Report on Appropriate Care for Everyone (ACE) consultation

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1. EXECUTIVE SUMMARY

1.1 Introduction
The ACE programme has been developed for all organisations across Oxfordshire working together to commission and deliver health and social care; so that every adult can say they are receiving care that is acceptable and appropriate to their needs in the 21st century. There are two key strands in the ACE programme: developing a model of care for older people with complex needs and the infrastructure required to support this.

1.2 The engagement process
The engagement was split into three strands of work:
- General engagement with the public for comment and feedback
- Patient experience
- Staff experience

The aim of this was to provide a whole picture of the issue to understand from more than one angle what actions may be needed.

1.3 Key finding from the consultation
Public engagement questionnaire
The most significant point raised was the importance of person centred care – taking into account the needs of family and informal carers as well as the patient.

The importance of working together and shared budgets was also mentioned.

Patient Experience – Questionnaire and individual interviews
In the questionnaire on the whole patients and carers expressed satisfaction with how their care and discharge had been managed. They felt involved in decision making and expressed positive responses. However, where the experiences were negative, there were expressions of extreme dissatisfaction.

By contrast the group of eight patient and carers interviewed individually who were all subject to delays expressed much more negative experiences. They rated their experiences of choice, information and hospital care very low. In fact three of the eight had lodged complaints about aspects of their care.

Staff Experience – Questionnaire and Individual interviews
Although staff felt they knew about services and kept patients informed there was evidence that most felt they did not have the authority to make a difference. Examination of the responses to the free text questions starts to show a very different experience. Though people felt they knew what was
going on there were suggestions that information should be kept centrally and up to date, that constant changes to services were confusing and not productive.

### 1.4 Key learning

**Making a difference**
There is a large resource of staff who would like to see change and feel that they could make a difference to delays. It is important to capture this enthusiasm and take it into the changes that are made.

**Families and delays**
The underlying reasons for families causing delays should be investigated.

**Barriers between organisations**
It is particularly concerning to note that it is felt that barriers have increased rather than decreased recently.

**Disempowered staff and GPs**
Although GPs did not specifically say they were disempowered there was a strong sense of disempowerment in some of their responses. Social services staff throughout the responses were seen as the key people to have the power to make decisions but they did not actually perceive that themselves.

**Right information, right time, right place**
Families, patients and staff all mentioned the need for accessible up to date information, plainly expressed and provided at the right point in the care pathway.

**Shortage of community carers**
There were many suggestions for why this was occurring.

**Communication**
This relates to communications up and down, between organisations and most significantly with patients and carers.

**Care availability and provision**
This was seen as a key issue in breaking the cycle of DTOC.

**Cross-cutting themes**
Communication cuts across all the work and seems to be where the most change is needed.

**Barriers between organisations**
It is particularly concerning to note that it is felt that barriers have increased rather than decreased recently. There is clearly much that both sides of the coin agree about: the importance of a single point of contact, the absolute necessity to remember that at the centre of this process is a person, the need for effective communication in all its forms. It will be important to recognise
that these barriers should be brought down – that they are recognised by everyone so it is likely that the will is there to bring them down.

1.5 Recommendations

The Ace Programme has already identified and is tackling many of the issues raised within the report such as issues around domiciliary care availability / provision and the need to integrate health and social care services to support the transfer of patients from acute to their onward care setting. Below are recommendations developed from the report findings:

- Development of patient information: organise a multi-disciplinary task and finish group to develop patient information on the discharge process with the close involvement of patients and carers.

- Commence discharge process earlier: develop a process that initiates the discharge process soon after admission and involves families / carers from the beginning.

- Support for families: undertake a further review on the underlying reasons for families causing delays and what support that could be put in place to help families and carers to help then through the discharge process efficiently.

- Improve communication between acute and community health and social care: provider organisations to develop a culture to encourage cross organisational communication.

- Improved information for GPs: understand GP and practice requirements for information to support admissions avoidance and facilitate discharge.

- Focus on specific groups of patients: focus on those patients that staff felt were most impacted by Delayed Transfers of care (1) the cognitively impaired and (2) those waiting for long term placements.

2. BACKGROUND

2.1 ACE Project background:

Delayed transfers of care (DTOC) within Oxfordshire are currently the worst in the country. This is not a new problem; it has been an issue for 10 years. In that time several external organisations have come in to review and report, put in plans to reduce the number of DTOCs – but the delays have not changed sustainably.

In July 2011 senior clinical and organisational leads from across the Oxfordshire health system, came together with commissioners from both health and social care, to debate the system wide issues that have
contributed to the high level Delayed Transfers of Care (DTOC) in the county. All organisations involved (Oxford Health Foundation Trust, Oxford Radcliffe Hospitals NHS Trust, the Nuffield Orthopaedic Centre, NHS Oxfordshire and Oxfordshire County Council) agreed that although Oxfordshire does many things very well for 90% of the people who flow through the care system, the shortfalls in this area were leading the system to fail the most vulnerable people in the community. The current systems and process do not meet the needs of our ageing population.

The emphasis going forward is on joint working across organisational boundaries and across health and social care. The aim is to make services fit for the challenges the health system faces. A working plan to re-design current processes and systems has been agreed. The ACE programme will look to ‘make a difference’ to the typical person who gets stuck within the health and/or social care system and for whom we are failing. The programme is doing this primarily in three ways; by ensuring we have the right definitions and information to track successful outcomes, by improving the processes and services, making them more integrated, by using the new funding from health to social care to improve the ‘flow’ through the care pathways and by reviewing how these services are funded in an integrated way. The programme is also about pulling together the change and modernisation projects including services across all the organisations to ensure that they are all working towards shared aims and a common outcome.

### 2.2 ACE Project Objectives

**Overall ACE Programme Aim:**

All organisations across Oxfordshire working together commissioning and delivering health and social care, so that every adult can say they are receiving care that is acceptable and appropriate to their needs in the 21\textsuperscript{st} century.
Project scope:

There are two key strands in the ACE programme: developing a model of care for older people with complex needs and the infrastructure required to support this.

**Model of Care** – The purpose of the model is to develop a clear coherent offering of support and care for older people in Oxfordshire across health and social care. The model will ensure that the right support is available in the right place at the right time.

**Infrastructure** – In order to deliver the model of care we must:
- Have a clear set of outcomes we are aiming to achieve and be able to monitor the delivery of those outcomes
- Pool our resources together so that we can ensure that funding is available in the right place at the right time
- Support the market so that we have high quality flexible providers
3 ENGAGEMENT

The engagement has been split into three strands of work:

- General engagement with the public for comment and feedback
- Patient experience and
- Staff experience.

These are separately reported here and brought together in a series of suggestions for next steps. The aim of this was to provide a whole picture of the issue to understand from more than one angle what actions may be needed.

3.1 Public Engagement

3.1.1 Methodology
A questionnaire was developed for distribution to members of Taking Health. This was also sent out to the voluntary sector via the OCVA mailing and distributed to GP practices and via Oxford University Hospitals, Oxford Health and Oxfordshire County Council internal mailing systems. It was available as paper version or to complete on line.

An offer was made to talk to groups about the programme via all these methods but this was not taken up.

Stakeholder briefing
Senior officers met with The Older Peoples Panel (Age UK) and with the Local Involvement Network (LINk). The ACE work was presented formally to the Health Overview and Scrutiny Committee on several occasions in public including 10/11/11, 19/1/12 and informal meetings were held with the Chair. Delayed transfers of care were also discussed on a regular basis including the ACE programme at the Adult Services Scrutiny Committee.

Stakeholder briefings were sent the later part of 2011 and at the beginning of 2012 explaining the work of the ACE programme and the various consultations to the LINk, HOSC and NHS Provider Trusts.

Engagement questionnaire
The questionnaire explored aspects of the public views on what the experience of using services could be like. We wanted to identify what was important in delivery of a service to the public and their references for how it was delivered.
3.1.2 Main findings from public engagement

The Questionnaire
The questionnaire is included as Appendix 1

96 responses were received in total. In some instances extensive quotes have been used because it was not possible to capture the flavour of them in an abridged format. The quotes do reflect some very difficult and personal issues.
The majority of respondents had chosen to respond because of an interest in services (46%) or because they represented an organisation with an interest (18%). 25% of respondents had a direct experience of hospital services either as a carer or user of services.

