**Oxford University Hospitals** **NHS**

**NHS Foundation Trust**

**Health Overview and Scrutiny Committee Meeting**

**Thursday 15th September 2016**

| Title | Rebalancing the System – Update and review of an Oxfordshire-wide initiative to address patients delays in hospitals beds |
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31 August 2016

*On behalf of the System-Wide Chief Operating Officers*

**Rebalancing the System – Update and review of an Oxfordshire-wide initiative to address patients delays in hospitals beds**

**Summary**

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| 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, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council) led to the implementation of an innovative approach to address delays and improve patient flow and experience. The aim of the initiative was to create a sustainable approach that would 'rebalance the system'. |
| 2. | The impact of this project on the number of patients delayed in OUH and OHFT beds and more widely across Oxfordshire has been significant. Since the end of March 2016, the number of patients delayed in beds across Oxfordshire has been on a downward trajectory with the lowest level of DTOC in OUHFT beds in the previous five years recorded in June 2016. |
| 3. | Given the different approach to care of patients, insight into the impact on quality and patient experience was vital. The Liaison Hub has clearly played a crucial role in ensuring effective communication and coordination of patient care and discharge processes and in particular, effectively managing complex discharges. Cross system working was highly valued by all staff involved particularly by those who had been involved in previous attempts to work in an integrated way and who commented that this time 'we have got it right'. |
| 4. | Discussions with nursing homes and staff across the health and social care sector found that the experience of working with nursing homes has been mutually rewarding and positive. Nursing homes, without exception praised the Liaison Hub as being responsive, experienced and knowledgeable. A number of areas were identified that can inform the future and expanded role of the Liaison Hub, including continuing the strengthen governance processes. The paper outlines the plans in place to address these. |
| 5. | A patient survey sent to the first 150 patients who had received care in nursing homes found that most were very positive about their experience, with the majority agreeing that a nursing home bed was a better environment for them while they waited for ongoing care. There were a small number of patients who raised some issues and concerns which mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes. Review of these concerns has shown that, the hub were aware of these and that changes had been made (where possible) to processes to address these. |

**Rebalancing the System – An Oxfordshire-wide Initiative to Address the Issue of Patients Delayed in Hospitals Beds**

## 1. Purpose

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, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council) led to the implementation of an innovative approach to address delays and improve patient flow and experience. The aim of the initiative was to create a sustainable approach that would 'rebalance the system'.

1.2. The approach focused on transferring patients who were delayed into beds in 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). This approach had been tried the previous winter on a much smaller scale.

## 2. Background

2.1. 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 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.

2.2. 'Intermediate care beds' (now called transitional beds) were commissioned and managed by Oxford University Hospitals NHS Foundation Trust (OUHFT). Initially, this included 130 beds to the end of March 2016, reducing to 75 in April 2016 and then to 55 in August 2016 and onwards. Medical cover for the patients in the interim nursing home beds was provided by specifically commissioned primary care or by the OUHFT directly. Additional nursing, therapy, social work and domiciliary care support was provided by OUHFT, OHFT and OCC. These beds and the supporting social work and therapy staff were funded via a £2m allocation from OCCG.

2.3. Critically, in order to coordinate and manage the needs of the patients being transferred to the care homes, a multi-agency Liaison Hub, located in OUHFT, was established in December 2015. This included involvement of the three provider organisations. The hub (which is still in place) acted as a key liaison point supporting patients during this transitionary period. In particular it:

- Ensures proactive discharge planning for patients who are transferred
- Administers arrangements and agreements with nursing homes, social workers, therapists, GPs and hospital clinicians.
- Manages the logistics of communication with patients and families and escalates any concerns and issues.
- Maintains a tracking system via a virtual ward on all patients who have moved and their onward destination.

- Provide day to day support to nursing homes to proactively support patient management.

## 3. Programme Implementation

### 3.1. Governance and Management

3.1.1. Rapid implementation of this programme was undertaken with senior management oversight of six work streams and representation from each of the four organisations in each of these work streams. These were:

- Communication and patient information
- Procurement of Nursing Home Beds, Transport, Logistics and nursing Home Exit Strategy
- Risk Assessment, Mitigation and Patient Safety
- Workforce
- Performance Management, Escalation and Finance
- Pathways (models of care linked to stabilisation and patient acuity).

3.1.2. A daily command and control structure (the DTOC Control Group) was put in place with the Chief Operating Officers from each of the four organisations meeting daily with senior clinical and operational managers. This daily contact enabled close monitoring of developments, but also resolution of factors across the system that were contributing to patient delays.

3.1.3. A project manager was appointed to support and oversee the programme of work. In order to manage the work programme and associated risks, a detailed workplan and risk register was developed and regularly reviewed by the DTOC control group.

3.1.4. In early December 2015, a workshop was held to bring managers and clinicians together from across the health and social care system to further develop implementation plans for each of the work streams.

