RU Having your say?
RU Hearing what's happening?
RU Happy to be involved?

Royal United Hospitals Bath
NHS Foundation Trust

Meet your RUH Governors

James Colquhoun ,Public Governor

Today's Meeting

Time	Subject	Presenter
14:00	**Welcome and Introductions** Your Governors and You	**James Colquhoun, Public Governor**
14:10	Update from the RUH Board of Directors	**Lisa Cheek, Acting Director of Nursing & Midwifery**
14:40	**Audience participation:** Questions and answers	**All**
15:00	Discharging Patients	**Clare O'Farrell, Deputy Chief Operating Officer & Annette White, IDP Programme Lead**
15:25	**Audience participation:** Questions and answers	**All**
15:45	Feedback	**All**
16:00	Close	

Introductions

James Colquhoun, Public Governor for South Wiltshire

Lisa Cheek, Acting Director of Nursing & Midwifery

Clare O'Farrell, Deputy Chief Operating Officer

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News from the RUH

Summer 2018

Everyone Matters
Working Together
Making a Difference

Lisa Cheek, Acting Director of Nursing and Midwifery

Summer at the RUH

Summer at the RUH

Frailty Flying Squad

Summer at the RUH

Home First

Summer at the RUH

Get up, get dressed, get moving!

Summer at the RUH

NHS 70th Birthday

http://www.ruh.nhs.uk/NHS70/index.asp

Summer at the RUH

RNHRD and Therapies

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Improving Together

RUH Strategy 2018 - 2021

Everyone Matters
Working Together
Making a Difference

Hearing from you

Workshops with:

- 140 public members and volunteers
- 300 members of staff
- 30 representatives from partner organisations

Survey responses:

- 200+ participants

Hearing from you

Workshops with:
- 140 public members and volunteers
- 300 members of staff
- 30 representatives from partner organisations

Survey responses:
- 200+ participants

Healthcare is not a constant, and no single day is perfect.

Quality targets should be shared with patients so they and their families and carers have a clear understanding about what the Trust is striving to achieve and what part they can play in realising those goals.

I know the limitations of my body best

Enough clinical staff to meet patient needs promptly, safely and with dignity

Our vision

To provide the highest quality of care;
delivered by an outstanding team who all live by our values.

Our goals

Recognised as a listening organisation; **patient** centred and compassionate.	Be an outstanding place to work where **staff** can flourish	**Quality** improvement and innovation each and every day.	Work together with our **partners** to strengthen our community	Be a **sustainable** organisation that is fit for the future

Our values

Working Together

Everyone Matters

Making a Difference

Everyone Matters
Working Together
Making a Difference

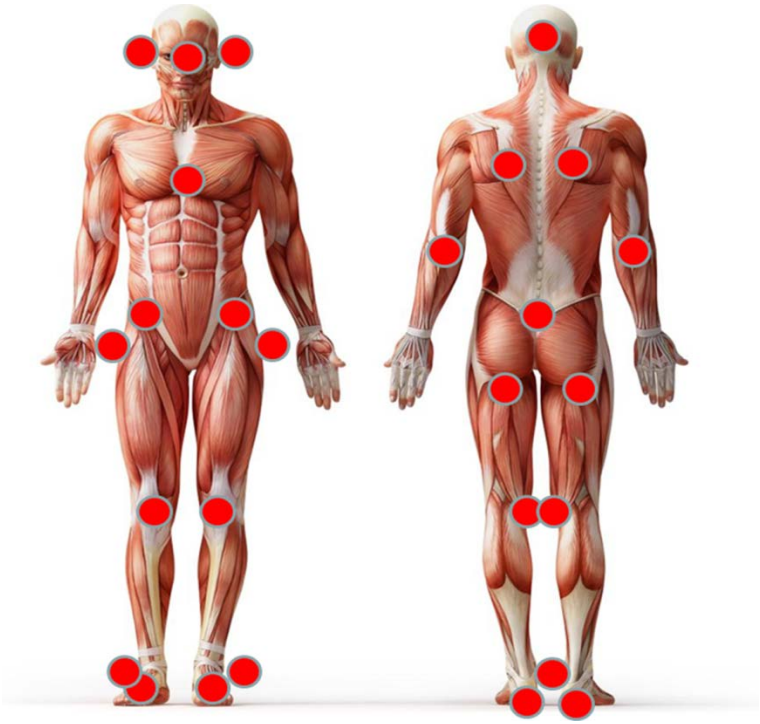
NHS
Royal United Hospitals Bath
NHS Foundation Trust

Pressure Ulcers

What are we doing?