A closer look at the responses of those who responded ‘other’ shows that eight were responding because of experience of poor care. The story below is illustrative of this.

“My wife, who suffers advanced dementia, was admitted to the JRH on 13th December with inexplicable lethargy and muscular spasms (‘myclonic reactions’). After thorough tests it was concluded that she had simply been on a cocktail of too many drugs for too long a period. She was taken off all medication and began to revive so quickly that after three days (by 16th, and certainly by 19th) the consultant declared her medically fit to go home. However, because of her lethargy, she was unwilling to exert herself, so the physio- and occupational therapists concluded that she should not be allowed to go home until a hoist had been installed and a full care plan established - and because of the Christmas and New Year holidays we were unable to find any care agency with spare capacity until 4th January. Because of the holidays, visits to her bedside by therapists were rare and very often coincided with her being asleep; consequently she had practically no exercise whatsoever for three long weeks, so that when she did come home we have been having practically to teach her to walk again, and she has lost most of
the strength in her legs - simply by being confined to an expensive hospital bed for three weeks, instead of three days!'

2) Have you heard about Delayed Transfers of Care (DTOC)

The majority of respondents were aware of delayed transfers of care and others who completed the free text indicated that understood it to be 'bed-blocking'. However, there are many respondents who are complexly unaware of this.

3) Thinking about the times when you or someone you care for might have needed help from the health service or social care - what is important to you?
This was a multiple choice question so respondents could indicate more than one option. On average respondents selected 4.5 options. 83% of respondents selected ‘Understanding what is going to happen and what will happen next’. There was little difference between the weightings for other comments though ‘If I am not seriously ill being able to get the kind of care I might usually expect in a hospital in my own home or in my care home’ was weighted a little more strongly with 70% selecting. There were no significant themes from those responding ‘other’.

4) Please tell us, what you think, would be the best way of helping people to use hospital less and leave earlier. Ticking a number from one to seven please tell us how important each answer is to you. (One means it is least important seven means it is most important).

The detailed breakdown of responses to each of these questions is provided in the tables below. The questions relating to social care and to health and social care were significantly highly rated. They also show as those most likely to be rated as ‘7’ in the weighting choices. Least important was ‘GPs doing diagnosis in the surgery or in my own home’. 32% rated this or ‘4’ or below. 27 people responded to the open question about this. Significant mention was given to issues related to timely support, joint working and patient centred support.

‘It seemed to us that the hospital-based therapists (Physio and OT) wash their hands of a patient the moment (s) he leaves to hospital, without ensuring that the case has been taken over by properly briefed community therapists. My wife was sent home on 4th January; to date (18th) we have had no communication whatsoever from any such specialists, although my wife evidently badly needs their advice.’

‘NHS Continuing Care and Adult Services need to work together. Hospital Social Workers were too busy and overworked. There was a three week delay in discharge because of reluctance to provide and fund the care package required. Further surgery has been proposed but I AM RELUCTANT TO AGREE. I don't want to get stuck in hospital again!’
As someone who is on the autism spectrum, hospital stays with their changes of my normal routine, huge sensory issues and social communication issues are immensely frightening places to be. With so little training given to staff at present, anything that minimises the trauma and keeps us local and with excellent but known staff is beneficial.

My GP doing more diagnosis in the surgery or in my home

Help to sort out how to stay at home rather than go to hospital
Support put in quickly so I can stay in my local area

NHS and social services working together to help me to stay in my local area
Health and social care services designed to respond quickly when I need them

A process which means I do not have to go to an acute hospital if I am not feeling well enough to stay at home
Social services and health working more closely together

Being able to go home quickly, if I am well enough to leave hospital
5) Do you have any other comments on this if so please put your thoughts in the box?
There were 36 responses to this free text question. There was a wide range of responses but only one really significant theme which links closely with one of the themes in the last question. Patient centred care was mentioned 13 times across a range of topics. Of particular note within this theme were mentions of the need to involve carers and to be holistic in approach.

‘Partnerships have been spoken about many times and the patient/client being at the centre of the care plan being important; not the patient having to fit into the template care plan. If any of this could happen it would be so beneficial to all concerned patient; client; staff; budgets!’

‘The co-ordination between the various agencies is a vital ingredient in this initiative. One of the most frustrating problems is the apparent inability of next of kin (and patients) to be able to find out what is going on. carers and next of kin must be kept in the loop and at the moment ‘confidentiality’ gets in the way!’

Working together and shared budgets were also mentioned several times.

‘Whether one has to go into hospital or not it is important to feel that the various organisations involved are working together and that you will be safe.’

‘… it looks as if the division of budgetary responsibility leads to X in the NHS hospital fighting to keep their £1 to pay for a bed and support for a patient who should go home, rather than letting Y in Local Government have 60p to support the patient at home. A loss to the community.’

3.2 Patient Experience

3.2.1 Methodology
There were two parts to the patient experience work. A questionnaire was issued on paper and on line and one to one interviews with a small number of patients who had been affected by delays were undertaken.

The questionnaire was sent out as for the public engagement questionnaire above and was also made available in all the community hospitals on paper.

3.2.2 Main findings from Patient experience
Although there was a reasonable amount of interest in the questionnaire, with 63 respondents, the filtering put into the questionnaire to screen out those who did not have relevant experience or were not of a relevant age, left only 26 responses to the main part of the questionnaire. Of these 18 gave their postcodes which showed that responses came from across the district. The results from the questionnaire have been analysed below.
The questionnaire

Personal experience

1. How old are you or the person you care for?
20 of the respondents were under 65 or caring for someone under 65 so were ineligible to respond. The age filter was included to take account of the fact that DTOC tends to be an issue primarily affecting the older population.

2. Have you or someone you care had experience of being in hospital during the past year?
We wanted responses from those with recent experience so filtered again by experience in the past year. This excluded another 15 leaving us with 26 respondents.

3. Please tell us whether you are answering as a carer/family member for someone who has been in hospital or as a patient.

Eleven of the respondents were family members or carers and a further eleven indicated that they had been a patient in the past year or were currently a patient.
4. The decisions about next steps:
Thinking about when you or the person you care for were in hospital
please indicate the statements below which are true for you. (Tick all
that apply).

- Other (please specify)
- I did not think that was important to me as long as everything was organised.
- I do not know who was responsible for the next steps but I did try to find out
- Although it took a while to find out who was responsible for the next steps once I knew
  everything went smoothly.
- I tried to find out who was responsible for supporting me (or the person I care for) to leave
  hospital but it took a long time to find out who that would be.
- I always knew who to ask about what would happen after I (or the person I care for) left
  hospital.

The majority felt that they always knew what was going to happen next. However others indicated that they that did not know and could not find out (6) or that it took time to find out (3). Those who responded ‘other’ made a range of comments.

‘It was not clear to me nor it appeared the Hospital Staff: What if any help was needed.’

‘It didn’t occur to me to ask ‘what next’ as I had a discharge letter medication
and paperwork with all the exercises etc clearly explained and instructions...’
(Royal Berkshire Hospital patient)
5. The staff dealing with next steps:
Thinking about how effective the staff were who dealt with you in relation to leaving hospital, please tell us which statements come closest to your point of view. (Tick all that apply)

Although eleven patients indicated that they thought staff knew what to do 17 indicated negative responses to this, that staff did not always know what to do, were blocked or had little power.

Two people wrote comments in the ‘other’ section. They were very different but both referred to inadequacies in care but in different hospitals.

‘I was just told (on a Sunday morning) to come and pick up my mother - so I did. Despite knowing they should have been sorting out a proper discharge process. They were treating her so badly (leaving her alone in a room with no drink or food, not helping her to the toilet, etc.. and she was so very frightened by the experience that I couldn't play brink-manship with the JR - so came and got her and took her home.’

‘Very confusing dealing with staff, cant read their badges easily and such a variety of uniforms, colours also such complicated rotas meant that you rarely seem to see the same person twice.’
6. How decisions were made:
Thinking about the way decisions were made about your care please indicate what comes closest to your experience. (Tick one only)

- I tried to make sure I had my say but wasn't allowed to
- I didn't feel I understood the options for the next steps
- I found the options confusing
- I wasn't involved at all in any decisions about what happened next
- I felt involved in the decisions that were made about the next steps for me
- Other (please specify)

Thirteen respondents indicated that they felt involved in decisions made. However 38% did not express this certainty. There were two responses recorded as ‘other’.