3.1.5. Weekly updates on progress were provided to the four Chief Executives of Oxfordshire Clinical Commissioning Group (OCCG), OUHFT, Oxford Health Foundation NHS Trust (OHFT) and Oxfordshire County Council (OCC).

3.1.6. Comprehensive modelling of the expected pathway of the initial 150 patients was undertaken. This was based on 200 patients tracked over the same period in the previous year to provide an indication of the number of patients that would move to a nursing home permanently, how many would go home (with and without support), how many might be expected to be readmitted and what the expected mortality rate would be. The outcome data for the initial 150 patients transferred is shown below:

*Table 1:Patient transfers at 12<sup>th</sup> March 20165 at point 150 Patient Discharges Attained*

|  | Actual | Projected Profile based on 150 Discharges |
|---|---|---|
| Transferred to Nursing Home Beds | 250 (222 OUH/38 OH) | - |
| Number Discharged Home | 72 | 65-89 |
| Number Permanent Placements | 56 927) | 48-55 |
| RIP in Nursing Home Beds | 22 | 20-30 |

|  | Actual | Projected Profile based on 150 Discharges |
|---|---|---|
| Total Number Discharged | 150 | - |
| Number of Patients Currently in Nursing Home Beds | 80 | - |
| Number Readmitted | 30 | 10 |
| Number Readmitted and Returned | 19 | - |

3.1.7.   The following metrics were developed and monitored weekly by the DTOC Control group.

*Table 2: 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 reablement support | SHD/ORS report | |
| LOS | Average length of stay (LOS) in hospital 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 by OUHFT | virtual ward report | |
| Flow | Total beds utilised | virtual ward report | |
| Workforce | Additional staff recruited/ redeployed to support initiative | HR report | |

3.1.8.   Daily updates were also presented on the development of the Liaison Hub, procurement of nursing home beds, flow of patients through the beds, and progress on the recruitment of the additional workforce required.  However it is acknowledged by all partners that the reporting information and performance indicators need to be strengthened prior to the coming winter.

3.1.9.   Communication to patients directly and to the wider media was managed by the three communication teams (OUHFT, OHFT and OCCG). The relevant

Boards and the Health and Overview Scrutiny Committee were regularly updated on progress.

3.2. **Development and work of the Liaison Hub**

3.2.1. In December 2015, in order to make staff available to lead on the hub development and enable patient moves, 76 acute beds were released in the OUHFT. The Liaison Hub was established and rapidly began to develop processes to support patient moves to the nursing homes. The hub's multi-disciplinary team (MDT) consists of qualified nurses with acute medical experience and expertise in discharge planning with discharge planners working alongside them, the OUH lead for discharge planning and an administrator. The hub worked closely with staff from adult social care, therapy staff, consultant Geriatricians and senior interface Physicians.

3.2.2. Careful and detailed planning was undertaken to ensure that the move for patients, many of whom were frail with complex needs, was well managed. This included the following processes:

- Each patient had a long term discharge and therapy plan where necessary targeted at maintenance or rehabilitation.
- Adult Social Care actively involved in discussing and agreeing patient moves.
- Once determined as medically fit for discharge, patients and their families were informed of the move and had an opportunity to discuss this with staff.
- Each patient and their family/carer was provided with a personalised letter explaining the reason for the move and a contact number for the Liaison Hub.
- The patient's GP was also informed by letter that the patient had been transferred to an intermediate care bed whilst discharge planning continued.
- Each patient was transferred with a pack which contains the following:
  - Nursing Summary
  - Medical summary (EiDD) with list of take home medication
  - If relevant a completed Do Not Attempt Resuscitation (DNAR) form.

3.2.3. Importantly, arrangements were made for each nursing home to have an assigned MDT. This includes a named nurse from the Liaison Hub, social worker, therapist where required and medical staff member. The contact details for each one was made available to the Care Home Support Service, Adult Social Care and the Liaison Hub team.

3.2.4. A weekly MDT review of all patients was put in place to review their progress and ensure their onward transfer was expedited.

3.2.5. Patient moves began in early December 2015 and while the initial plan was to move patients quickly in cohorts, it was apparent that more time was needed to put logistical arrangements in place. Nursing homes also needed a managed approach, so new patients could be adequately supported and settled into the home. Rapid progress however was made with careful management. By 10 December 2015, 126 nursing home beds had been procured and by 31 December, 115 patients had been moved into the beds procured in 15 nursing homes across Oxfordshire.

## 3.3. Impact of the programme on DTOC

3.3.1. The impact of this project on the number of patients delayed in OUH and OHFT beds and more widely across Oxfordshire has been closely monitored. After a promising start in December 2015 (when the number of patients delayed in OUHFT and OHFT beds fell from 159 to 83), the figures for late January showed an increase to 168 patients delayed within OUHFT and OHFT beds.

3.3.2. At this time, system leaders agreed a new single cross-system approach was required to more effectively manage patients who required support to leave the nursing home. A central 'Gold Command' structure was introduced at the end of February, based at the OUHFT to prioritise patients with complex discharge needs to identify available resources more quickly and unblock any barriers or delays.

