Poole Hospital NHS
NHS Foundation Trust

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Length of stay case study

Poole Hospital NHS Foundation Trust

Poole Hospital NHS Foundation Trust is an acute general hospital with 621 beds. The Trust provides general hospital services to the population of Poole, Purbeck and East Dorset, covering a population of around 280,000 people. It also provides a range of additional services such as maternity and neonatal care, paediatrics, oral surgery and neurology to a wider population including Bournemouth and Christchurch.

The hospital has a 24-hour major accident and emergency department and is the designated trauma unit for Dorset.

Approaches to reducing length of stay

The hospital has utilised a number of different approaches for reducing geriatric length of stay. However, the main approaches stemmed from the drive to establish a more efficient flow, a £10million overspend, and recognition that geriatric medicine could be configured more efficiently to improve patient care and reduce patient length of stay.

The development of the Rapid Access Consultant Evaluation (RACE) unit and productive ward programme were the start points for reducing length of stay; however, the hospital has implemented a number of inter-linked approaches.

Rapid Access Consultant Evaluation (RACE) unit

Prior to the establishment of the RACE unit, there was a general medical admissions ward, which provided a strong platform on which to develop a dedicated frail elderly assessment unit. Once the hospital had designed the RACE model they invited all stakeholders to look around the department and talk to the staff.

The directors of the 3 adult social care local authorities fully supported the approach as made the decision to keep social care packages open for 3 days after admission, enabling patients to be returned home more easily. In addition there was an integrated care team established in the community, which was able to support an approach that resulted in faster turnaround of frail elderly patients.

The 24 bedded RACE unit separates out the frail elderly from the general medical take (based on need) and is focused around a dynamic and proactive approach to comprehensive geriatric assessment. The unit is geared towards patients who are likely to be able to return home within 48 hours; patients requiring a longer stay are admitted direct onto the geriatric medicine wards.

The unit provides assessment and care to around 400 patients a month, which is roughly 13 patients admitted and 13 discharged a day. The average LoS on the unit is 1.5 days.

Patients are admitted directly from their GP to the unit, or may arrive from the emergency department. The consultant or senior registrar takes the call from the GP, intermediary care team or ED requesting patient admission and can sometimes provide advice to enable a patient to remain at home or come in for specific investigations to prevent a full admission.

The unit is staffed five days a week, 8am-5pm, by four consultant geriatricians (on rotation); weekend cover is provided by the on call consultant that weekend. The four consultants work in twos, with two covering the RACE unit for 3 months then rotating – this model enables the consultants to maintain general geriatric medicine skills and prevents burnout from the faster paced RACE unit.

The unit is also staffed seven days a week by junior doctors, 2/3 senior nurses, health care assistants and therapy staff with specialist skills in the evaluation of older people. The senior nursing staff have clear control of processes and ensure individual patients receive tailored support.

The ward round is at 8:30am and the MDT meeting at 11:30am. After lunch the consultants identify the patients that they could make the most difference to and progress their care. The unit trialled an evening ward round during the winter pressures; although it didn't reduce LoS significantly (as it would not be appropriate to discharge a frail elderly patient after 7pm), there is anecdotal evidence that it improved patient flow as the consultants had started the following day with a clear idea of the priorities for the day and may have prevented some patients decompensating.

Patients are comprehensively assessed early after admission to the unit and an estimated date of discharge provided. Not all patients receive a diagnosis before discharge, but have a plan to get to a diagnosis, through further tests and investigations as an outpatient.

Discharges are carefully planned at daily multidisciplinary meetings, where both health and social care work to support the patient returning home.

A weekday emergency clinic is also held on the unit for those patients who require specialist medical expertise but do not need to be admitted.

Red cross befriending and support on discharge
An audit of the readmissions found that some patients were returning due to anxiety and a lack of confidence to stay at home. The hospital commissioned the Red Cross to support patients for 72 hours post-discharge from the RACE unit. The Red Cross are part of the MDT and when a patient is identified as needing additional social support the Red Cross takes them home or meets them at home, and helps the patient in the initial few hours and days by making them a hot drink, stocking their fridge, and providing telephone calls and similar basic support.

The Red Cross are on the unit most days and if they are concerned about a patient that has been discharged then a consultant can provide advice or go out to see the patient.

Advanced nurse practitioners for older people
During the establishment of the RACE unit it was recognised that there was a need to develop a team of advanced nurse practitioners who could enable rapid triage of patients and ensure they were streamed into the right patient pathway.