‘During the Christmas/New Year holiday season there seldom (if ever) seemed to be a quorum of decision-makers. Each would say “as far as I am concerned but I don't know what the therapists would think.”’
7. After leaving hospital:
Thinking about what happened after you left hospital please indicate what comes closest to your experience? (Tick one only)

- Other (please specify)
- I don't know
- I think I would have done better if I had moved out sooner
- I didn't feel ready to leave hospital
- I felt that I would have been better if I had had another option
- I felt I had been moved to the right place for me

The majority were happy with their next step. Of those who responded to the ‘other’ question two mentioned issues for single people.

‘I arranged my own care to a private nursing home as I could not be one my own at home.’
8. The length of your hospital stay:
Thinking about how long it was before you moved out of hospital after you started to feel better please indicate which of these options comes closest to your experience. (Tick one only)

Again the majority were happy about what happened when they left hospital. However four gave other responses and four felt that they were in hospital longer than was needed.

There was no new theme in the comments.
9. What happened next?
Thinking about the move from the hospital please tell us where you went next. (Tick one only)

There was a mix of responses to this question. Those who responded ‘other’ all referred to the lack of support in one way or another.

‘Back home wife supporting No contact from local gp’

The following six questions relate to care in a community hospital. Just one of the respondents had experienced care in a community hospital. That response is recorded below.

10. The decisions about next steps:
Thinking about when you or the person you care for were in hospital please indicate the statements below which are true for you. (Tick all that apply)

*Although it took a while to find out who was responsible for the next steps once I knew everything went smoothly.
11. The staff dealing with next steps:
Thinking about how effective the staff were who dealt with you in relation to leaving hospital, please tell us which statement come closest to your point of view. (Tick all that apply)

*The staff I dealt with seemed to know what to do and were well organised

12. How decisions were made:
Thinking about the way decisions were made about your care please indicate what comes closest to your experience. (Tick one only)

*I felt involved in the decisions that were made about the next steps for me

13. After leaving hospital:
Thinking about what happened after you left hospital please indicate what comes closest to your experience? (Tick one only)

*Other (please specify) – still in a community hospital

14. The length of your hospital stay:
Thinking about how long it was before you moved out of hospital after you started to feel better please indicate which of these options comes closest to your experience. (Tick one only)

*Did not apply

15. What happened next?
Thinking about the move from the hospital please tell us where you went next. (Tick one only)

*Did not apply

16. Thinking about how you are now which of these statements comes closest to how you view your experience of leaving a community hospital or an acute hospital? (Tick one only)

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>I think I left hospital at the right time for me</td>
<td>50% (2)</td>
</tr>
<tr>
<td>I think I really needed longer in hospital</td>
<td>25% (1)</td>
</tr>
<tr>
<td>I think I would have got much better quicker if I had left hospital sooner</td>
<td>0% (0)</td>
</tr>
<tr>
<td>I don't know</td>
<td>25% (1)</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>

17. Comments
If you would like to tell us anything about your experience of leaving hospital which we have not asked about please put that information here.

We received ten responses to this question. There were no strong themes in the responses but a range of issues were raised. There were comments about both unsatisfactory hospital care and unsatisfactory social care.

'I have been in hospital twice recently one unexpected and one planned. The unexpected was a nightmare and no one told me anything. I saw so many people who all said different things, and mistakes were made. The planned hospital stay did not prepare me for the things I would not be able to do for myself and no extra help was offered.'

'Because my wife's "savings" exceed the statutory £23,000, the social services don't want to know about her and so no-one came to follow up her hospitalization, nor to give us advice as to where to turn.'

3.2.3 In depth interviews

A full report on these is attached at Appendix 2. There were eight participants in this process. A range of topics was discussed with each participant and they were asked to rate the quality of their experience. The following information is extracted from the report.

The rating of experiences/satisfaction is shown below. This illustrates that respondents were least happy about the hospital, the choices they had and the information. They were most happy/satisfied with the people and pets in their lives. All the other options hovered around the 50% mark.
An extracted set of responses under each heading is shown below.

**Choices**

‘JR too sudden, no notification. Wallingford better – more involvement’

**Money**

‘Cost of living shooting up. Worrying’

**People**

‘Sons and daughter great support. Neighbour sorted fire alarm. Tesco delivers groceries!’

**Pets**

‘Scrap, Jack Russell – I talk to him all the time. Cuddles and strokes. He’s a good house dog and good company’

**Services**

‘OT twice a week, very good. Social worker also very good. Carers didn’t have enough time. Very busy. Sometimes up at 7.00am and sometimes had to wait till 11.00am. Soon stopped them!’

**Waiting**

‘Couldn’t wait to get out of hospital and into Larkrise’

**Information**

‘Not much information. You have to do what you’re told.’

**What’s available?**

‘When they said Wallingford I said No way! Papers were lost. Social worker didn’t come back until after Christmas’ (4)

**Health and Recovery**

‘District Nurse twice a week to do feet. Bampton gives better care but twice a week not enough.’

**Safety**

‘Can’t go home. I feel homeless.’ (0)
Coping

‘They take him to dining room, cut his food up. Carers came four times a day.’

Hospital

‘25 weeks not knowing where I was going. Bed rest! There were times I didn’t want to be here.’

3.3  **Staff experience**

3.3.1  **Methodology**

A questionnaire was developed to explore issues for staff in relation to delayed transfers of care. This was sent out for distribution to the Oxford University Hospitals trust, Oxford Health Foundation Trust, Oxfordshire county Council and all GP practices in Oxfordshire. It was set up so that all responses were anonymous.

In addition it was agreed to set up individual interviews with a small number of staff to explore some of the issues particularly in relation to risk. These were done by an external provider. The key findings from this are shown at the end of this section and the full report is appended at Appendix 3. These interviews were publicised by the same routes and lead contacts for each organisation were identified.
3.3.2 Main findings from Staff Experience

The questionnaire

1. Please tell us who you work for:

183 people started to respond to the questionnaire. However, of these, fewer went on to complete the full set of questions (130). The largest response came from the county council, followed by Oxford Health and GP practices. A smaller response came from Oxford University Hospitals. However a cross tabulation between this question and question 3 shows that 30 county council staff went on to answer the questionnaire (25 fewer) and the balance between organisations was much closer ranging from 21 up to 37 responses.

Respondents were asked to give us more information about where they were from and this indicated we had responses from across the county plus one or two from Bucks. We had a notable number of responses from the Witney area – particularly from staff at the community hospital in Witney but also from GP surgeries there.
2. Thinking about your role at work. How often do you work on issues to do with the needs of those over 65?

For the majority of the respondents this was the main part of their work. For over 80% it was what they did as a main part of their job or on a daily basis. So respondents were well equipped to comment on this topic by their experience.

3. What do you think the impact of your role is in delayed transfers of care?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>My role makes no difference at all</td>
<td>16% (24)</td>
</tr>
<tr>
<td>My role makes some difference</td>
<td>47% (61)</td>
</tr>
<tr>
<td>I am not sure</td>
<td>7% (9)</td>
</tr>
<tr>
<td>My role could make more difference than it does at the moment</td>
<td>20% (36)</td>
</tr>
</tbody>
</table>

47% felt their role impacted on transfers of care. However an almost equal number felt they made no impact or could make more difference (46%).

84 respondents answered the free text question. The most mentioned was communication which covered a range of issues – in particular communication within the system and between parts of the system, but also with patients and families. There were also significant mentions of resources (meaning a range of different things well expressed by the quote below), care management and pre-discharge planning.
‘There are plenty of dedicated and hardworking staff in the social and health care field, trying to work together. The problem is that resources or rather the lack of them are the main difficulty in trying to successfully and safely discharge people from hospital in a timely way. There just isn’t enough domiciliary care or funding available, pocket areas where care is extremely hard to get and where people can literally wait months for care. By the time we look at SDS, people have already been waiting several weeks. Supported Hospital is a good idea, but does not cover a wide enough area and like AES will soon if not already be clogged up with people that they can’t discharge and move on. Until this is resolved, there will never be a huge difference in delays. The most distressing of all; terminal pts whom are too ‘well’ for palliative services and wait weeks for care and by the time it is available, are in no position to go, or ironically then eligible for palliative services. To have to look patients and relatives in the eyes and try and be positive about getting them home, yet explain the delay is the most soul destroying and distressing part of my job.’

