The Health Foundation
Inspiring Improvement

Right place, right time commission on transfers of care

Health Foundation submission

September 2015

Introduction
The Health Foundation is an independent charity working to improve the quality of health care in the UK. We are here to support people working in health care practice and policy to make lasting improvements to health services. We carry out research and in-depth policy analysis, fund improvement programmes in the NHS, support and develop leaders and share evidence to encourage wider change.

To inform NHS Providers' Right Place, Right Time commission, the Health Foundation would like to share three case studies of locally-led improvement. These projects have been undertaken by Health Foundation grant holders with the aim of improving the transfer of care process for patients moving from acute to community settings. They offer learning about the process undertaken by three clinical and managerial teams to develop local solutions to locally identified challenges.

Improving discharge of frail older patients (Sheffield)

Overview
As part of its involvement in the Health Foundation's Flow Cost Quality programme, Sheffield Teaching Hospital NHS Foundation Trust tested an innovative discharge process, where patients leave hospital as soon as they are medically fit to have their support needs assessed at home. This 'discharge-to-assess' scheme emerged iteratively after an extended period of system diagnosis and data analysis. The trust had to invest significant time in building the will for change among staff and it only became possible to successfully implement the approach once the trust had become integrated with community care.

Approach
Prior to the introduction of the discharge-to-assess scheme, frail older patients who were clinically well but would have found it difficult to manage at home were usually kept in hospital for an assessment of their intermediate and social care needs. Only when this assessment had been carried out and an appropriate package of home-based care arranged for them would they have been discharged. In many cases, patients underwent multiple assessments over the course of several days or weeks by a range of community and social care professionals.

Sheffield's project team worked closely with stakeholders involved in each step of the assessment pathway to redesign the process and ensure that appropriate support packages could be made available in the community as soon as they were needed. As an integrated provider, the trust was able to call on its own community-based care teams to give immediate support to patients at home once they were medically ready to be discharged.

Impact
The first ward to fully implement the discharge-to-assess model in 2013 achieved a reduction in the mean patient length of stay of seven days, ensuring patients were able to return home

sooner. A further benefit to patients has been a reduction in the number of falls from a mean of almost 14 to just under 10 following the launch of the model.

Achieving change

To implement discharge-to-assess, staff had to change their working practices and the way in which they saw their role. Ward-based staff had to overcome their reluctance to discharge patients before they had been assessed and before it was clear what level of support they would receive at home. There were also challenges in ensuring that post-discharge services were able to deal with the demand posed by this discharge-to-assess model.

For these reasons the model is being rolled out gradually across the trust. In the pilot ward the new approach was tested over several weeks, patient by patient. Only when the benefits to these patients became clear did they move from testing to full implementation. Discharge-to-assess has been fully implemented on one ward and is now being tested on other wards.

Changing the culture of the organisation, building up support among external partners and embedding the changes into practice has taken time. Creating a shared understanding of the need for change, establishing effective working relationships between the acute and community sector, and reconciling different working practices and professional perspectives is not easy.

Discharge-to-assess is not an 'off the peg' solution that can be replicated in a straightforward way in different contexts. To implement a change on this scale and then sustain it, you need time, patience, compelling data, trusted and empathetic project leaders and effective operational management. And perhaps most importantly, you need to ensure that the staff responsible for delivering the model 'own the change' and have a long-term commitment to it.

Improving the discharge process for patients with dementia (London)

Overview

The Health Foundation funded a project led by Royal Free London NHS Foundation Trust that aimed to give every patient with dementia a safe, dignified, timely and sustainable discharge. It involved a specialist dementia occupational therapist providing a single point of contact for the patient, family members and staff throughout the admission and discharge process. The project successfully reduced patients' length of stay ensuring they were able to return home sooner and is expected to make cost savings.

Approach

Originally delivered as part of the Health Foundation's Shine 2012 improvement programme, the project was designed to offer:

- A bespoke and personalised service that works in partnership with patients, their care support network and community providers
- Improved signposting for patients and their families and carers to relevant national and local services
- Coordination and development of a community-based infrastructure to ensure adequate ongoing care
- One-to-one training, guidance and support to external carers and family members on the individuals' care needs.

Impact

All patients seen by the project team were keen to return home, however they faced challenges due to the complexity of their dementia and concerns of family and community services. By focusing on bridging the transition from hospital to community, the project was able to:

- Decrease the average length of patients' hospital stay by 1.9 days
- Support 90% of patients to return home
- Reduce re-attendances to A&E by 26%
- Secure acknowledgement from 100% of carers that the personalised approach was effective
- Make an estimated cost saving of £48,708 after the first 9 months.

To build on this success, the Royal Free London NHS Foundation Trust funded a therapy assistant post to support the specialist dementia occupational therapist. This gave the project team the means to focus on the complex environmental and organisational challenges in delivering care to people with dementia, in addition to managing the discharge process.

More recently, the project team has used its learning to design a model of care that can be embedded at the trust and disseminated to all staff involved in the care of people with dementia. The Health Foundation is supporting implementation of this model by providing funding through its Spreading Improvement programme.

Improving communication during transfer of care processes for frail older patients (East Kent)

Overview

Supported by the Health Foundation, a team at East Kent Hospitals University NHS Foundation Trust worked on a project to improve communication during transfer of care processes for elderly and frail patients. Focusing on admissions to William Harvey Hospital via the unscheduled care pathway, the project aimed to develop a formal support structure for patients, carers and primary care providers following discharge.

The project team found that inadequate communication between the acute and community sector led to 'revolving door' admissions, with patients being admitted and discharged without adequate information being shared.

An Electronic Discharge Notification (EDN) system had been set up to communicate information about the patient's plan for ongoing care. However, there were a number of challenges:

- Junior doctors did not always have enough time to complete the EDN, meaning crucial information was not being passed on to primary care.
- Only doctors could input information on the system so other health professionals were using different systems to record information, duplicating effort and causing delays.
- An estimated date of discharge was often not set; this was associated with an increased length of stay and could lead to patients being discharged without appropriate assessments or an inadequate care plan.

Approach

To address these challenges the project team implemented the following measures:

- Developed a simple two-sided form to accompany the patient and support communication between their acute and community care providers. One side of the form was for the care home to fill in when sending a patient to hospital, the other for the hospital to complete upon discharge.
- Set up a community geriatric team, comprising a community-based geriatrician and an extra community matron, to prevent re-admissions from local care homes. An evening 'on call' service and a 24 hour telephone service were also established to provide additional support for care homes.
- Established a care home forum to improve relationships between hospital and care home staff, and to deliver bespoke training to care home staff.

- Amended the EDN system to allow allied health professional input and provided new training for staff on how to use the system.
- Provided training sessions for medical staff in how to define a valid estimated date of discharge.

Impact

Following the implementation of these measures, the trust reported that re-admissions from care homes to the hospital had reduced from 25% to 15% at 30 days, without a rise in the length of stay in hospital. Ashford Clinical Commissioning Group also reported a reduction in total admissions of older people, leading to an estimated saving of £500k in the first year of the project.

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