There are 8 advanced nurse practitioners who cover the ED, RACE unit and main wards. Three of the nurses work in the ED on rotation seven days a week and provide support turning older patients around, preventing admissions. The nurses also support the RACE unit by undertaking triage of patients before the 11am MDT meeting and they also support elderly patients on the main wards. The nurses are available on the RACE unit seven days a week (at the weekend the nurses split their time covering the RACE unit and the ED).

There is also a dedicated dementia nurse specialist with a team of three band 5 nurses who undertake the dementia assessments of all over-75 year old patients – this team was established in response to the CQUIN, and the hospital determined that the requirement should be based on improving the care for patients, rather than a tick box exercise of simply undertaking an assessment.

Discharge co-ordinators
Alongside the development of the RACE unit there was an identified need to ensure the inpatient elderly wards maintained a good patient flow as the patients were likely to be of increasing acuity. The need for a dedicated resource to organise patient discharge was identified as ward nurses were often called to respond and (rightly) prioritise patients with urgent medical needs, which led to delays in the transfer of patients who were medically fit for discharge.

The approach was trialled on the stroke ward, where 5 days was taken off the average LoS. Each elderly inpatient ward implemented a dedicated discharge co-ordinator, who was found within the existing workforce establishment.

Many of the co-ordinators are band 2s or 3s and after initial training in supporting the discharge documentation and systems manage to reduce LoS by an average of 2 days – the most effective discharge co-ordinator is a band 2 who is highly respected by the hospital and other stakeholders.

The RACE unit has a band 5 discharge co-ordinator reflecting the need to have a more confident communicator as the current public expectation is that an elderly patient will have a long stay in hospital, rather than being turned around within 48 hours.

The discharge co-ordinators have strong relationships with community providers and social care, to enable easier discharge; they are also developing the role of a trusted assessor.

Although some of the discharge co-ordinators are unable to sign off the documentation (due to their band level) they work up assessments and documents to a point that enables effective use of qualified nurse time. When on annual leave or off work with sickness their role is covered by the senior sisters to enable them to keep up to date with discharge.

On the elderly wards the co-ordinators work Monday to Friday from 8am-4pm and in the RACE unit seven days a week. Other wards, such as trauma and orthopaedics are also moving to establishing a dedicated discharge co-ordinator.

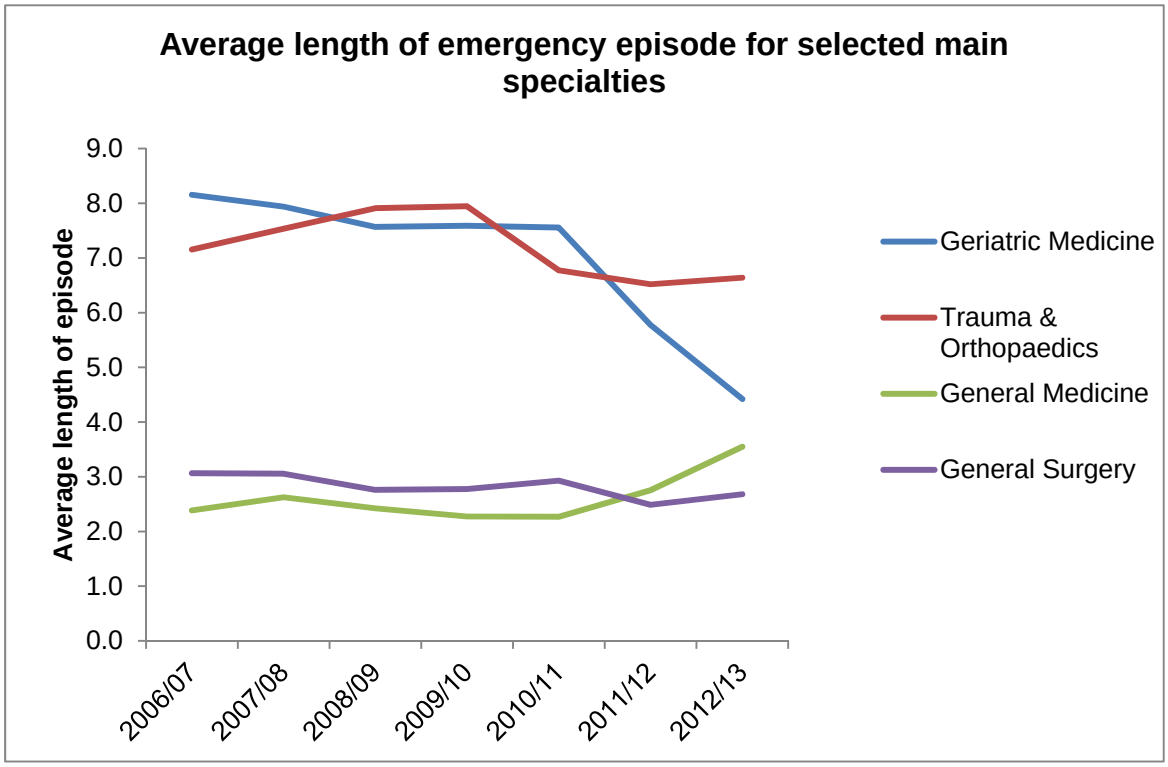
Constantly reviewing pathways
The senior clinical leadership is proactive in reviewing pathways and auditing readmissions and other indicators of concerns. For example an audit of readmissions found that some patients who had fallen, but not broken their hip were discharged after 24 hours, but returned due to poor pain management. This prompted the hospital to recommend these patients stay 48 hours and improve pain management.