3.3.3. On a daily basis, a nominated 'Gold Command' representative was to lead on behalf of all three organisations involved in the DTOC project and make the necessary decisions on behalf of one or more of the organisations. This includes allocation of available resources and directing senior staff to address any issues.

3.3.4. In addition, in order to improve the discharge of patients waiting for reablement or domiciliary care in their own homes, it was also identified that the system needed to provide an additional 1,600 hours of home care each week. The decision was taken in March 2016 for the OUH (as a registered social care provider) to directly recruit and train 50 new home carers to increase the overall availability of home care in Oxfordshire. This has not been without its challenges, due to the well-known recruitment and retention issues in Oxfordshire. However, by July 2016 the OUHFT had recruited an additional 47 WTE care workers.

3.3.5. These additional actions alongside the multi-agency working has had a significant impact on the number of patients now delayed in an inpatient bed. Since the end of March 2016, the number of patients delayed in beds across Oxfordshire has been on a downward trajectory, as shown in Chart 1 below. In June 2016, the lowest level of patients delayed in OUHFT beds in the previous five years was recorded.

Chart 1: Delayed transfers of care at OUHFT and OH CH
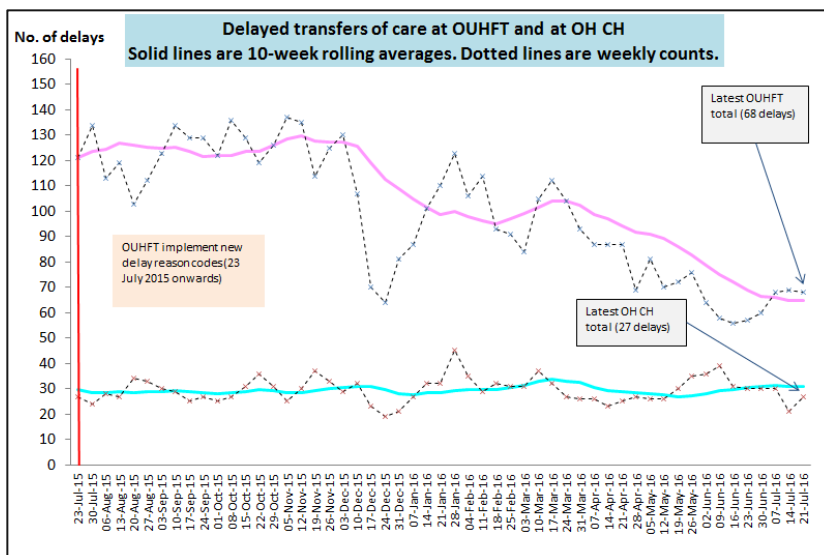
3.3.6. Since the beginning of the 'Rebalancing the system' initiative, across the whole of the Oxfordshire system, the numbers of patients delayed has significantly fallen as shown in Chart 2 below:

*Chart 2: Oxfordshire Delayed Transfers of Care Total*
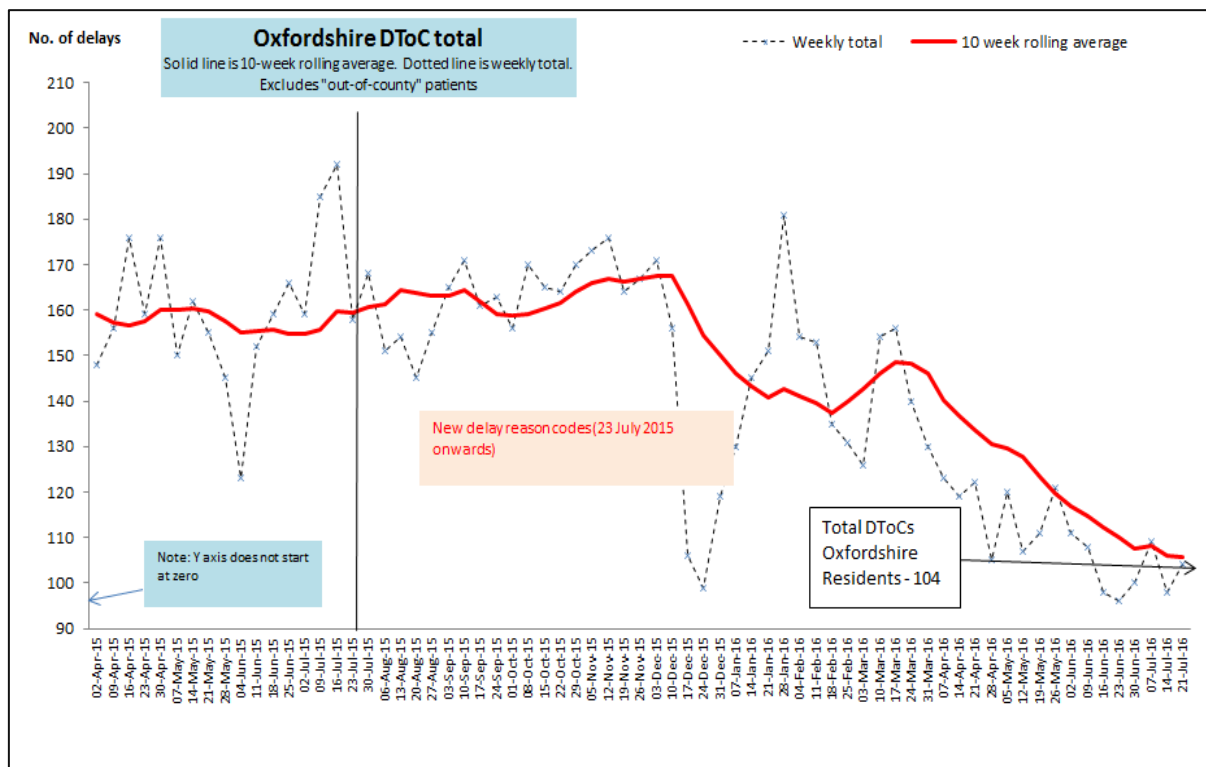


