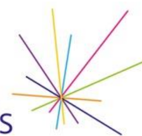
Nottingham University Hospitals NHS
NHS Trust



East Midlands
Academic Health
Science Network
Igniting Innovation

Readmissions
Reduction
Programme

Discharge case study
Nottingham University Hospitals NHS Trust

Reducing readmissions

Overview

Nottingham University Hospitals NHS Trust (NUH) is one of the biggest employers in the region, with around 14,500 people working across Queen's Medical Centre, Nottingham City Hospital, Ropewalk House and in the community.

The NUH portfolio of specialist services includes major trauma, cancer, stroke, renal, neurosurgery, heart and spine. QMC is home to the Nottingham Children's Hospital, where 40,000 young patients from Nottinghamshire and beyond are cared for annually.

The Trust is at the forefront of many world-leading research programmes and new surgical procedures. In partnership with the University of Nottingham, they operate two National Institute for Health Research (NIHR) Biomedical Research Units - in hearing and digestive diseases. NUH also hosts the East Midlands Academic Health Science Network.

Background

There are significant readmission rate problems in England as identified in "A million readmissions nationwide". In 2014 staff in NUH started to look at this issue and soon realised that there was not sufficient data or data sets available to understand what was really happening within the Trust.

The information available was anecdotal and only available in pockets and not brought together. Staff were not clear what their own statistics were and therefore how they could make a valid contribution to improving patient care and treatment and thus prevent future avoidable readmissions.

At NUH there were approximately 17,500 annual readmissions (including excluded patient groups under Payment by Results) within 28 days when the project started in August 2013. The level of readmissions was making a massive impact on the quality and experience of patients and the cost of the readmissions was rising. This was considered to be a systemic issue across the hospital, community partners and in the care home sector.

One in 6 of all emergency admissions was a readmission. At any given point in a day there were approximately 300 patients in the hospital who were readmissions. On average there were 47 emergency readmissions each day. 8.7% of discharges were readmitted within 28 days.

These figures and issues facing the wards, staff and discharge teams only became clear once the issue was explored.

The staff felt that there needed to be a change which would increase the quality of patient care and experience in the initial episode of care. The staff wanted to extend this change to transfer/discharge as they felt it would help to prevent subsequent frequent readmissions and maintain patients' safely too

Understanding the problem

The problem was that the volume of readmissions was unsustainable in the longer term. It was felt that a number of re-admissions were justifiable and not preventable but that a proportion of the readmissions could be supported in a different way and thus prevented from returning to hospital. The questions posed were:

- Was it a poor original discharge?
- Was the readmission occurring because of a failure of follow up of community services to support the patient?
- Was the level of support needed in the community actually unavailable?

It was identified that there was limited understanding of what was happening over the entirety of the period of time between the original spell in hospital the 28 or less days in the community and the next episode of care in the hospital.

It was then decided that in order to understand why patients returned to hospital better, a patient centred readmissions review would be undertaken with the patient when they were readmitted. This could help to pinpoint elements of the original discharge/transfer process which could have been improved and also if there were any community issues that needed attention.

A process was set up so that on readmission the patient is visited by a patient liaison officer and an in depth review takes place. The results of this review are shared with the ward that the patient was discharged from previously to see if anything could have been done differently. Patients are asked about their discharge previously, their care package, medications and their care in the community. They are also asked if they had felt well enough to go home at the time of the previous discharge.

Data systems have now been set up to capture relevant data so that staff can see where the problem areas are (taking a no exclusions approach). A predictive modelling tool (which is condition specific) is also under development to help plan care better and support discharge for patients.

Solutions

Data is now used from patient centred readmission reviews and datasets to support improvements in discharge processes.

The Cancer Admissions Task Team (CATT) is one task force that has been locally developed with the support of the Readmissions Reduction Programme and is seeing excellent improvements in the quality of discharges for patients. In their efforts to reduce readmissions they have set up a triage advice line for all oncology patients. Patients are also followed up post discharge after cycle 1 chemotherapy. This offers an opportunity to address any concerns or challenges that the patient may face and help to resolve these without the need for an admission.

Patients are also visited by the team in the emergency department to explore appropriate alternatives to admitting them, for example; a patient with severe nausea as a side effect of their treatment would be seen by a nurse prescriber who can advise and prescribe or change appropriate medication so that the patient can stay at home rather than being admitted.

The healthcare of the elderly wards are analysing data from patients admitted from care homes with schemes being developed to help prevent readmissions. A tool called eHealthscope is being used with support from GPs and community staff.

The result is a more active follow up of patients to provide more continuous support.

Impact and outcomes

- **Patients**
  There has been an improvement in patient experience and care and a decrease in patient stress and anxiety. With the CATT nurse triage system set up patients can speak to a nurse 24 hours a day and 365 days a year which means that patients do not have to be readmitted unless absolutely necessary.

  Serious conditions can also be monitored more closely and interventions take place at an earlier stage thus also preventing readmissions.

  It has been found that the Patient centred readmission review with the patient provides the patient an opportunity for in depth feedback about what has happened to them and has helped to ensure changes are made to improve their care in the future both internally at NUH and across the healthcare community.

- **Whole System**
  From 2013/14 to 2014/15 there was a decrease in the readmission rate from 8.7% to 8.4%. To date 80 fewer people readmitted each month in 2015 than during the same period in 2014. In the context of increased activity this represents good progress.

Communications about what is happening has improved and the data sets are making staff proactively compare their figures with others and make efforts to improve discharge the first time round. Datasets are also used to support decision making both during and up to discharge by clinical staff.

There has also been an improvement in integrated care across the health and social care system in Nottingham including better liaison with the council housing department.

Further Quality Improvements and Spread

- There is still a need to improve data across the health care system so that there is better information available to all sectors.
- More teams need to proactively make changes in their systems and processes to reduce readmissions using the teams, such as CATT, as examples of good practice.
- Further integration and working together across health and social care will continue to support improvements.

Top Tips

- Establishment of datasets early on is crucial for better comparison.
- Use electronic evaluation forms for easier review.
- Get community engagement at all levels.

For more information about this project contact:

readmissions@nuh.nhs.uk

Themes

- Electronic systems and records
- Policies and systems that link health and Social Care
- Systems that involve patients in their care
- Systems that ensure provision of high quality information