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Orthopaedic early supportive discharge

In this Future Hospital Programme case study Dr Radcliffe Lisk describes an orthopaedic early supportive discharge service that achieved reduced length of stay for people who had undergone hip surgery.

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Person-centred care

Key recommendations

- Formulate and resource discharge plans for patients identified as being appropriate for early supportive discharge following surgery for hip fracture.

- Identify suitable patients by multidisciplinary team assessment.

- Deliver rehabilitation support to patients at their usual place of residence with a multi-agency team.

- The same staff should support patients on the ward and then in their home to provide consistency of care – promoting trust and improving communication.

- Undertake a daily virtual board round to discuss all patients within the community, assess progress and highlight and address any issues.

- Fast track patients to fracture clinics or a rapid access clinic for an orthogeriatrician review.

- Meet with GP colleagues to describe the pathway and agree together what is best for these patients.

The challenge

Prolonged length of stay and 44% of hip fracture patients were being sent for rehabilitation under general medicine in another hospital which is part of the trust.

Our solution

Along with my team at Ashford and St Peter's Hospitals (ASPH) NHS Foundation Trust, I set up a 6 month pilot looking at the effectiveness of an orthopaedic early supportive discharge (OSD) team using £90,000 from the Trust's innovation fund. The OSD team is made up of a physiotherapist (band 7), an occupational therapist (band 6), a nurse (band 6) and two therapy assistants (band 3).

The project has continued beyond the 6 months due to the excellent patient outcomes and credible evidence of financial benefits.

ASPH OSD describes a pathway of care for people transferred from an inpatient environment to a primary care setting to continue a period of rehabilitation, re-ablement and recuperation delivered by staff with the same level of expertise as they would have received in the inpatient setting.

Within the pathway there are three essential gateways:

- **Patient assessment** - Orthogeriatric patients are assessed by orthogeriatricians for OSD suitability. Suitable patients will have their impairments identified, goals set and appropriate discharge plans formulated and resourced.
- **Discharge** - Discharge is decided based on NICE guidelines.

- **Rehabilitation support** - A multi-agency team will deliver rehabilitation to patients at their usual place of residence.

Methods

Patients who are mentally alert, medically well and mobile postoperatively are most likely to benefit from a supported discharge scheme, and should be identified by multidisciplinary team (MDT) assessment.

The OSD team take up to eight patients at any given time. They are based on an orthogeriatrics ward to ensure that patients are reviewed promptly. Patients benefit from knowing the members of the team who will be giving their care within their home setting; this promotes trust and improves communication between the patient, relatives and the ward MDT.

The orthogeriatricians within the OSD team provide clinical leadership and undertake a daily virtual board round discussing all patients within the community, assessing progress and highlighting and addressing any issues.

Patients can be fast-tracked to fracture clinics where they can be seen by an orthopaedic consultant and also fast-tracked to the Rapid Access Clinic for an orthogeriatrician review, which is quicker than the pre-existing route whereby GPs have to see patients and then refer to the specialist.

As part of the service development process, we had various meetings in order to liaise with and engage the North West Surrey CCG, Virgin Care (community providers) and Social Services to ensure that the final design provides a workable and resourced integrated pathway.

We found that using NICE guidelines to develop a supported discharge scheme led to high patient satisfaction and lower 30-day readmission rates.

Outcomes

Patients were given an ASPH friends & family questionnaire to complete at the end of their treatment with OSD. Of the 141 patients who responded, 100% provided positive feedback.

These patients are taken on average 9.15 days post-surgery and this reduced the length of stay (LOS) for hip fracture patients from 21.5 days (March-February 2014) to 18.2 days (March-February 2015) without a change in readmission (7.89% to 7.57%, respectively).

Cost savings

The service was established at £83,517 for 6 months but the total cost for the year was £175,211 due to the extra staffing required.

There were 423 hip replacements for the period March 2014 to February 2015. With a bed day costing £275, and a 3.3 reduction in bed days (calculated as 21.5 days minus 18.2 days), the possible savings are £383,873 (423x275x3.3). With the OSD costs for 2014-15 of £175,211, this shows that the model was cost-effective for 2014-15 with savings of £208,662.

Key learning

When setting up the service, we faced concerns from GP colleagues that patients would be sent home prematurely when more unwell. Meetings with GP colleagues were important to describe the pathway (see figure 1) and GPs agreed that this was best for the patient and hence agreed to look after the patient following hospital discharge. Expectations were exceeded as GPs were only called out in 17 out of the 178 patients discharged with OSD.

Person-centred care

Following feedback from patients, families and OSD staff, education of patients and families about OSD was increased. Initially a hip fracture information booklet was given, along with the falls and bone health booklet. An additional OSD booklet was also created. An additional information sheet entitled 'Pain Relieving Advice' was also developed recently to improve the compliance with taking analgesia, which was impacting on patients' mobility.

Patient feedback

'I wish every hospital in the land could take up this scheme. St. Peter's Hospital has shown what the NHS is about: care and love for patients.'

Summary

We feel that this initiative should be replicated across all hospitals providing care for hip fracture patients as it is a cost-effective way to improve the patient experience, improve home-to-home within 30 days, and reduce LOS and readmissions. We feel that it is important to point out that our success is based on a specialist team who understands the needs of our specific patient group and is part of the discharge planning process and may not work as well if it was part of a generic community rehabilitation team.

NICE commissioning guidelines suggest that commissioners should work with providers to establish a service model for early supported discharge, led by the hip fracture programme team. We are therefore working with the CCG, who would eventually be asked to commission this service.

What's next?

Communication barriers are a constant challenge, with IT systems that are not fully joined up across the health and social care sectors. Electronic patient records help to allow multiple sites to share information about patients and this is an evolving process.

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