact - Methodology

It was agreed that the impact of the pilot would be monitored during the duration of the pilot using the following measures:

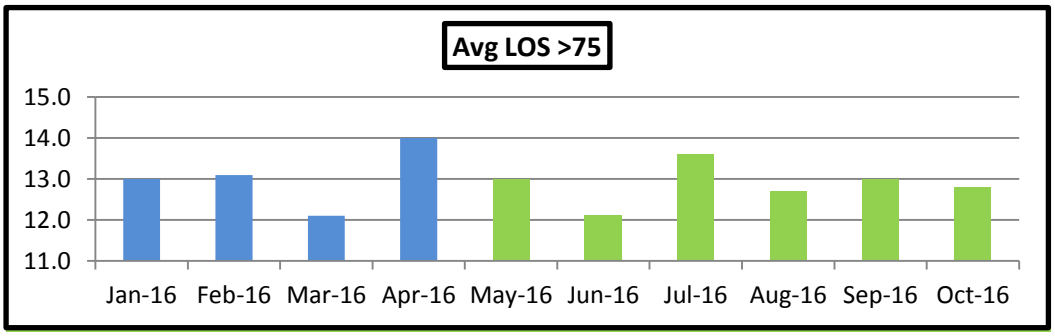
- Average length of stay for older people
- Number of interim packages of care provided
- Discharge destination for older people
- Patient related outcomes measure and patient related experience measures
- Number of admission avoidance delivered by REACT and community healthcare teams
- Focus groups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

6. Analysis of the Impact

a) Review of the length of stay of older people remaining in an acute bed.

The lengths of stay of older people over the age of 75 were reviewed in order to determine if converting to alternative community models of care in the system resulted in an increase in the overall length of stay of older people.

The analysis included those patients who remained in hospital past a 14 day threshold who were often waiting for complex packages of care, rehousing or adaptions. The length of stay in the key wards both at Wycombe and Stoke Mandeville that previously referred to ward 5b were also reviewed. This was to establish if there was an impact on the flow through these wards as a result of the pilot.



During the pilot phase there was no significant increase in the length of stay of patients over the age of 75 years on acute inpatients which indicated that patients were not being unnecessarily delayed in the system by this change. Across the trust the average length of stay reduced by 1 day for this cohort of patients to 12 days.

b) Number of interim packages of care provided (discharge to assess)

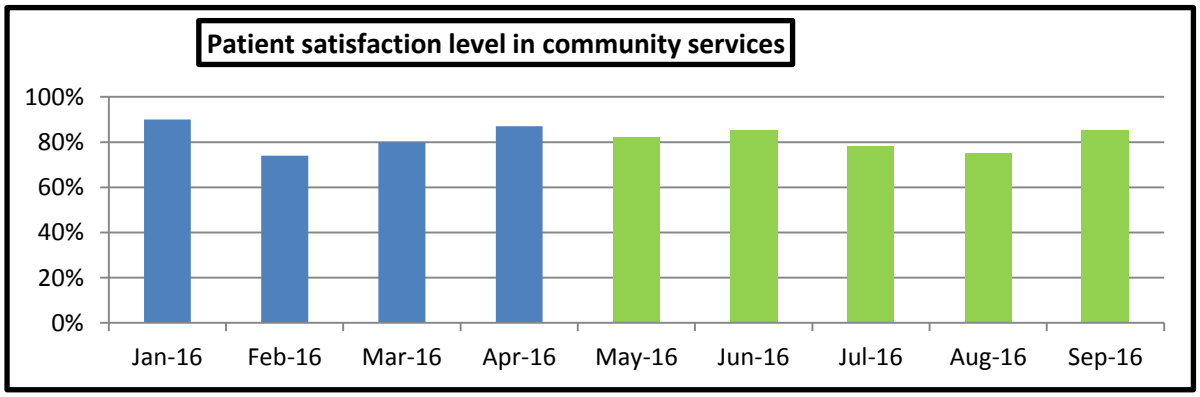
The Trust developed a transitional care model (Discharge to Assess) that allows patients to be transferred to either a care home setting or at home with an interim package of care where they can recover and be assessed as to the level of care they require to meet their needs in the longer term. This provides up to 60 hours of domiciliary care a day and up to 20 care home beds across the county. This is delivered in partnership with domiciliary care providers and care home providers in the county. This is being utilised across the county We are providing on average 60 hours of domiciliary care a day and currently up to 11 care home beds.

c) Patient related outcome measure and patient related experience measures

Patient experience and satisfaction for the community services is currently measured through satisfaction questionnaires.