## 3.4. Current flow of patients through Liaison Hub beds

3.4.1. In summary, as of the 24 August 2016, 476 patients have been transferred to nursing home beds. The outcome for the 426 patients that have been discharged/left the nursing home beds is set out in Table 3:

*Table 3: 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 Reablement Service | 83 (70 SHDS and 13 ORS) |
| Home with domiciliary care | 70 (11 of these private funders) |
| Home with no care | 18 |
| Readmitted | 62 |
| Died (in hospital or nursing home) | 48 |
| **Total** | **426** |

3.4.2. There are currently 50 patients in the 'hub' beds awaiting various discharge care packages. Some require further assessment and rehabilitation.

## 4. Patient experience and feedback

### 4.1. Survey Methodology

4.1.1. Given that this initiative was unprecedented in its scale, it was important alongside the MDT feedback, to gain direct feedback from patients and their carers about their experience of being transferred, cared for in nursing homes and discharged to their onward destination.

4.1.2. In April 2016, patient 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, 23 from those who had returned home and 17 from patients and their relatives/carers who had moved to a care home permanently. Of those returned, 11 were filled out by patients, 14 by patients with support and 13 were completed on behalf of the patient by a relative or carer (one did not state who had completed the form).

4.1.3. Patients and their families/carers were asked to rate a series of statements (with 5 options from strongly agree to strongly disagree), with the opportunity to comment on each statement.

### 4.2. Survey findings

4.2.1. Feedback from patients and their families was largely positive, with the majority of respondents strongly agreeing or agreeing with all statements (see Appendix 1 for the full responses to each of the statements). However, there were a small number of patients who raised some issues and concerns. These mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes.

4.2.2. **Involvement in the decision to move**

- Of those who responded, 77.5% strongly agreed or agreed that they were involved in the decision to be moved to a care home, with 12.5% (5) saying that neither agreed nor disagreed. Two patients commented that they didn't feel they had a choice whether they moved or stayed.

4.2.3. **Information about the move**

- 77.5% of respondents strongly agreed or agreed they had sufficient information about their transfer and the support they would receive once in the care home. 7.5% (3) said they neither agreed or disagreed. Comments highlighted that a few patients and their families felt they could have had more information about the home (prior to their transfer) and more information once they reached the care home about what to expect.

4.2.4. **Family/carer involvement**

- 85% of respondents strongly agreed or agreed that their family/carer was involved as much as they wanted them to be in decisions relating to their care. Two disagreed. One patient stated that the care home had not managed their care well and another commented that they wanted to be at home.

4.2.5. **Transfer process**

- 92.5% of respondent agreed they had been treated with dignity and respect in the move to the care home. One patient was unhappy about the welcome they received when they arrived. They stated that they were '*just put in the room, no menu's given'.*

4.2.6. **Health and social care needs being met, while in the care home**

- Patients (and their families) were asked whether their health and social care needs had been met while in the care home and the majority (82.5%) strongly agreed or agreed. Patients commented positively '*Staff looked after me very well. Physio was excellent and there were social activities every afternoon, if you wanted to join in'.* Four respondents disagreed that their needs had been fully met, commenting that they were not happy with the standard of care within the nursing home. One family member stated that they had not received enough therapy support.

