Good Hope hospital, Heart of England Foundation Trust - Length of stay case study October 2014

Good Hope hospital has around 400 beds and provides acute, general medicine and some specialist services to a catchment population of approximately 450,000 across North Birmingham, Sutton Coldfield and a large part of south east Staffordshire.

Between February and March 2013 a weekly point prevalence survey was conducted across 6 medical and elderly care wards at Good Hope Hospital. This audit revealed that 32% of patients were medically fit, but could not be discharged because they were waiting for:

- placement in a nursing or residential care home; or
- a package of care to commence; or
- transfer to another facility or rehabilitation.

In 2013 the Oak Group International undertook an acuity audit across the site at Good Hope Hospital which revealed that 41% of patients could have had their medical needs met at a lower level of care.

Following identification of the need to improve the patient flow for the frail elderly through the hospital the Trust, under the leadership of a new Managing Director, developed an overall site strategy at Good Hope hospital to provide appropriate "out of hospital care."

The strategy focused on implementing a number of inter-related approaches based around improving the patient flow in the hospital and enabling the transition between hospital and the community (either the patient's home or a nursing home). These included:

- Collaborating with all providers of out of hospital care
- Consistent proactive patient management
- Recovery at home
- Domiciliary reablement care
- Bridging Social Care Packages

Approaches to reducing length of stay

"To reduce length of stay you have to actually manage it and have a variety of different approaches along the patient's pathway." Liz Hamilton, previous General Manager for Out of Hospital Care, Good Hope, Heart of England Foundation Trust

Collaborative care programme

The hospital identified a lack capacity able to respond rapidly in the community as a block to transferring patients.

The hospital worked with the private sector and NHS community providers to develop capacity to enable improved flow and reduce acute beds. It provided leadership to enable providers to work collaboratively – being clear to both NHS and private providers that there were enough patients in the system to ensure sustainability of all providers. The hospital runs monthly meetings with operational managers from each provider to maintain communication channels and work through issues, such as developing a single assessment document. By opening the market it also encouraged competition and incentivised NHS providers to improve responsiveness and efficiency.

The hospital actively sought to improve the relationship with social care; it stopped implementing delayed transfer of care fines (which often resulted in social workers being pulled into discussions around assessments), this had a dramatic impact on increasing the capacity of social workers to improve their work flow and prioritisation of the assessment of patients.

Consistent proactive patient management
The hospital implemented a white board approach on each ward that outlined clearly what each patient's estimated discharge date was and what they were waiting for (with columns for physiotherapy / pharmacy / assessments and so on). This has now evolved to be electronic and feeds into a global hospital view.

There are board-ward rounds every morning to go through each patient and determine what their status is and what they are waiting for. Each ward has a ward co-ordinator of the day (who is a band 6 nurse or above) who uses the board as a 'to do' list for the day.

There is a General Manager for Out of Hospital care, who meets with all Ward Managers, social care and community teams on a Tuesday to focus on what needs to happen to get the delayed transfers out of the hospital, then again on Thursday morning to maintain the focus on progressing patients. Any remaining issues are then taken to a Thursday afternoon conference call between more senior managers to unblock more challenging issues.

Healthcare at Home: Recovery at Home
In September 2012, Good Hope partnered with Healthcare at Home to provide home recovery care to a proportion of Good Hope patients under a virtual ward approach.

This takes patients who are clinically stable who could recover at home supported by a nursing team on a virtual ward. Patients eligible for recovery at home include: frail elderly; surgery; trauma and orthopaedics; gynaecology.

HAH has an office with the hospital's capacity managers, which has helped with developing communication and trust. Their nurses go around the wards to identify and assess patients who could be on the virtual ward and liaise with the consultants. Each patient has to consent to being transferred and is given a clinical management plan and EDD from their hospital consultant.

The virtual ward is staffed by a multidisciplinary team that covers the service from 8am-10pm, 7 days a week. Patients and clinicians have access to a 24hr Healthcare at Home Care Bureau for advice and support.