Pressure Ulcers

Pressure Ulcers are painful sores that people get when they are vulnerable, unwell and immobile.



What are we doing at the Royal United?

- Training for all clinical staff on induction to the hospital
- Early identification and prevention in the Emergency Department
- Skin assessment at every position change to detect any skin changes
- Early provision of pressure relieving equipment such as air mattresses and foot protectors
- Nutritional supplements and access to the dietician for those not able to eat adequately
- Robust investigations and action plans when something goes wrong
- Patient stories to improve care
- Participation in the National “Stop the pressure” programme led by NHS Improvement

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Falls Improvement Programme (Adult Inpatients)

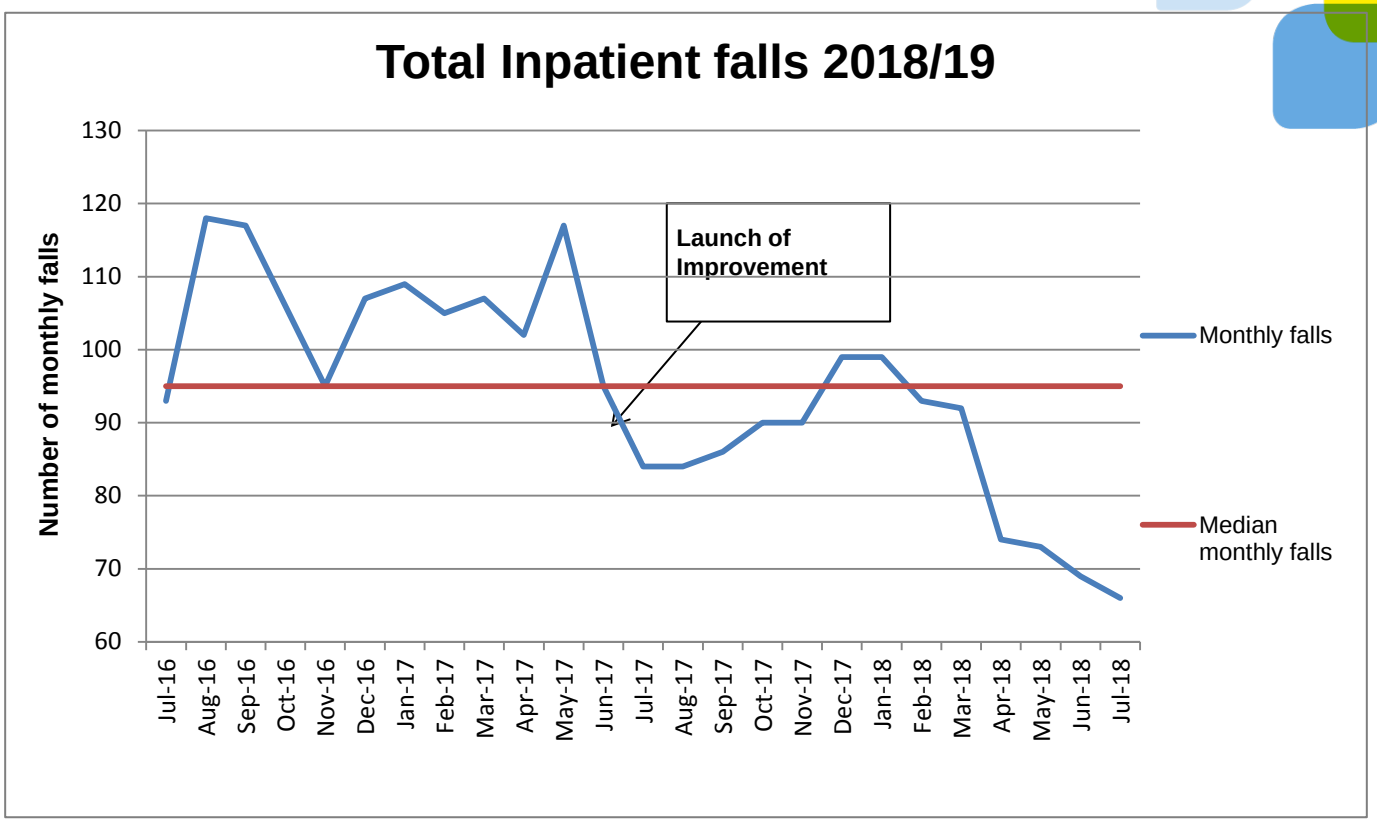
TRUST WIDE FALLS IMPROVEMENT PROGRAMME (Adult Inpatients)