‘Developing better communication with the acute sector. sharing detailed knowledge of the patient’s home and family context with the acute sector and community colleagues to enable appropriate discharge arrangements.”

‘Many people want to go home from hospital, not into Residential or Nursing Care, but finding a Home Support Agency to provide services can be difficult as capacity is limited. I have been leading on the Support with Confidence Personal Assistant scheme for two years and know that many of the Approved P.A.s’s could supply a service to these Clients’

4. Could you do things differently to positively impact on reducing delays?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>41% (51)</td>
</tr>
<tr>
<td>No</td>
<td>31% (39)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>28% (35)</td>
</tr>
</tbody>
</table>

41% felt that they could do things differently to make a difference to DTOC in a positive way. This compared with 31% who felt they could not do anything differently. A cross tabulation between the organisation and the response to this question shows that those who feel they could make a difference are fairly balanced across the organisations though those in GP practices were more likely to say they could not make a difference.

57 respondents answered the free text question. Eleven mentioned resource in some respect. This was not about financial resources but people resources particularly mentioning the importance of having a care manager on the wards. Liaison between primary care and the hospital and within the hospital was also mentioned ten times. There were also eight responses mentioning
aspects of discharge including timing, early planning and the need for specialists dedicated to the patients needs.

‘A care management or coordinator allocation for each admission to look at discharge. This person would engage with patient, family, GP and Social Services to facilitate speedy discharge.’

‘Efficiency can be improved if social workers can work across the board i.e. between hospital and community. Failing that may be there should be better liaison between hospital and community social workers.’

5. Do you feel you have sufficient authority to make a real difference to delayed transfers of care?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>22% (28)</td>
</tr>
<tr>
<td>No</td>
<td>66% (84)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>12% (15)</td>
</tr>
</tbody>
</table>

The table below shows a cross tabulation between question 4 (the column down) and question 5 (the row across). This appears to indicate that those who feel they could make a difference are more likely to be those who feel they have the authority to make a difference. However 29 people who felt they had authority to make a difference also answered that they could not do anything differently to make a difference. This response may merit further investigation. Is this because they feel they are doing all they can or because despite their authority they can make no difference?

Cross-tabulation of "Could you do things differently to positively impact on reducing..." against "Do you feel you have sufficient authority to make a real..."

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>7</td>
<td>5</td>
<td>28</td>
</tr>
<tr>
<td>29</td>
<td>29</td>
<td>24</td>
<td>82</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>51</td>
<td>39</td>
<td>35</td>
<td>125</td>
</tr>
</tbody>
</table>

The importance of senior managers was identified by 14 respondents in the free text section. This included senior managers in health, social care delivery and commissioners.

Ten respondents mentioned social services as having the control.
‘It appears to be in the hands of the social services and the care providers’

In the context of these comments it is notable that social care staff were least likely to say they had sufficient authority as shown in the cross-tabulation below.

Cross-tabulation of "Please tell us who you work for :" against "Do you feel you have sufficient authority to make a real..."

<table>
<thead>
<tr>
<th></th>
<th>OUH</th>
<th>OHFT</th>
<th>OCC</th>
<th>A GP practice as a member of administrative staff</th>
<th>A GP practice as part of the medical team (including GPs and nursing staff)</th>
<th>NHS Oxfordshire</th>
<th>Another provider of NHS or social care services</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9 (7.1%)</td>
<td>4 (3.1%)</td>
<td>4 (3.1%)</td>
<td>0 (0.0%)</td>
<td>10 (7.9%)</td>
<td>0 (0.0%)</td>
<td>1 (0.8%)</td>
<td>28 (22.0%)</td>
</tr>
<tr>
<td>No</td>
<td>11 (8.7%)</td>
<td>28 (22.0%)</td>
<td>23 (18.1%)</td>
<td>3 (2.4%)</td>
<td>14 (11.0%)</td>
<td>2 (1.6%)</td>
<td>3 (2.4%)</td>
<td>84 (66.1%)</td>
</tr>
<tr>
<td>Don't know</td>
<td>2 (1.6%)</td>
<td>4 (3.1%)</td>
<td>4 (3.1%)</td>
<td>1 (0.8%)</td>
<td>3 (2.4%)</td>
<td>0 (0.0%)</td>
<td>1 (0.8%)</td>
<td>15 (11.8%)</td>
</tr>
<tr>
<td>No answer</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>22 (17.3%)</td>
<td>36 (28.3%)</td>
<td>31 (24.4%)</td>
<td>4 (3.1%)</td>
<td>27 (21.3%)</td>
<td>2 (1.6%)</td>
<td>5 (3.9%)</td>
<td>127 (100.0%)</td>
</tr>
</tbody>
</table>

Thinking about the services which are available as alternative to hospital admission or in supporting people return at home:

6. Do you know what services there are?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>81% (103)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>5% (6)</td>
<td></td>
</tr>
<tr>
<td>I am not sure</td>
<td>14% (18)</td>
<td></td>
</tr>
</tbody>
</table>

The majority felt they knew what services there were, though almost 20% either did not know or were not sure.
In the free text there was a strong demand for information – sometime this was expressed as not knowing where to find it or that it was complex and constantly changing. A single point of access regularly updated is suggested.

‘At present we receive this information via email, then we get lots of changes or trials, these then disappear What would be helpful is a booklet which covers NHS/social and community which is updated yearly, can be sent out to all staff in all areas, who can see what could be more appropriate for that person. It difficult remember all of the services which are on offer. We forget what is out there which then causes that service not to continue etc. then when we do wish to access it’

7. Do you know how you can access them on behalf of those you care for?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73% (92)</td>
</tr>
<tr>
<td>No</td>
<td>8% (10)</td>
</tr>
<tr>
<td>I am not sure</td>
<td>19% (24)</td>
</tr>
</tbody>
</table>

When question 6 and 7 are cross tabulated this show that 70% answered yes to both questions. So 30% either don’t know or are unsure what services there are or how to access them. This suggests and information gap that needs to be filled.
Thinking about your role when people are waiting:
8. Please indicate which of these statements reflect how you work now.

- The majority indicate that they keep people informed, 69% indicating they do try to keep people informed.

The following questions all followed on from this and were free text responses. It is notable that respondents found it far easier to explain barriers (110 responses) than to offer solutions (88 responses).

What circumstances make it easier for people to move on to the next stages of their care?
Care availability (25 responses) and discharge planning (20 responses) were both significantly mentioned in these responses. Less important but still with significant mentions were family support and funding.

‘Availability of funding for domiciliary care or care home placement; availability of quality domiciliary care or placement’

**What are the main barriers in helping people to leave hospital beds?**

More than half of the respondents (57) mentioned issues to do with care provision – most significantly lack of community carers. This also included delays, lack of spaces and lack of beds (in care homes, the community and for step down). Funding and discharge planning were also significantly mentioned.

‘Not enough care agencies in particular areas. When one has been found it can often take up to 2 weeks for them to pick up the care. Needs to be improved.’

‘Slow availability of social care. People waiting for inappropriate community hospital placement when they should be going home’

**What changes could make a difference to this?**

The most mentioned were finance and care provision. This included suggestions about rebalancing the system, less fragmented care services and improving availability of care in the community. Suggestions for change were threaded throughout the responses and they have been included in an appendix at the end of the document (Appendix 4)

‘increase manpower in the community to provide the care’

‘Reduction in acute and community hospital provision and move of resources to support care at home.’

**Thinking about the patients and their families:**

9. How much influence do they have on what happens when some leaves a hospital/ community bed?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>31% (38)</td>
</tr>
<tr>
<td>Some</td>
<td>40% (49)</td>
</tr>
<tr>
<td>Little</td>
<td>23% (28)</td>
</tr>
<tr>
<td>None</td>
<td>9% (10)</td>
</tr>
</tbody>
</table>

34 respondents (28%) thought families had little or no say in what happened to patients when they leave hospital. The majority were indicating that they did have influence. However there is an indication below that some of this influence is negatively perceived rather than positively perceived.
10. In your view what sort of influence do patients and their families have? Please mark all those statements you think are true.