4.2.7. **Medication review**

- 80% of respondents stated that they had their medication was reviewed and they were informed about the changes. 12.5% remained neutral with some stating they didn't require a review. Three respondents disagreed. One stated '*I had to follow up to ensure my mothers' medications were correct'.* Another commented that '*Anxiety tablet given although I felt this was not needed. Made him very drowsy and more confused. He is not taking it anymore and is now more aware of his surroundings'.*

4.2.8. **Feeling safe while in the care home**

- 87.5% of respondents strongly agreed or agreed that they had felt safe while in the home. Three respondents, however, disagreed. One stated '*I was troubled by another resident of the care home for 2/3 nights who insisted on coming into my room'.* Another commented: '*My Dad felt reasonable safe, but not as safe as when he was in hospital and we felt as though if he had a fall, staff would not have reacted quickly enough as he was not checked upon regularly while he was in his room'.*

4.2.9. **Was the care home a better environment?**

- The majority (77.5%) of respondents either strongly agreed or agreed that the nursing home was a better environment for them while they awaited further care, with 17.5% (7) respondents neither agreeing nor disagreeing. One patient commented: '*It was lovely, I had my own private room and en-suite. Very peaceful. Food Good. Would go to [this care home] again, if the occasion arose'.* Four respondents disagreed, with three making the following comments:

  - *'My Dad feels he would rather have come straight home as he is better cared for than he was in the care home. Dad received no rehabilitation from the care home or any physiotherapy'.*
  - *'The care home was not for me. I was treated like one of them, though I was perfectly normal'.*
  - *As there wasn't a choice of care home at this stage, it felt mum was very isolated there and not very happy.*

*Chart 3: Analysis of feedback of 3 key questions*
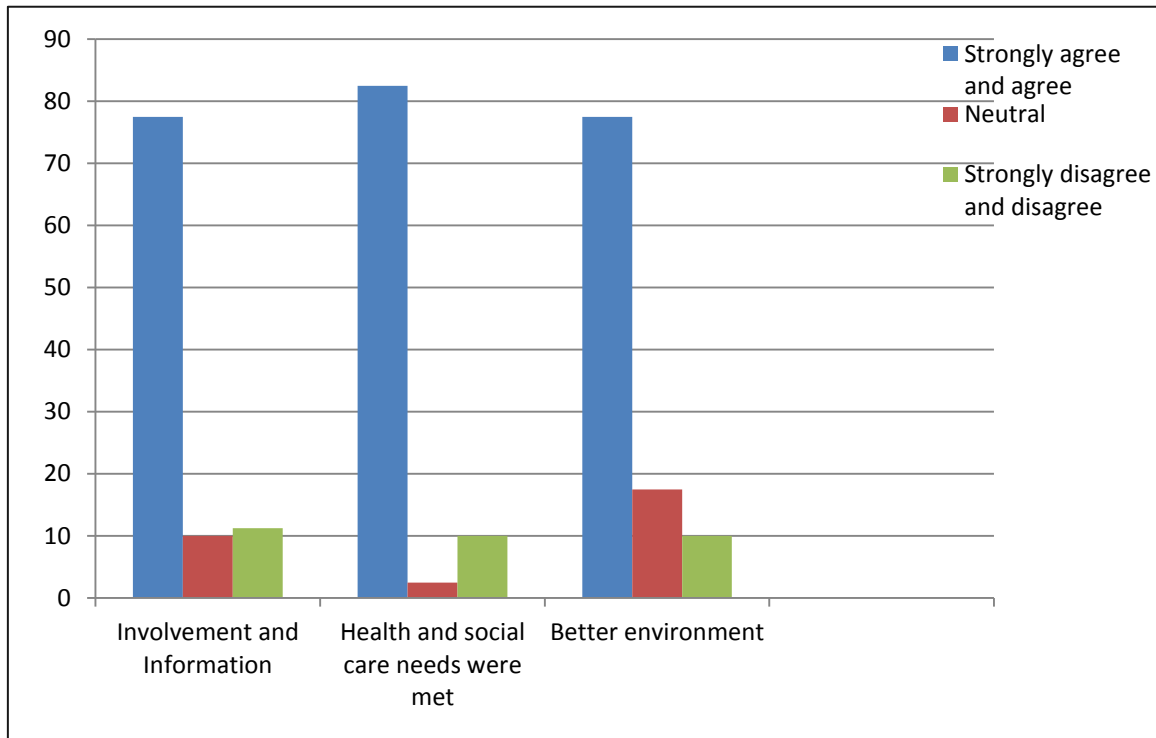


### 4.2.10. Managing the move to home or permanent care home

- Of those who returned home, 91.2% agreed that they were well supported and informed about the move. Respondents commented positively on the support in place: '*OT was wonderful – had everything in place for when I returned home*'. Another stated: '*Dad has been very well supported by Occupational therapists and social services. They have made sure everything is in place to care for Dad's needs at home and the NHS nurses have been wonderful – for this, we are grateful*'.

- One respondent who had not wanted to move to a care home stated that: '*I was only happy to get out. I missed X-mas with my family and hopefully I will never have to go in one of those places. I had a lot of support once I was home*'.

- Of those who moved permanently to a care home, 70.6% strongly agreed or agreed that the move was well managed. 17.6% did not respond. One respondent commented: '*I love it in my permanent care home. I'm very happy here*'. One disagreed stating '*It was very rushed and when transport was arranged, it was very late in the evening. When mum arrived, the staff were not aware of her background*'.

## 4.3. General feedback

4.3.1. A few patients and their families raised some issues in their responses:

'*Had concerns about transport home – should have been 4p.m. and arrived at 6.45 and he was quite grumpy*'.