Trust wide falls improvement programme launched 19th June 2017. The aim is to ensure all staff follow the Falls prevention pathway.

Successes:

- Achieved over the 10% reduction for all falls
- 46% decrease in the number of repeat falls compared to same period 2016/2017
- 40% decrease in the number of patients who fall more than once compared to same period 2016/17

OUTCOME


Total Inpatient falls 2018/19
Number of monthly falls
130
120
110
100
90
80
70
60
Launch of Improvement
Monthly falls
Median monthly falls
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18

NEXT STEPS

- Relaunch of the falls prevention pathway September 2018
- Further development of the Enhanced Observation inniative
- A successful bid to Health Education England South West Simulation Network (HEESWSN) for allocation of £25,000 to support Falls simulation training : project commenced April 2018
- Development of a falls e learning training packager

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Patient Experience

Focus of our Patient and Carer Strategy is to:

We will **listen** to patients and carers

We will **communicate** clearly

We will **involve** patients and carers in improving services

‘See it my way - living with a life limiting condition’

Over 50 staff attended the **‘See it my Way – Living with a life limiting health condition’** event on 14th May. This was a joint event in partnership with Dorothy House Hospice.

Comments regarding **increased understanding were:**

‘How people are made to feel is what stays with them, be compassionate, but be flexible and always individual’

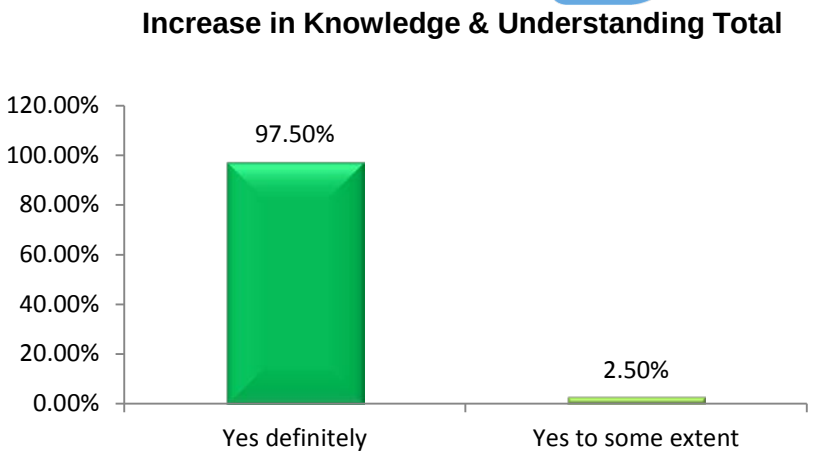
‘Small things make a difference, be open and honest’