- They often cause delays because they do not make decisions quickly
- They do not really get a chance to make much difference
- Sometimes delays are caused by patient or their families
- Sometimes delays are caused because patients and their families have not been asked for their views
- Patients and families usually work with staff to try to prevent delays

52% of the responses indicated that families were seen as a negative force because they did not make decisions quickly enough or they directly caused delays.

11. If you have told us that families delay because they do not make decisions quickly enough please tell us more about this. Could you indicate any of the points below which you think are true?

<table>
<thead>
<tr>
<th>Option</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>They are not happy about the funding on offer</td>
<td>18% (3)</td>
</tr>
<tr>
<td>They are not happy with the quality of what is on offer</td>
<td>12% (2)</td>
</tr>
<tr>
<td>They are worried about the risk to their relative if they are moved on.</td>
<td>6% (1)</td>
</tr>
<tr>
<td>They see hospital as a safe place to be</td>
<td>35% (6)</td>
</tr>
<tr>
<td>They need to pay themselves for the care which will be needed and are slow to sort this out</td>
<td>24% (4)</td>
</tr>
<tr>
<td>Other</td>
<td>6% (1)</td>
</tr>
</tbody>
</table>

There were only a small number of responses to this question so it is difficult to draw conclusions from the responses.

12. Please tell us anything else you think may be helpful.
Most of these responses have been picked up elsewhere in the commentary. Once more families were significantly mentioned. Otherwise topics were quite scattered.
3.3.3 **In depth interviews**
Overall respondents have painted a picture of transfers of care as a complex and fragmented system. The key issues seem to be leadership, coordination and communication rather than whether staff are prepared to take a risk.

**Detailed Findings**
- The barriers between health and social care professionals have increased.
- The section 2 process in hospital is not working.
- Preventing admission should be more of a priority and needs to be better supported.
- Uncoordinated or lack of communication with next of kin is delaying transfer of care. Families often need a lot of support through the discharge process.
- There are delays and bottlenecks in the transfer of care system some of which are harder to resolve than others.
- Respondents generally feel able and supported to take risks.

**Improving the Transfer of Care process**
- Better teamwork (“team spirit is key”)
- More support specifically for older people
- More support in the home
- Increase access to community hospitals
- Change the role of/ownership of social care in hospital
- Develop better information
- Plan better

**Recurring themes**
Throughout the responses there were some strong recurring themes. In particular the need for a single point of contact for the patient - someone who would see through their care planning. This might be a nurse or a social worker or someone in the community (where admission avoidance is important). It is also important to recognise the significance of communication with families between services across organisations throughout the system.

A strong message which was spread across the responses was the importance of starting the process of discharge early – preferably on admission and the literature referred to above emphasises the importance of this. Several respondents mentioned that they felt the human being at the centre was being lost in all the administration and that indeed the administration was top heavy and time consuming.

4 **OTHER RELEVANT INFORMATION**

There were many thoughtful and lengthy responses to this questionnaire and it has been very difficult to capture them all effectively.

**Public engagement questionnaire**
The most significant point raised was the importance of person centred care – taking into account the needs of family and informal carers as well as the patient.
The importance of working together and shared budgets was also mentioned

**Patient Experience – Questionnaire and individual interviews**
In the questionnaire on the whole patients and carers expressed satisfaction with how their care and discharge had been managed. They felt involved in decision making and expressed positive responses. However, where the experiences were negative, there were expressions of extreme dissatisfaction.

By contrast the group of eight patient and carers interviewed individually who were all subject to delays expressed much more negative experiences. They rated their experiences of choice, information and hospital care very low. In fact three of the eight had lodged complaints about aspects of their care.

**Staff Experience – Questionnaire and Individual interviews**
Although staff felt they knew about services and kept patients informed there was evidence that most felt they did not have the authority to make a difference. Examination of the responses to the free text questions starts to show a very different experience. Though people felt they knew what was going on there were suggestions that information should be kept centrally and up to date, that constant changes to services were confusing and not productive.
5 SUGGESTIONS MADE BY RESPONDENTS

These are shown at Appendix 4

6 KEY LEARNING

Making a difference
There is a large resource of staff who would like to see change and feel that they could make a difference to DTOC. It is important to capture this enthusiasm and take it into the changes that are made.

Families and delays
The underlying reasons for families causing delays could be investigated. Is it linked to the lack of information early in the process? Does the information about hospital discharge encourage families to feel they are participants in the decisions making or incidental to it?

Families themselves mention not having the right information or not being communicated with. Without a clear idea of pathways they might follow it is challenging to families to make these kinds of life changing decisions quickly and easily. It is notable that there is a marked difference in the tone of the information given to families and patients at OUH and that given to patients in the Royal Berkshire Hospital or to go farther afield in the Derby hospital (see links in the references below).

Barriers between organisations
It is particularly concerning to note that it is felt that barriers have increased rather than decreased recently. There is clearly much that both sides of the coin agree about: the importance of a single point of contact, the absolute necessity to remember that at the centre of this process is a person, the need for effective communication in all its forms. It will be important to recognise that these barriers should be brought down – that they are recognised by everyone so it is likely that the will is there to bring them down.

Disempowered staff and GPs
Although GPs did not specifically say they were disempowered there was a strong sense of disempowerment in some of their responses. Specific mention was made by GPs that they often knew a lot about the patient but were not involved in the discharge planning and one GP mentioned the impossibility of getting through to social services quickly and simply – often experiencing being redirected several times. More notable was the fact the throughout the responses social services staff were seen as the key people to have the power to make decisions but they did not actually perceive that themselves (ref Q5 analysis).

Right information, right time, right place
Families patients staff all mentioned the need for accessible up to date information, plainly expressed and provided at the right point in the care pathway.

**Shortage of community carers**  
There were many suggestions for why this was occurring. Low pay not attracting sufficient carers, the current contractual arrangements not being flexible enough so that agencies could not pick up care needs quickly, care packages being dismantled soon after admission so that a new package has to be put into place which takes time and lack of consultation with community staff who already know the patients needs well.

**Communication**  
This relates to communications up and down, between organisations and most significantly with patients and carers. Comments suggest it is not really working. There were many mentions of funding and resources but these sit alongside a range of very carefully considered well-structured suggestions which will be drawn out separately.

**Care availability and provision**  
This was seen as a key issue in breaking the cycle of DTOC.

**Cross-cutting themes**  
Communication cuts across all the work and seems to be where the most change is needed. This includes small changes like enabling GPs to ring just one number to refer a patient for ongoing support to creating a much more effective information source so that all the information anyone in the process needs is in one place and up to date and to provide information more effectively to families.

7 REFERENCES
Oxford University Hospitals patient discharge leaflet  

Royal Berkshire Hospital Foundation Trust patient discharge leaflet  

Derby Hospitals patient discharge leaflet  

8 THANKS  
We would like to thank all the members of the public, patients and staff who took time to respond so thoughtfully to the questions. We hope we have captured their views in this document.
APPENDIX 1 – PUBLIC ENGAGEMENT QUESTIONNAIRE

Appropriate Care for Everyone (ACE) – Patient Experience Questionnaire

What is this about?
Health and Social care services are working together to deliver services in a joined up way. This will mean that every adult in Oxfordshire will be receiving care that is timely, in the right place and suitable for their needs.

At the moment some people get ‘stuck’ in the system and may find themselves in hospital for much longer than they need to be. This is a problem we are trying to solve in Oxfordshire by closer working between organisations.

We want to understand more about what happens to people when they leave hospital. So this questionnaire is particularly aimed at people who have had a recent experience of a hospital stay and are in age the group that we are targeting or their families and carers.

Who is involved in this?
Oxford Health Foundation Trust, Oxford University Hospitals NHS Trust, NHS Oxfordshire and Oxfordshire County Council are committed to working closely together to deliver the right care, in the right place, first time.

If you have a recent experience of hospital care and you are 65 or over or care for someone who is 65 or over we would be grateful if you could take few minutes to complete the following questions.

You can find out more about this work in our factsheets:
‘Appropriate care for everyone’
‘Appropriate care for everyone – A sample of the services currently available’.