'*They should put the right people in the right places. I had my hips done – that's the reason. But I should never have been put in there. The food was cold, bland, no choice*'.

4.3.2. However, most comments highlighted that moving to the care home was a positive experience where they felt their needs were met. Comments included:

*'I was very well looked after, both in the hospital and in the care home. I am very appreciative of everything that was done for me'*

*'On the basis that I was deemed unsuitable for a hospital bed, I was very grateful that a nursing home was an option whilst I got a feel a bit better'.*

*'We would like to state that we have been delighted with Dad's care under the NHS at the Horton Hospital and Wallingford Community Hospital'.*

*'Very impressed that effort was made by all concerned to get home into this care home as he had a long standing female friend already resident'.*

*'The process was well managed throughout which was helpful to a person who was new to this environment (regarding a person with dementia)'.*

4.4. **Summary**

4.4.1. The feedback from patients showed that on the whole, patients and their families and carers felt the care was good and their experience of care within nursing homes had been positive. However, it is clear that for a few patients, there was scope to improve the management of their care within the nursing homes and ensuring their needs were well matched to the nursing home placement.

4.4.2. Some of the problems identified have been addressed by the Liaison Hub as it has become more established and more familiar with the individual nursing homes. This familiarity has enabled more effective communication and placement of patients. Where there have been persistent issues identified during OCC assurance visits and by the hub staff within any of the nursing homes, the procurement of beds has been discontinued.

4.4.3. Patient surveys will continue to be undertaken at regular intervals to inform future developments and any further changes that may be required.

5. **Reviewing the Liaison Hub systems and processes**

5.1. **Review methodology and approach**

5.1.1. Given the initiative's success in relation to effective and sustained cross system working, patients being cared for in a better environment and more effective discharge processes, agreement was reached with commissioners to extend and expand the role of the hub for a further year. As part of this agreement OCCG have provided a significant level of the resource required to develop the hub.

5.1.2. It was agreed that a review of the hub, and feedback from nursing homes in particular, would be valuable to inform the future development and the expanded role of the Liaison Hub.

5.1.3. The aim of the review was to gain more formal and comprehensive feedback from nursing homes and from staff involved about the process of transferring, caring for and moving patients to their final destination, thereby enabling any required improvements to be made.

5.1.4. This section outlines the findings from the review that included speaking to nursing home managers, Liaison Hub staff (cross system), OUH medical staff

providing care to the hub patients, and ward sisters and discharge planners at the OUH.

5.1.5. The review used semi-structured (informal) interviews to gain feedback. Of the 15 care homes, eight interviews were conducted face-to-face and a further seven were telephone interviews.

5.2. **Findings**

5.2.1. The findings have been into broad key themes and have been fed back to those leading and working in the Liaison Hub to inform developments and improvements to ways of working.

5.2.2. **A positive initiative**

- All hub staff highlighted that the development of the Liaison Hub and the initiative to transfer and improve discharge processes had been a positive and exciting programme of work to be involved in. The Liaison Hub was valued as being well placed to 'respond to issues as they arise'. Some staff stated that they felt proud to represent their organisation in such an initiative.
- The overwhelming feedback from nursing home managers was that the provision of transitional beds and support from the Liaison Hub throughout this process had been very positive. They commented that their staff enjoyed working with a range of patients, enabling some of them to go home.
- Those involved in previous arrangements to have interim beds (in 2014/15) felt that the hub had enabled better communication and smoother processes for staff and patients.
- Nursing home managers, without exception, commented that they had a good relationship with the Liaison Hub. They commented that staff were responsive and that communication and the coordination function was excellent. The nursing homes in the North of the County, which were supported by the discharge planning team within the Horton General Hospital also commented that support and communication was very good.

5.2.3. **Factors that have supported developments**

- Liaison Hub staff highlighted that the initial stages of establishing and implementing the programme was intensive. There were high expectations and the initial set up was rapid and focused, where they were on a 'steep learning curve'. Staff identified a range of factors that supported them including:

  - detailed planning and regular meetings to sort out logistical arrangements which were very inclusive
  - being able to use a trial and error approach, which meant that could make swift immediate changes as work progressed
  - effective and proactive communication with those wh o manage MDT members including social workers and the therapists
  - within the OUH, having direct access for patient referral and assessment to the (relatively) newly formed Adams Ambulatory Unit was seen to be invaluable
  - having dedicated transport was highlighted as essential for ease of transfer and positive patient experience.