Once transferred to Recovery at Home patients remain under the care of the consultant who can electronically access their patient's notes taken by Recovery at Home nursing staff who visit the patient. The consultant also undertakes a weekly virtual ward round to oversee care and patient progress.

The virtual recovery at home ward started with 29 patients and due to its success has increased to 39 patients.

HAH are monitored through monthly key performance indicators which outline how many patients were: discharged early from the virtual ward; discharged on time; readmitted; and discharged late (including the reasons as to why, which are mainly due to waiting for social care packages to commence).

The service aims to work collaboratively with existing health and social care providers and patients are discharged from the service to their GP/community services.

Benefits - up to June 2014:

- Bed Nights Saved – 18672 (target = 15424) from September 2012 and June 2014.
- Only one complaint between September 2012 and June 2014.
- Majority of patients are discharged either on planned day of discharge or earlier.
- Care and treatment provided in comfort of patients' own home.
- Freed up beds for acutely ill patients at the front door.
- Enables capacity for elective patients.
- Clinicians happy for their patients to be managed on virtual wards.
- Reduced care packages and lower rick of decompensation. The hospital found that frail elderly patients are at risk of decompensating quickly in an acute hospital setting but recover quicker in their home environment. This has been borne out recently with the Recovery at Home service, where patients who return to their home for assessment for a small package of care, once home do not actually require this service.

Midland Heart

The population which Good Hope hospital serves is an increasingly elderly population who often are unable to return to their home environment due to an acute medical episode (for instance stroke) or the deterioration of an existing condition (such as chronic obstructive airways disease, heart failure). It is not best practice for patients to make decisions regarding their long term care in an acute environment; however this is increasingly becoming common-place and alternatives to this need be found.

In light of the above, the feasibility of a Domiciliary Reablement Unit to be based in the Good Hope hospital site was investigated. The aim for this was to provide a robust model of care for those patients who are medically fit and no longer require an acute hospital bed. The intention of the facility is not to replace the existing services provided, but to offer a complementary service to support patients who require a different level of care. As identified above these patients do not need an acute medical facility, but do need some domiciliary care to help them with their onward journey home.

The Cedarwood enablement unit opened in December 2013 with 29 single rooms, a social area, and an area for people to make their own breakfast and snacks to encourage independence. Midland Heart housing organisation operates the unit and Healthcare at Home provides additional nursing care if required.

Two patients are admitted and discharged every day, demonstrating good flow through the unit. 95% of patients return to their own homes with no additional on-going support.

An interim cost impact found the following:[1]

- £1338.30 saving per patient admitted to Cedarwood Enablement Unit and an extrapolated annual saving of £729,775 (based on reduced delayed transfers of care and overall shorter length of stay).
- Reduction in length of stay of an average of 6.1 days for the defined group of patients.

Benefits

- Patients have an appropriate environment in which to make decisions regarding their long term care.
- The risk of unintentional harm is significantly reduced.

[1] Data based on 133 patients who were admitted to Cedarwood from 26 November 2013 to 23rd February. Based on elderly ward day rate of £120 and Cedarwood day rate of £77

- The improvement of flow will positively support the 95% Emergency Care Standard.
- Patients are enabled to reach their full potential in an appropriate environment and so reduce the need for extra care and the potential to avoid readmission.
- Patients undergo enhanced assessment which proactively manages their care needs and places patients according to their social and health requirements.
- A repeated Oak Group Audit in 2014 showed a reduction in the non-qualified category from 41% (2013) to 28% (2014).

St Giles

The hospital also identified that there was regularly a 3 to 4 day wait between patients being ready for transfer home with a social care package, and the package commencing. The hospital commissioned a private sector bridging service to support patients in their home until the statutory care package is available.