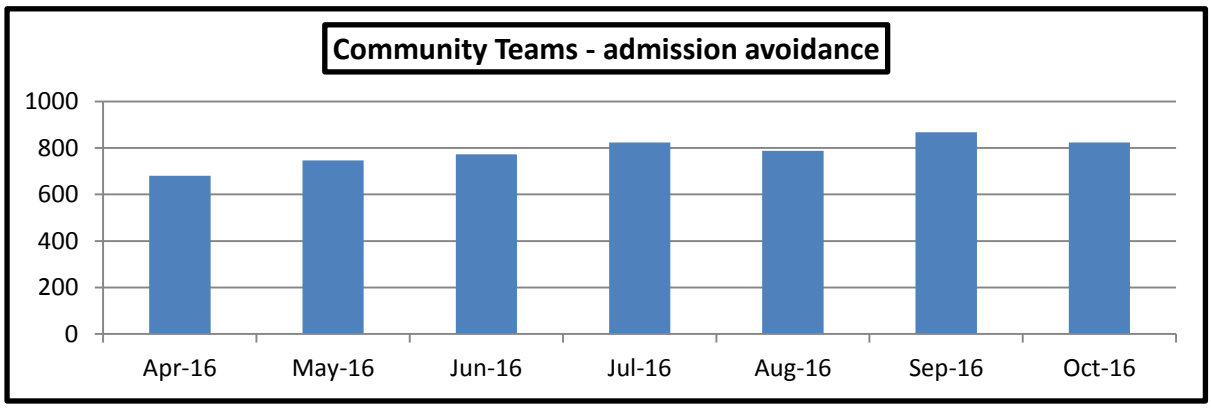
A random sample of patients is selected every month – on average the response rate is 62% of all patients who receive care.

We have measured the levels of satisfaction to determine if there has been any drop in patient experience. Over 80% of patients continue to report that the service they receive as excellent or good.



d) Number of admission avoidance delivered by the community healthcare teams

The Adult Community Healthcare Team (ACHT) collect the number of admissions avoided in order to demonstrate the effectiveness of their urgent response to a patient need. Meeting this need would often avoid an emergency attendance at A&E which could have resulted in an admission. Ongoing monitoring of this would be a key determinant in demonstrating the success of additional investment in the community especially in our single point of access and rapid response services.



Over the last seven months during the pilot stage, there was an increase in the number of admissions avoided by the community services by 150 a month.

e) Staff feedback during deployment phase of the pilot

Forums and informal meetings have been held with all ward 5b staff redeployed to alternative clinical areas for the duration of the pilot.

The feedback indicated that most staff had settled well into their new roles and felt that the redeployment had given them an opportunity to develop further skills.

A staff survey conducted in September, nearing the end of the pilot, determined staff would be happy to remain in the roles to which they had been redeployed. 92% of staff stated they would be happy to stay in their current positions and this can be accommodated. A small number of staff (less than 5) would either like or would need to be redeployed out of their current roles. A staff consultation process is about to be commenced to fully engage staff in understanding the rationale for the changes and how it will affect their current roles. This process provides individual staff with the opportunity to discuss their specific situation and career aspirations for the future.

7. Summary of evaluation

This report provides 6 months of data of the pilot and has provided a data comparison spanning the 4 months prior to temporary transfer of resource from 5b. The data has been analysed and conclusions from the data have been drawn.