### 5.2.4. Importance of effective MDTs

- Staff commented that the hub demonstrated excellent multi-agency working which enabled an appreciation of each organisation's pressures and ways of working.
- This was reiterated by nursing home managers who saw the MDT meetings as essential and helpful, with good attendance from all relevant disciplines. They commented that health and social care staff were experienced and knowledgeable. There was one exception to this, with one home commenting that agency staff were assigned late and that assessments took far too long. This was verified by the doctor providing cover to this home and has been fed back to the relevant team.
- The MDTs were seen as an effective approach as they brought varied expertise and experience into one domain and enabled access to all relevant agencies required to resolve complex discharge delays including the Fire service, Environmental health, Housing via District Council and the Voluntary sector.
- Many hub staff commented that the process had helped the different organisations to be more open and transparent, where issues could be dealt with on the ground by front line staff rather than 'escalating them upwards'. However, when necessary, the Gold Command approach was seen to be helpful in resolving difficult problems. The hub was also seen as useful in exposing where system-wide improvements were required.
- Liaison Hub staff stated that, they had developed a greater understanding and insight into how nursing homes operated. In working closely with the homes, they had become familiar with how they worked, could identify their strengths and were therefore able to place patients more easily.

### 5.2.5. Clinical governance systems and processes

- It was decided at the outset of the initiative that the governance systems for each organisation would remain in place. Each staff member would follow their own policies and procedures, including incident reporting and safeguarding.
- There were, however, inherent challenges in ensuring that there was a joined up incident reporting system, due to the multiple systems being used. Due to regular and effective communication, hub staff felt that they were aware of most incidents, but acknowledged that they sometimes found out about incidents at a later date or inadvertently. Hub staff stated that any safeguarding concerns were reported directly to the OCC team.
- Nursing homes managers were clear on processes for reporting safeguarding concerns and stated they used their own systems to report any incidents that occurred while a patient was in their care. Similarly, staff from OHFT and OCC reported incidents as they occurred.
- Staff felt that in order to gain oversight of all incidents and safeguarding alerts, that they needed to implement a process that would enable these to be logged and regularly reviewed by the MDT. This would ensure they received feedback on the outcomes of investigation into incidents and enable shared learning with colleagues.
- Since December 2016, there have been two formal complaints relating to patients who have been transferred to a nursing home bed. A review of PALS contacts relating to discharge in the OUHFT (across all areas) has

shown a gradual decline in the number of concerns raised, with 16 contacts in January 2016, eight in May and four in June.

- Hub staff developed a tracking system of all patients, their status and review dates and any issues that needed to be resolved with their discharge.
- A more detailed communication log was not maintained, simply due to time constraints and in hindsight, staff commented that this would have been helpful to track any issues within nursing homes more systematically. Some felt that more formal links to the OCC team who conduct assurance visits within nursing homes would be valuable.
- Overall, hub staff fed back that, given the greater permanency of the hub that they recognised the need to develop more formal and robust governance processes and that they were in the process of implementing the following:

  - a single approach to incident reporting using the OUH Datix system to enable feedback and learning
  - monthly governance meetings
  - ongoing mortality reviews
  - clinical supervision processes to raise concerns and provide support to resolve any ongoing issues
  - a review of communication with wards and patients including transfer documentation.

5.2.6. **Medicines management**

- Liaison Hub staff fed back that medicines management processes could be 'tightened up', and acknowledged that this wasn't unique just to 'hub' patients. Some staff felt that because it was sometimes difficult to coordinate the timing of patient transport with medicines being ready 'to take home' (TTO) that they would often use couriers to send TTOs once patients had been transferred. Ward staff commented that while not ideal, it enabled the patient to be transferred when transport was ready and to make beds available for other patients.
- Some processes had the potential to lead to errors if careful medicines reconciliation was not maintained. For example, when nursing home managers assessed patients while they were still in hospital, they were provided with a copy of the drugs chart. Patients are then discharged with a letter and a list of their TTOs. This list and the drugs chart have the potential to be different. This has now been addressed with one chart only being provided on discharge.
- Nursing home managers reiterated some concerns about the management of medicines. There was confusion about the amount of supply of medication (whether 14 or 28 days). This was, in part, due to the fact that the OUH processes changed at this time. Some managers commented that medication had sometimes been missing or required clarification and they would phone the Liaison Hub who 'always sorted it out'. They acknowledged that this issue had improved over time.
- Some homes felt that more information on review dates for medications would be helpful. One nursing home commented that sometimes patients came with the drugs they had at home (before they came to hospital) and that it would be helpful to relabel them as they are out of the boxes.

- OUH medics covering the homes stated that they had tightened up on prescribing considerably as there had been issues such as requests for repeat medications from nursing homes when a prescription had been recent been made.
- There is clearly scope to review and improve on processes for supply and management of medicines. The pharmacy team within the OUHFT have been involved in reviewing processes as the Liaison Hub has developed. An audit is underway to review the extent to which medicines are missing or incorrect for patients and this will include process mapping to determine where improvements can be made.