We are also running a consultation about this so if you do not fit into the groups we are interested in hearing from you may still wish to take part. You can follow the link or request a questionnaire. Full details are at the end of this questionnaire.
About you or the person you care for
Please start by telling us a few things about yourself or the person you care for.

How old are you or the person you care for?
☐ Over 64
☐ Under 65

If you have answered under 65 we would like to thank you for your interest but will not be collecting your experience. You may be interested in taking part in our consultation survey and you can find out more about this at the end of our questionnaire.

Have you or someone you care had experience of being in hospital during the past year?
☐ Yes
☐ No

If you have answered no we would like to thank you for your interest but will not be collecting your experience. You may be interested in taking part in our consultation survey and you can find out more about this at the end of our questionnaire.

Please tell us whether you are answering as a carer/family member for someone who has been in hospital or as a patient.
☐ I am a patient
☐ I have been a patient within the past year
☐ I am a carer
☐ I am a family member
☐ Other (please state)

About your experiences of the arrangements for leaving acute hospital care for you or the person you care (this means hospitals as the Oxford Radcliffe or the Royal Berkshire).
Please tell us about your experiences when you were waiting to leave hospital. This asks about how arrangements were made and how effective this was.

The decisions about next steps:
Thinking about when you or the person you care for were in hospital please indicate the statements below which are true for you.
☐ I always knew who to ask about what would happen after I (or the person I care for) left hospital.
☐ I tried to find out who was responsible for supporting me (or the person I care for) to leave hospital but it took a long time to find out who that would be.
☐ Although it took a while to find out who was responsible for the next steps once I knew everything went smoothly.
☐ I do not know who was responsible for the next steps but I did try to find out
☐ I did not think that was important to me as long as everything was organised.
☐ Other (please tell us about this)

The staff dealing with next steps:
Thinking about how effective the staff were who dealt with you in relation to leaving hospital, please tell us which statement comes closest to your point of view.
☐ The staff I dealt with seemed to have very little power to make decisions
☐ The staff I dealt with seemed to know what to do and be well organised
☐ The staff I dealt with sometimes knew what to do and sometimes didn’t and this depended on the individual
☐ The staff I dealt with seemed to know what they wanted to do but seemed to be blocked by problems with the organisation
☐ I do not know if anyone had this role
☐ It was not important to me who was taking the decisions as long as I got the care I needed
☐ Other (please tell us about this)

How decisions were made:
Thinking about the way decisions were made about your care please indicate what comes closest to your experience.
☐ I felt involved in the decisions that were made about the next steps for me
☐ I wasn’t involved at all in any decisions about what happened next
☐ I found the options confusing
☐ I didn’t feel I was able to understand the options for the next steps
☐ I tried to make sure I had my say but wasn’t allowed to
☐ Other (please tell us about this)
After leaving hospital:
Thinking about what happened after you left hospital please indicate what comes closest to your experience
☐ I felt I had been moved to the right place for me
☐ I felt that I would have been better if I had had another option
☐ I didn’t feel ready to leave hospital
☐ I think I would have done better if I had moved out sooner
☐ I don’t know

The length of your hospital stay:
Thinking about how long it was before you moved out of hospital after you started to feel better please indicate which of these options comes closest to your experience.
☐ I felt I stayed in hospital a lot longer than I needed to
☐ I felt I stayed in hospital a little longer than I needed to
☐ I felt I left hospital at just the right time
☐ I don’t really know what would have been best
☐ I am not sure
☐ Other (please tell us about this)

What happened next?
Thinking about the move from the hospital please tell us where you went next.
☐ To a community hospital
☐ Back home with a care package
☐ Back home with reablement support
☐ Back home with reablement support and a care package
☐ Into a care home or a nursing home
☐ Other (please tell us about this)
The following questions are for anyone who moved from an acute hospital to a community hospital. We would be grateful if you would answer them again as they will tell us about whether there are any differences between the experiences. If you (or the person you care for) left to go somewhere else please go the question (to be inserted)

About your experiences of a community hospital or the Horton hospital
On-line respondents will be directed to this if they respond that they went to a community hospital
Repeat above

Final question

Thinking about how you are now which of these statements comes closest to how you view your experience of being in an acute hospital?
☐ I think I left hospital at the right time for me
☐ I think I really needed longer in hospital
☐ I think I would have got much better quicker if I had left hospital sooner
☐ I don’t know
☐ Other (please tell us about this)

Comments

If you would like to tell us anything about your experience of leaving hospital which we have not asked about please put that information here.
How to get involved
Take a look at the Talking Health pages on our website http://bit.ly/ACEOXON. You will be asked to register before you can get all the information.

Complete our questionnaire either on our webpage or available as a hard copy by contacting us as shown below.

How to find out more
Email: talking.health@oxfordshirepct.nhs.uk
Phone 01865 334636

You can also write to us with your views at:

Communications & Engagement,
FREEPOST RRRKBZBTASXU
NHS Oxfordshire, Jubilee House, 5510 John Smith Drive
Oxford Business Park South, OXFORD OX4 2LH
APPENDIX 2 – STAFF EXPERIENCE: IN-DEPTH INTERVIEWS

Face to face interviews with staff on Delayed Transfers of Care and attitudes to risk - FINAL REPORT

Prepared by: Margaret Melling (MM Consulting Limited)
On behalf of: Jon Ray (Oxfordshire Clinical Commissioning Group)
Date of this report: 30th April 2012

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Margaret Melling
MM Consulting Limited
07958 239857
margaret@mmconsulting.org.uk
Introduction

This report gives the findings from face to face interviews carried out as part of the public, patient and staff consultation on Appropriate Care for Everyone.

Staff from Oxford University Hospitals Trust, Oxford Health Foundation Trust, Oxfordshire County Council plus all GPs were invited by email to complete a questionnaire on Delayed Transfers of Care OR to participate in a face-to-face interview with an independent researcher.

130 staff chose to complete the questionnaire and 12 participated in an interview.

Interviews lasted at least an hour and gave an opportunity for in-depth reflection on the causes of delays, attitudes to risk and where improvements might be made in the transfer of care process.

The author wishes to thank all of the respondents who gave their time to meet and discuss these issues in such an open and professional way.

Experience of carrying out this research indicates that, whilst transfer of care is a hugely complex and pressured process, multi-disciplinary staff at all levels have lots of suggestions for improvements and there is much good work to be celebrated.

Methodology

Interviews were organised by the Oxfordshire Clinical Commissioning Group and carried out by Margaret Melling, an independent researcher.

It was emphasised at the start and end of each face to face meeting that responses would be anonymous.

The 12 respondents included:

- 6 staff based at an acute hospital (1 social worker, 1 physio and 4 nurses at differing levels of management)
- 3 community social workers (2 working in community hospitals)
- 2 managers in Social and Community Services, Oxfordshire County Council
- 1 GP

Although the sample is small, participants gave detailed and thoughtful responses to the questions including, in many cases, descriptions of the experiences of patients (some of which illustrate the findings in this report).
SUMMARY

1. This research set out to explore attitudes to risk and the impact of this on delayed transfer of care and found that respondents generally feel supported and confident to take risks.

   - All of those expressing an opinion (10 out of 12) agreed that “my organisation is one that supports risk in certain situations” and the same number agreed with the statement “I feel confident to take risks”.

2. There were very different views on whether patients were being affected by attitudes to risk and these differing views were broadly related to the respondent’s base (hospital vs community).

   - 5 out of 12 agreed (or strongly agreed) and 5 out of 12 disagreed that “there has been a detrimental effect on patients because no-one was prepared to take a risk and transfer their care”.

   - Hospital-based staff tended to agree and community-based staff tended to disagree.

3. Overall the picture that emerged was of a complex and fragmented transfer of care system where the key issues are:

   - a lack of teamwork,
   - difficulties with communication and
   - a lack of community resources.

4. Patients that are being particularly affected are those that are cognitively impaired and those waiting for a long term placement.

5. The themes from discussions with staff on the transfer of care process were:

   TEAMWORK

   - All respondents gave examples of a lack of teamwork and (sometimes) a culture of blame between health and social care professionals. This appears to have been made worse by the conflict over delayed transfer of care which communicates down from senior management to staff.

   - Social workers are feeling very pressured and under-valued. Some nursing staff mentioned feeling criticised.