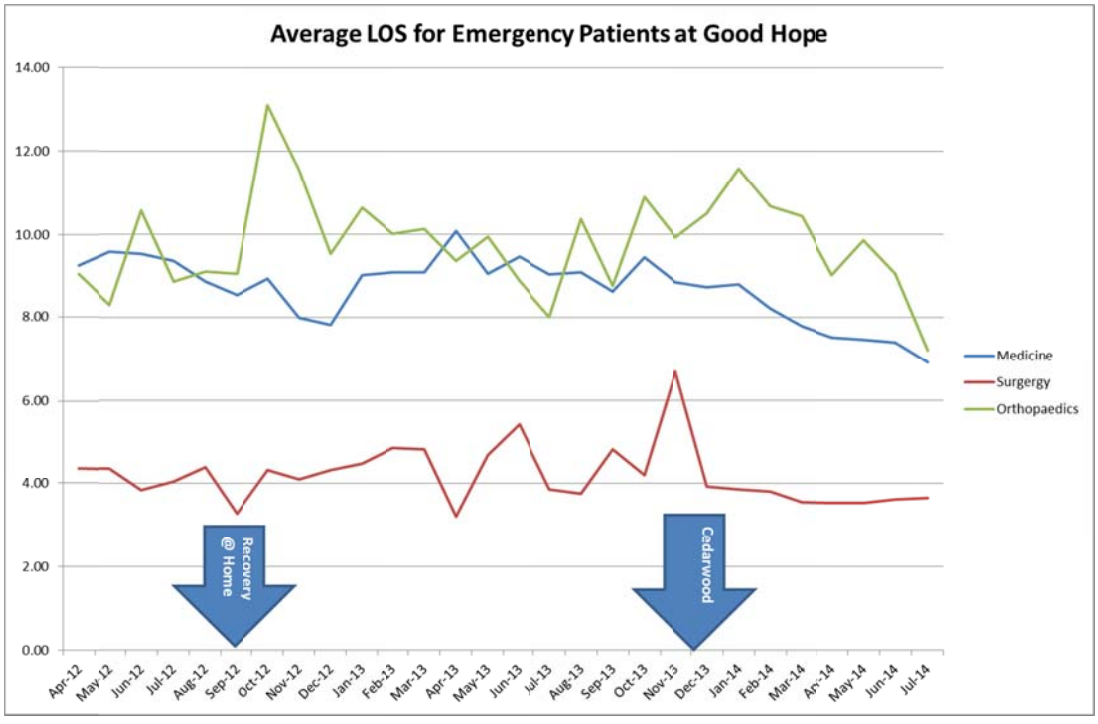
Front door turnaround

The hospital has recently started to make a geriatrician available in the emergency department, acute assessment unit and short stay units from 8am-6pm to identify, assess and turn appropriate patients around into alternative pathways. This approach is underpinned by a FRED (facilitating rapid early discharge) dashboard to track patients.

So far the success is anecdotal and the geriatrician reports 1-4 patients are turned around a day. Other consultant geriatricians are starting to support the approach which is likely to increase the number of patients streamed into alternative pathways.

Impact

- Analysis of data from Good Hope indicates that between 2007/08 and 2012/13 the average length of stay in hospital decreased from 6.2 days to 5.7, a reduction of 9.5%. This compares with an overall reduction of 6.1% nationally over the same time period.
- Recovery at home has led to the closure of a 30 bedded ward.



Source: Good Hope internal analysis

Before the recovery at home and Cedarwood approaches were implemented in July 2012 the average length of stay for emergency patients was 8.7 days, this has been reduced to 6.33 days by July 2014.

Critical success factors

- Change was enabled by having a senior manager who had credibility in the Trust driving the approaches.
- Constantly reinforcing a culture of proactive patient management.
- Looking for alternative solutions and having the confidence to try new models of service delivery.
- Discharge facilitators from Healthcare at Home developing sound professional relationships with ward teams to identify suitable patients for service.

Challenges

- The hospital found there was an inherent mistrust of the private sector that needed to be addressed through committed senior leadership and open communication.
- Being clear on the expectations of each organisation and giving partners the ability to communicate issues early so that they can be resolved. For example the hospital and Midland Heart are working to ensure patients are transferred to Cedarwood at an appropriate time and that patients arrive with all their medication.

Next steps

- The hospital hopes to develop the single assessment document to a single assessor trusted by all providers.
- Increase the FRED team approach to provide further alternative pathways at the front door.

Contacts

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