STANDARD 5
ACCESS TO DIAGNOSTICS

NHS England

SEVEN DAY SERVICES
CASE STUDY

OCT 2015

Aylesbury Vale Clinical Commissioning Group, Chiltern CCG, Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council

Using an improvement method to review transfers of care seven days a week

AT A GLANCE:

- **NHS Improving Quality supported Buckinghamshire System Resilience Group (SRG) to review practice at Stoke Mandeville Hospital in relation to meeting standard 9: transfer of care.**
- **Buckinghamshire Healthcare Trust (BHT), Buckinghamshire County Council (BCC), Aylesbury Vale Clinical Commissioning Group (AVCCG) and Chiltern CCG co-designed the methodology to identify where improving access to services may add the most value to inform seven day plans.**
- **Information from case note reviews, observations in clinical practice and semi-structured interviews with staff identified variation in practice in relation to weekend and weekday practice and opportunities for improvement.**
- **The evidence assisted the SRG to assure improvement plans and the methodology would benefit other healthcare communities check and challenge assumptions in relation to transfer of care issues.**

In June 2015, NHS Improving Quality supported Buckinghamshire System Resilience Group (BSRG) to undertake a 'snapshot' review of simple and complex discharge/transfer of care pathways for older people admitted as an emergency to Stoke Mandeville Hospital (SMH), part of Buckinghamshire Healthcare NHS Trust. The work was sponsored by the commissioners and a key driver was to better understand the transfer of care issues and identify the focus for new initiatives in preparation for winter pressure planning.

Since 2013/14, BSRG had implemented a variety of interventions to reduce the demand on urgent care and to meet urgent and emergency care standards.

A number of these have been highly successful, however, despite managing 'front door' demand at SMH, discrepancy remains between demand for admission and the number of discharges/transfers. Issues around acute capacity, including 100% bed occupancy at times, had not yet been resolved.

Across the system, it was noted that there were reduced transfers of care at weekends, but what was less clear were the reasons for this. As a result, commissioners and providers worked in partnership to co-design the review methodology to understand current transfer of care practice and identify areas for future improvement.

How was the review undertaken?

1. Engagement of system leaders to co-design scope of work and methodology, via urgent care commissioning lead and providers.
2. Engagement exercise, with clinical leaders and managers, across health and social care to understand current pathways of care and test tools for data collection.
3. Information was gathered using three methods:
   - Semi-structured interviews with fifteen health and social care staff to understand staff perception of issues, including the barriers, challenges and opportunities for improvement.
   - Case note review of ten patients who had been discharged from hospital against the clinical standards and discharge best practice guidance.
   - Observations in practice of patients in the emergency department, assessment units, short stay ward and three ward areas over four consecutive days (Friday, Saturday, Sunday and Monday).
4. Findings were analysed and validated with staff and key stakeholders which included:
   - Group presentation of findings to clinical staff, clinical leaders and managers of health and social care providers to enable challenge and discussion.
   - Sense checking of key findings with individual key stakeholders within acute provider, social care, and commissioners and SRG members.
5. Submission of a final report to stakeholders and discussion of findings at SRG meetings to inform discussion on joint improvement plans.

What was achieved

The key findings enabled a transfer of care system-wide plan to be agreed and monitored by the BSRG.

The review identified key issues:

- Discharge planning was not as proactive and rapid on the main inpatient wards as in the 'front door' assessment areas.
- Lack of capacity and access to community services at the weekend, duplication of discharge assessment processes out of hours and gaps in weekend senior clinical decision making. There were delays in assessment, discharge planning and a lack of continuity. These were validated by observations and patient note reviews and provided objective, independent information upon which to develop relevant action plans.
- Staff were not always aware of referral criteria for different community services, this led to duplicate referrals and assessments, delays and potentially contributed to and increased length of hospital stay. Equally, some services were more risk averse than others in receiving patients and transferring patients.
- Variation in use of language in relation to understanding 'fit for discharge' which delayed referrals and plans.

What was the impact

- A clear picture of the discharge processes was objectively obtained and validated using a variety of evidence sources utilised to challenge existing assumptions.
- The collaborative approach enabled health and social care system leaders to have meaningful conversations regarding plans and identified where further evidence may be required to understand the issues.
- Findings provided the BSRG with assurance of plans and the ability to benchmark future progress.

"We (BSRG) have gained a shared understanding of what's really happening in clinical practice. This includes an agreed baseline upon which to develop an action plan. This will enable all organisations to have confidence through reduced confusion and duplication and so improve effectiveness and efficiency to benefit patients and the system as a whole. This has also provided a robust rationale for investment of system resilience funding and internal acute trust resources."

Ian Cave, Aylesbury Vale Clinical Commissioning Group

TOP TIPS

- **Gain early senior executive/ leadership 'buy in' to the approach to enable system ownership of resolving issues.**
- **Agree data collection tools with all to build confidence in method and findings.**
- **Triangulation of data helps to validate findings from different perspectives.**

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