   - The Multi-Disciplinary Team approach works, but is not used consistently.

   - There were strong but divided opinions on whether social workers should be ward-based or even hospital-based.
PROCESSES AND PAPERWORK

- The section 2 process in hospital is not working and the same information is gathered in multiple assessment processes and forms.
- Organising transport from hospital and lack of cover from services can cause delays.

COMMUNICATING WITH PATIENTS AND FAMILIES

- Respondents reported uncoordinated or a lack of communication with patients and relatives.
- There were several examples given of hospital doctors setting expectations of patients and families too early in the discharge process, making it difficult to communicate with the family if the patient then does not meet the criteria.
- Families often need a lot of support through the discharge process and family expectations can be “unrealistic”.

PREVENTING ADMISSIONS

- Preventing admission should be more of a priority and needs to be better supported.
- There is a need for more social care resources in the community and for better information and support to GPs.

AVAILABILITY OF COMMUNITY RESOURCES

- Delays are being caused by a lack of community resources, enablement and care services.
- Patients are being discharged to “inappropriate” places.
- The policy of moving patients to Community Hospitals to be assessed for placement is causing delays.

IMPACT ON PATIENTS

- A focus on delayed transfer of care may be encouraging unhelpful attitudes about patients such as the derogatory term “bed blocker”.
- Not all patients are affected equally. Transfer of care for older patients waiting for placement and those with cognitive difficulties appears to be most in need of improvement.
- Moving patients on too quickly can cause readmissions.
Suggestions made by respondents for improving the transfer of care process (see section 6):

- Better teamwork ("team spirit is key");
- More support specifically for older people;
- Ban the term "bed blocking";
- Increase access to community hospitals;
- Change the role of/ownership of social care in hospital;
- Develop better information for patients and for GPs;
- Plan better;
- Focus on reablement in hospital and at home;
- Focus DTOC improvements on those most in need.

Suggested next steps (in addition to those made by staff) are included in a separate short report.
Issues with the Transfer of Care process

This section highlights the key themes to emerge from the discussions about the transfer of care process illustrated with quotes from the respondents.

The themes have been grouped under the headings:

- Teamwork
- Processes and paperwork
- Communicating with patients and families
- Preventing admissions
- Availability of care
- Impact on patients

TEAMWORK

All respondents gave examples of a lack of teamwork between health and social care professionals. This appears to have been made worse by the conflict over delayed transfer of care which communicates down from senior management to staff.

- “There are a lot of fragmented relationships.”
- “The job has become more stressful since the introduction of these arbitrary targets for discharge”.
- “There are not enough people sorting things out holistically.”
- “Very uncomfortable pressure on social workers by health.”
- “Community social worker or case manager passes off responsibility to the hospital ‘you can deal with it now’. Not had a single good experience with a case manager in the community.”

Social workers are feeling very pressured and under-valued. Some nursing staff mentioned feeling criticised.

- “If anything goes wrong then who gets the blame? The social worker.”
- “Each level in the health service moans about the one below. Social workers are the end of the line.”
- “We are constantly being criticised.” [nurse]
- “I do feel that nurses are being pushed to the limit.”

The Multi-Disciplinary Team approach works, but is not used consistently.

- “MDT works well and is a useful way of coordinating.”
• “Some Doctors very pro-MDT. Some Doctors not very good at MDT. Doctor has ultimate decision and can discharge without social worker agreement.”

There were strong but divided opinions on whether social workers should be ward-based or even hospital-based.

• “Social workers should not be in a separate office in hospital, should be out on the ward.”
• “Potentially the hospital social worker team should be employed by the hospital and be on the wards.”
• “Don’t think there should be a social work team based in JR. Other hospitals have removed hospital-based social care teams.”

PROCESSES AND PAPERWORK

The section 2 process in hospital is not working and the same information is gathered in multiple assessment processes and forms.

• “We’re meant to send section 2 when we know there is a need for social care involvement but this is not working in practice.”
• “There are so few social care staff that (even with a section 2) cannot respond until the section 5.”
• “Separate paperwork for assessment and requisition of care could be amalgamated – there is a lot of duplication in the forms.”
• “Nursing admission pack includes a section on social history. Medical clerking also includes social history because doctors did not want to use the information in the nursing pack.”
• “I spend 60% of my time at my computer instead of with patients.”
• “System is so complex, something can get missed.” For example.. “A patient was about to be discharged to a house where the boiler was leaking, the bed was wet and there was nowhere to sleep.”

Organising transport from hospital and lack of cover from services can cause delays.

• “Transport is a real issue – there is a patient delayed today because there was no transport.”
• “A massive challenge is 24/7 cover. Social work office shuts at 4pm Friday.”
• “If a patient comes in Thursday then have to wait until Mon/Tues for OT/Physio to make an assessment.”
• “No social worker cover over the bank holiday and no duty social worker available.”

COMMUNICATING WITH PATIENTS AND FAMILIES

Respondents reported uncoordinated or lack of communication with patients and relatives.

• “Multiple different conversations between patient and different professionals and between professionals and different members of the family.”
• “Patients don’t always tell Doctors what is on their minds. Doctor may come round with students on a quick ward round.”

There were several examples given of hospital doctors setting expectations of patients and families too early in the discharge process, making it difficult to communicate with the family if the patient then does not meet the criteria.

• “Doctors sometimes act as if nursing home is a medicine “this person needs a nursing home”.”
• “Theory is that acute hospital is not the right place to make a decision about a care home BUT the doctor has made a decision and communicated this with the family.”

Families often need a lot of support through the discharge process and family expectations can be “unrealistic”.

• “Massive issue of relatives saying that patients can’t cope at home and they expect that hospital should assess for placement.” [Hospital nurse]
• “Families are often anxious and risk averse.”
• “Care in the home is intrusive and completely upsets people’s routines.” [Social worker]
• “If you are a family member and don’t live nearby then it can be hard to have your relative go home if you are not confident they will cope. BUT it is not appropriate to be occupying a hospital bed.”
• “One patient had a family who kept introducing delays until the patient died in hospital ..which was what the family wanted.”

PREVENTING ADMISSIONS

Preventing admission should be more of a priority and needs to be better supported.

• “The management of admissions is poor.”
“Should be avoiding admittance to hospital in the first place.”

Inappropriate admissions are “massively impacting the quality of care and the stress on the hospital. We know that a lot of patients would be better looked after elsewhere”.

There is a need for more social care resources in the community and for better information and support to GPs.

“So many people come into hospital having waited in the community for 3-4 months for assessment of care.”

“Social workers [in the community] know that patients are struggling and need more care or a placement but have no time to sort it out. Then patient hits hospital and the family are on their knees, the home is in a state.”

“The social services number is frequently unobtainable and in a crisis is not much use. GPs cannot call the access team directly.”

“It is very difficult for GPs to understand where to go for community care and support” [GP showing examples of multiple information leaflets]

“Patient on full care package not coping at home. Care agency did not inform anyone. Admitted to hospital and now waiting for placement. Should not have been admitted.”

AVAILABILITY OF COMMUNITY RESOURCES

Delays are being caused by a lack of community resources, enablement and care services.

“Biggest issue is lack of resources – however quickly the assessment is done you still have to wait for agencies.”

“Big issue about availability of care, e.g. Faringdon.”

“AES does not have the capacity.”

“Massive wait for funding for placements and care. There is a postcode lottery – especially for larger packages.”

“Resource allocation is where process gets held up – waiting for funding, we can't fund everyone.”

“Need domiciliary physio – providing exercise at home.”

“If there were more care workers then people would leave hospital sooner.”
• “Feels like there is not enough resource in the community – waiting for community beds, waiting for care.”

• “Lady in 90s living alone. Nearest relative in Norfolk. Had a fall, found by informal carer after half a day. Agreed couldn’t go home without 2 X care visits and help with medication. But she is an independent lady and not keen on care. Sent home with no extra care. Had another fall and was readmitted. She needed more rehabilitation.”

Patients are being discharged to “inappropriate” places.

• “Several clients being discharged to Knowl Abingdon, against policy.”

• “See around 1 patient a month who has been discharged to a non-local community hospital. Used to have GP beds in the community hospital.”

Policy of moving patients to Community Hospitals to wait for care home placement is causing delays.