Impact
Analysis of data from Poole Hospital NHS Foundation Trust indicates that between 2007/08 and 2012/13 the average length of stay in hospital decreased from 6.2 days to 4.9, a reduction of 20.9%. This compares with an overall reduction of 6.1% nationally over the same time period. This has been maintained for 2013/14.

From 2010/11 to 2012/13 there has been a 42% reduction in the length of stay in geriatric medicine, from an average stay of 7.6 days to 4.4 days.

Around half of geriatric medicine patients are discharged within 2 days on the RACE unit and there has been a mind-set change that a patient has to 'earn' the right to be admitted into the hospital based on their medical needs, with the belief that if a patient can go home this is the best bed that they can be in. The average LoS on the geriatric medicine wards is around 8.1 days. There has been an overall reduction in the number of beds in geriatric medicine from 200 to around 120.

The RACE unit reallocated the consultant work plan of four consultants, and reallocated junior doctors so did not increase overall numbers; however there were increases of 3 nurses and some therapists.



Source: Nuffield Trust analysis

The approach of the RACE unit has also led to indirect changes across the hospital; for example the diagnostic team changed their working practices to actively support the unit and improved prioritisation of scans.

Critical success factors

- The RACE unit was a key approach that facilitated far wider change in geriatric medicine. The approach evolved to improving the quality of patient flow throughout the hospital for older people – from the front to back door.
- The success of the RACE unit is predominantly down to the personalities of clinical leaders, who have set a culture of relentless proactive patient care and provide consistent oversight. Also as a leadership team they are not afraid to try new approaches and review and challenge current practices.
- A supportive consultant geriatrician team and senior nurse team that strives to continually improve.

Challenges

- The RACE unit is expensive and to enable the model to be sustainable the hospital is looking to expand the patient cohort.
- Implementing the discharge co-ordinators was a challenge as the role was found within the existing establishment and many of the matrons were resistant to taking a health care assistant away from direct patient care. However, the benefit in terms of reducing length of stay, having a dedicated resource to progress discharges, and continuity of communication to patients and carers has resulted in matrons valuing the roles.
- Moving to seven day a week working is a challenge and the hospital is reviewing both consultant and nursing establishments to redesign the workforce in geriatric medicine. Similarly there has been a 10% increase in emergency admissions and more patients arriving between 3pm-8pm and the hospital is looking to redesign the workforce to meet this shift in demand.
- The hospital interacts with three local authorities, all with different service offers. The multiple providers have also resulted in the social care market lacking a coherent control. This has a knock on impact in terms of discharge planning for the hospital.

Next steps

The hospital is looking to build on the success of the RACE unit and develop a discharge to assess model and an emergency ambulatory medicine model.

The number of patients arriving in the evening and overnight is increasing (when there is less consultant and senior nurse cover), the hospital is looking to work with the CCG to determine the causes of this shift.

The hospital is looking to implement flow bundles to support the further improvement of length of stay across the organisation and has developed a series of metrics to track progress.

The number of delays over 15 days in general medicine has recently started to increase; the hypothesis is that the pressures in social care may be impacting on the longer stays. The trust is exploring this cohort of patients and determining options going forward.

The hospital is keen to explore partnership working with the community trust and the opportunity to improve the community geriatrician resource and more efficient use of community beds. The hospital is also keen to support the care closer to home agenda, recognising that supporting patients with complex needs in their own home will require specialist advice and capability.

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