### 5.2.7. Ward liaison and discharge processes

- Most nursing home managers visited patients while they were in hospital to assess their suitability for the nursing home. However, many fed back that the single page handover document that was sent about patients (before the visit) lacked enough information to know whether patients would be suitable for placement. One commented 'things get missed off such as whether patient wanders. If we only have an upstairs room, then they would not be suitable'. Most acknowledged that this had improved over time, but that they would still appreciate more information on the form. Liaison Hub staff are in the process of reviewing the transfer document and its content to ensure all relevant information is relayed.
- A few managers commented that they had difficulties on the ward finding someone to help provide them with the necessary patient information. Some were more proactive than others and would visit the hub if they couldn't find what they needed.
- Ward sisters and discharge planners fed back that having a leaflet for patients and families (in addition to the letter they receive) would help in managing their expectations.
- Ward staff also stated that they had initially been briefed on the role of the hub but felt, with its expanded role, that they would welcome an update for staff. One staff member commented that an Standard Operating Procedure clarifying roles and responsibilities and selection criteria for patients being transferred would be a useful document to share with ward staff.

### 5.2.8. Medical provision and support

- The nursing homes without exception felt that the medical cover provided to patients was responsive, whether OUH staff or GPs. They said that GPs were complimentary about the role of the hub in coordinating responses and enabling patients to be readily brought into the Adams Ambulatory Unit when required.
- Given the greater permanency of the hub, medical staff also commented that while informal guidance and support had been provided to the SHO working within the nursing homes, this should be formalised.

### 5.2.9. Improving information systems going forward

- While effective workarounds have been established to enable oversight of patient information, the use of multiple systems across health and social care is not ideal. Some staff fed back that updating multiple spreadsheets duplicated information and was time consuming. Work is underway to

investigate the use of the OCC system, Liquid Logic, as the best joint system to use for patients under the care of the Liaison Hub.

## 6. Summary

6.1. The Liaison Hub has clearly played a crucial role in ensuring effective communication and coordination of patient care and discharge processes and in particular, effectively managing complex discharges. Cross system working was highly valued by all staff.

6.2. A patient survey sent to the first 150 patients who had received care in nursing homes found that most were very positive about their experience, with the majority agreeing that a nursing home bed was a better environment for them while they waited for ongoing care. There were a small number of patients who raised some issues and concerns which mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes. Review of these concerns has shown that, the hub were aware of these and that changes had been made (where possible) to processes to address these.

6.3. Discussions with nursing homes and staff across the health and social care sector found that the experience of working with nursing homes has been mutually rewarding and positive. Nursing homes, without exception praised the Liaison Hub as being responsive, experienced and knowledgeable. A number of areas were identified that can inform the future and expanded role of the Liaison Hub.

6.4. There was recognition of the need to create more formalised and robust governance systems and to ensure that learning from incidents was shared with all relevant staff.

6.5. The issues identified in this review relating to governance, provision of patient information, medicines management and communication between the hub and wards are in the process of being reviewed and addressed.


**Paul Brennan,**
Director of Clinical Services

# Appendix 1: Patient and carers survey: detailed findings

| Statements | Strongly agree | Agree | Neither agree nor disagree | Disagree | Strongly disagree | No response |
|---|---|---|---|---|---|---|
| 1. I was <u>involved</u> in the decision to be moved to a care home | 11 (27.5%) | 20 (50%) | 5 (12.5%) | 1 (2.5%) | 3 (7.5%) | |
| 2. I had <u>sufficient information</u> that I needed about my transfer and the support I would receive once in the care home | 8 (20.0%) | 23 (57.5%) | 3 (7.5%) | 4 (10%) | 1 (2.5%) | 1 (2.5%) |
| 3. <u>My family (or carer) was involved</u> as much as I wanted them to be in decisions about my care and support | 12 (30.0%) | 22 (55.0%) | 3 (7.5%) | 1 2.5% | 1 2.5% | 1 2.5% |
| 4. I was <u>treated with dignity and respect</u> at all times when being transferred from hospital to the care home. | 17 (42.5%) | 20 (50%) | 1 (2.5%) | 1 (2.5%) | 1 (2.5%) | |
| 5. My health <u>and social care needs were met</u> during my stay at the care home. | 17 (42.5%) | 16 (40%) | 1 (2.5%) | 2 (5%) | 2 (5%) | 2 (5%) |
| 6. Any medication <u>I was on was reviewed</u> and I was informed about any changes | 10 (25%) | 22 (55.0%) | 5 (12.5%) | 3 (7.5%) | | |
| 7. <u>I felt</u> safe while I was in the care home | 21 (52.5%) | 14 (35%) | 1 (2.5%) | 1 (2.5%) | 2 (5%) | 1 (2.5%) |
| 8. The care home was a <u>better environment</u> for me while I was waiting for be transferred back home | 19 (52.5%) | 10 (25%) | 7 (17.5%) | 1 (2.5%) | 3 (7.5%) | |
| 9. I was well <u>supported and informed</u> about the move back home  (23 returned) | 13 (56.5%) | 8 (34.7%) | 1 (4.4%) | | | 1 (4.4%) |
| 10. The <u>move to my permanent care home was well</u> managed (17 returned) | 2 (11.8%) | 10 (58.8%) | 1 (5.9%) | 1 (5.9%) | | 3 (17.6%) |