• “If patient needs to go to a care home then HAVE to first go to a community hospital. If community hospital has no beds then can wait 5-6 weeks.”

• “Always waiting for community hospital bed.”

IMPACT ON PATIENTS

A focus on delayed transfer of care may be encouraging unhelpful attitudes about patients such as the derogatory term “bed blocker”.

• “A lot of Doctors look at older people and think “here comes a bed blocker.” “

• “The term “bed blocking” should be banned.”

Not all patients are affected equally. Transfer of care for older patients waiting for placements and those with cognitive difficulties appears to be most in need of improvement.

• “Everyone pulled together for this patient – probably because she was so young.”

• “Particularly bad for older people and those with cognitive difficulties.”

• “Community hospital is there mainly for rehab so long term placements have a lower priority.”

Moving patients on too quickly can cause readmissions.

• “Getting it right takes time – if not you push the problem somewhere else.”
Risk

Respondents were given a set of questions on risk that they read and completed about half way through the interview. This section is an analysis of these tick box responses.

Respondents generally feel supported and confident to take risks.

- All of those expressing an opinion (10 out of 12) agreed that “my organisation is one that supports risk in certain situations” and the same number agreed with the statement “I feel confident to take risks”.

Some (but not all) respondents had opinions on staff who they perceived to be more or less risk averse.

- Examples were given of Consultants who were very prepared to take risks (sometimes with poor outcomes for the patient).
- In contrast respondents mentioned Social workers, Physios and Occupational Therapists who “want to wrap people up in cotton wool” and nurses who may be overly worried about people being discharged.

Some respondents wanted to clarify the wording of some of the questions.

- Question: Patients are being held back because of the perceived risk in moving them on
  Comment: “Perceived risk by whom? Agree if this is perceived risk by patient/relative”
- Question: Patient’s wishes are being overlooked or set to one side because of averseness to risk
  Comment: “Depends on the patient’s capacity”

There were very different views on whether patients were being affected by attitudes to risk and these differing views were broadly related to the respondent’s base (hospital vs community).

- 5 out of 12 agreed (or strongly agreed) and 5 out of 12 disagreed that “there has been a detrimental effect on patients because no-one was prepared to take a risk and transfer their care”.
- Hospital-based staff tended to agree and community-based staff tended to disagree but it was not clear cut and the sample is very small.

(see following table)
**Table 1** responses to all tick box questions on risk

<table>
<thead>
<tr>
<th><em>strongly agree+agree as % of total, excludes no response</em></th>
<th>Percent agree*</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients are being held back because of the perceived risk in moving them on</td>
<td>67%</td>
<td>2</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Patients wishes are being overlooked or set to one side because of averseness to risk</td>
<td>50%</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>There has been a detrimental effect on patients because no-one was prepared to take a risk and transfer their care</td>
<td>50%</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>There has been a detrimental effect on patients where they were moved on without properly taking account of risk</td>
<td>36%</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>I am supported in taking risks</td>
<td>58%</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>I feel confident to take risks</td>
<td>82%</td>
<td>1</td>
<td>8</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>My organisation is one that supports risk in certain situations</td>
<td>83%</td>
<td>0</td>
<td>10</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>If I take a risk this may impact my reputation</td>
<td>42%</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>If I take a risk I may be seen as a better employee</td>
<td>27%</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>If I take a risk I may be seen as a weaker employee</td>
<td>10%</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>I judge others on the degree to which they take risks</td>
<td>27%</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>I am advised against taking risks by my union / professional body</td>
<td>8%</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>My organisation makes decisions that are then overturned</td>
<td>70%</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

**Table 2** Variation in response to impact of risk on patients

<table>
<thead>
<tr>
<th>Respondent based in or mainly based in..</th>
<th>There has been a detrimental effect on patients because no-one was prepared to take a risk and transfer their care</th>
<th>There has been a detrimental effect on patients where they were moved on without properly taking account of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 County Council</td>
<td>Strongly agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>8 Hospital</td>
<td>Strongly agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>10 Hospital</td>
<td>Strongly agree</td>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>7 Hospital</td>
<td>Agree</td>
<td>Disagree</td>
</tr>
<tr>
<td>9 Hospital</td>
<td>Agree</td>
<td>Neither agree nor disagree</td>
</tr>
<tr>
<td>1 Community</td>
<td>Disagree</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>2 Community hospital</td>
<td>Disagree</td>
<td>no response</td>
</tr>
<tr>
<td>3 Community hospital</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>11 Hospital</td>
<td>Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>12 GP</td>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>4 Hospital</td>
<td>no response</td>
<td>Strongly agree</td>
</tr>
<tr>
<td>5 County Council</td>
<td>no response</td>
<td>Agree</td>
</tr>
</tbody>
</table>
Improving the Transfer of Care process

Some respondents felt overall that it is very hard to improve the current situation, but all came up with suggestions. Some ideas contradict and many (as you would expect) are influenced by the immediate working environment of the respondent.

Suggestions made by respondents were:

Better teamwork ("team spirit is key")
  - Arrange Multi-disciplinary Team awaydays to look at how things are done in other hospitals and develop some actions.
  - Involve providers, community, voluntary sector in the hospital’s daily tele-conference.
  - Appoint a liaison manager to improve the links between health and social care.
  - Stop practise of Doctors prescribing care.

More support specifically for older people
  - A community matron in each small locality (eg at GP practice level).
  - A Health Visitor for the elderly to coordinate care needs and prevent admission.
  - An acute geriatric admission service

Increase access to community hospitals
  - Discharge to a hospital that is local to the patient’s home.
  - Re-site the “holding ward” from the acute hospital to a community hospital.

Change the role of/ownership of social care in hospital
  - Transfer the hospital-based social care team out to the community.
  - Transfer the hospital-based social care team so that it is managed by the hospital.
  - Go back to having a ward-based social worker (‘in-reach’ is not working, paperwork should be secondary to making the right decision).
  - Change the process of re-starting care so that a social worker is involved.
Hospital to carry out 4 week review home visit (if hospital was following up care decision then might be more cautious).

Hospital teams need their own Self-Directed Support broker.

**Develop better information**

- Signpost people to the right services, involve the voluntary sector
- Provide better, joined up, information for GPs
- Develop information for patients on admission to set out their journey including the discharge process (designed with the involvement of patients).

**Plan better**

- Health analysts to predict seasonal variations in demand so that resources can be adjusted accordingly.

**Focus on reablement in hospital and at home**

- Nursing philosophy needs to be more able reablement, getting people up and about on the ward
- More home visits and more attention on how people are at home
- Improve rehabilitation
- Need a domiciliary physio – providing exercise at home

**Focus DTOC improvements on those most in need**

- Two groups need immediate attention (1) cognitively impaired and (2) waiting to be assessed for placement.
- Cognitively impaired should be assessed in own home.
- Why transfer those in need of placement (rather than rehab) to a community hospital?
APPENDIX 3 – STAFF SUGGESTIONS

Interviews with staff with reference to Delayed Transfers of Care and risk – NEXT STEPS

Prepared by: Margaret Melling (MM Consulting Limited)
On behalf of: Jon Ray (Oxfordshire Clinical Commissioning Group)
Date of this report: 30th April 2012

This short report proposes actions following face to face interviews carried out by Margaret Melling as part of the public, patient and staff consultation on Appropriate Care for Everyone.

In these interviews staff painted a picture of a complex and fragmented transfer of care system where the key issues were a lack of teamwork, difficulties with communication and a lack of community resources.

However there were many ideas for improvements and a strong concern from hospital-based and community-based staff about the impact that process issues were having on patients.

In the words of one of the respondents “teamwork is key” and everyone agreed on the importance of and the challenge of communicating effectively with patients and families.

**Suggested action 1:** that a multi-disciplinary project is convened to assess communication with patients and families and to plan how this could be improved.

**Suggested action 2:** that this multi-disciplinary project team develops patient-orientated information on the discharge process **with the close involvement of patients and carers.**

This research highlighted two categories of patient that staff believe are most affected by delays.

**Suggested action 3:** that improvements in the transfer of care process are focused on those patients that staff feel are most impacted by Delayed Transfers of care *(1) the cognitively impaired* and *(2) those waiting for long term placements*

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