The pilot has increased the number of people that have been managed under our admission avoidance pathways and we have reduced the length of stay of over 75s by 1 day.

It can be concluded that from the analysis that there has been no negative impact created in the system as a result of the pilot. This is both across the whole system and from those wards that transferred patients to 5b. Patients that would have ordinarily been transferred to 5b now have alternative care pathway options which are providing better quality and a better experience as well as increases the number of patients cared for in the community.

There has been no drop in the satisfaction experienced by patients accessing community services; this will continue to be monitored closely especially as new services come on line over the forthcoming year.

The impact on the workforce has in fact been generally positive with staff welcoming the opportunity to develop new clinical skills.

We believe that we can confidently move forward to making recommendations for the next stage of plans for ward 5b.

8. Recommendation and Next Steps

In the light of the analysis of the impact of the 5b pilot the following steps should be taken:

- Continue with the new models of care supporting patients in the community that commenced as part of the pilot. Do not transfer care back into ward 5b. Progress staff consultation by January 2017.

- Fully operationalise all our planned community service developments, reporting back to HASC in September 2017 on the impact on care closer to home.

Work stream one	**Single Point of Access**
Developing a single point of access to include all referrals of those patients ready for discharge from Buckinghamshire acute services who require community services. The community services will include: • Rapid response and Intermediate Care • District Nursing services • Community Physiotherapy • Community Hospitals • Transitional care options (beds/ interim packages of care) where available Further work will be undertaken with the development of 111 to ensure this is a point of flow as part of the clinical hub.	
Work stream two	**Rapid Response Intermediate Care (Reablement)**
Rapid response & Intermediate Care The plan is to combine the current REACT team with the reablement capacity within existing services to create a single Rapid Response and Intermediate Care Team that offers: • Continuation of a strong multi-disciplinary assessment and rapid response service from 8am – 8pm 7 days a week at the front door for all emergency admissions. • Multi-disciplinary assessment and treatment in patients' homes for admission prevention and supporting early hospital discharge. • Intermediate care support at home 8am - 9pm 7 days a week. • Daily in-reach and outreach presence at the front door acute services and deep wards. • Rapid assessment and interventions for patients requiring support on hospital discharge or to prevent a hospital admission. • Community physiotherapy for on-going rehabilitation needs to maximise independence • Outreach with the South Central Ambulance Service.	
Work Stream Three	**Buckinghamshire Locality Teams**

To integrate GPs, ACHTs, MH & social care professionals into multi-disciplinary teams, to work with the person and their carer/wider family to agree and deliver a personalised plan of joined up care and support, designed to meet their holistic needs (physical health, social care and mental health) and remain independent for as long as possible, and be supported by a care coordinator in the team. This is building on the work of the LIT in the South of the County and Over 75s Project in the North.

The proposed model is between 7 – 9 (to be determined) integrated locality teams operating across Buckinghamshire, working to a geographical cluster of GP practices aligned to the Clinical Commissioning Group GP practice localities. The integrated locality teams will liaise closely with a wide range of other services

The team will have access to rapid support close to home in a crisis and intermediate care services such as the expanded rapid response & Intermediate care team and home based step up transitional care bed provision, while available.

Access to the Integrated Locality Teams will be via the single point of access from 8am to 8pm seven days a week, including bank holidays. Subsequent contact can also be direct to the person's care co-ordinator. Early referral by professionals will be encouraged and there will be no 'wrong door for referrals', with onward referral to the appropriate service as required.

- Continue to monitor the impact of the transfer of care closer to home provision on quality of patient care and experience.

- Use the vacant space of ward 5b for additional patient services. From January 2017 ward 8 will temporarily relocate into this space to allow for the refurbishment and expansion of our stroke service in readiness for Wycombe Hospital becoming the stroke centre for patients from east Berkshire. Further details of this expansion is available here http://www.buckshealthcare.nhs.uk/About/cardiac-and-stroke-services-go-from-strength-to-strength.htm.

References

- NHS England October (2014)*: Five Year Forward View*

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- DOH, Lord Carter Review (2016)

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