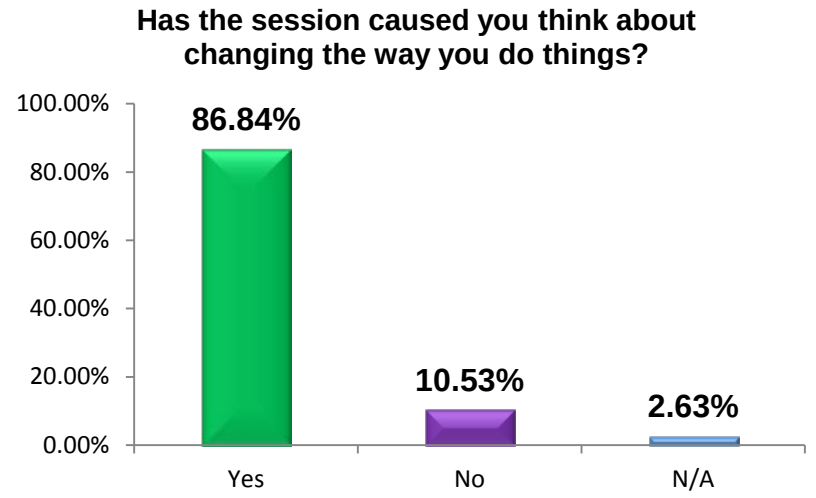
Comments regarding **‘what will you do differently’:**

‘Approach patients I have met before, even just to say hello, as I understand the benefits of seeing a familiar face’

‘Try to be as flexible as possible in providing nursing care to patients with life limiting conditions’

‘Keep in mind what the individual can do for themselves and support when asked’





SHARING PATIENT AND CARER STORIES WITH THE BOARD OF DIRECTORS AND STAFF

FFT sentiments for April to June 2018

Figures do not represent individual cards; a comment maybe broken down into more than one category and / or sentiment, this applies to all 'free-text' reports.

	Sentiment			
Category	**Positive**	**Neutral**	**Negative**	**Grand Total**
Attitudes and behaviour	3804	23	44	3871
Care and Treatment	561	4	13	578
Communication	447	61	80	588
Cleanliness	106	3	5	114
Facilities	178	103	135	416
Food	248	48	50	346
Resources	1323	69	50	1442
Timeliness	523	47	200	770
Overall Experience	880	4	5	889
Grand Total	**8070**	**362**	**582**	**9014**

Facilities and **timeliness** had the highest number of negative comments in Quarter 1 18/19; the top 3 most commented on **facility areas** are - Ward temperature, parking, noise at night. Top 3 most commented on **Timeliness areas** are: waiting to be seen in ED, waiting to be seen in clinic, waiting for an appointment.

Top theme – positive

- 'Staff attitude and behaviour'

Top themes – negative

- Telephoning the hospital – cannot get through to the department they need to speak to
- Waiting in the hospital – for discharge or waiting in clinic or for an appointment
- Facilities – access to Wifi, temperature of the ward, car parking
- Communication

Changes as a result of patient feedback

- Installed 19 **electronic information screens** in 16 outpatient areas giving information on waiting times
- **Appointment Communication questionnaire** – collected 260 responses regarding how we can best communicate with patients about their appointment/changing appointments. This will be used to influence the development of our IT systems (patient portal)
- Changes to the food menu/plate warmers/increase in the amount of food cooked in the RUH kitchen
- Improvements to bathroom and toilet facilities

Thank you

Any questions?

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Understanding Discharge

Clare O'Farrell
Deputy Chief Operating Officer

Annette White
Integrated Discharge Service Programme Lead

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Content today:

1. Starting discharge
2. Why good discharge planning is important
3. Home First
4. Integrated Discharge Service
5. Anne's story (Home First)
6. Time for Questions

The Four Questions

1. What is wrong with me?
2. When will I leave hospital?
3. What is going to happen to me today?
4. What do I need to do to leave hospital?

Assessment and Discharge Process Leaflet available for patients and families.

We work with 4 Discharge Pathways

Pathway 0	The discharge can be lead by the ward team
Pathway 1	Home First, can go home but requires support. Safe to be left between visits
Pathway 2	Rehabilitation, will require transfer to a bed
Pathway 3	Long term care at home or placement is required (Complex on-going care needs)

We now identify and record all patients expected discharge pathways

#Last1000days

- https://www.youtube.com/watch?v=HynytVepxZc

Global Aim

Our challenge is to improve everybody's understanding, in our hospitals and communities, that home is the best place to recover, regain and maintain independence.

The Home First group will evidence the balance of risk of hospital versus home, in order to ensure that all stakeholders will have a shared philosophy of what Home First represents.

Minimise hospital stay, maximise independence at home.

#homefirst

Discharge Home is always considered first

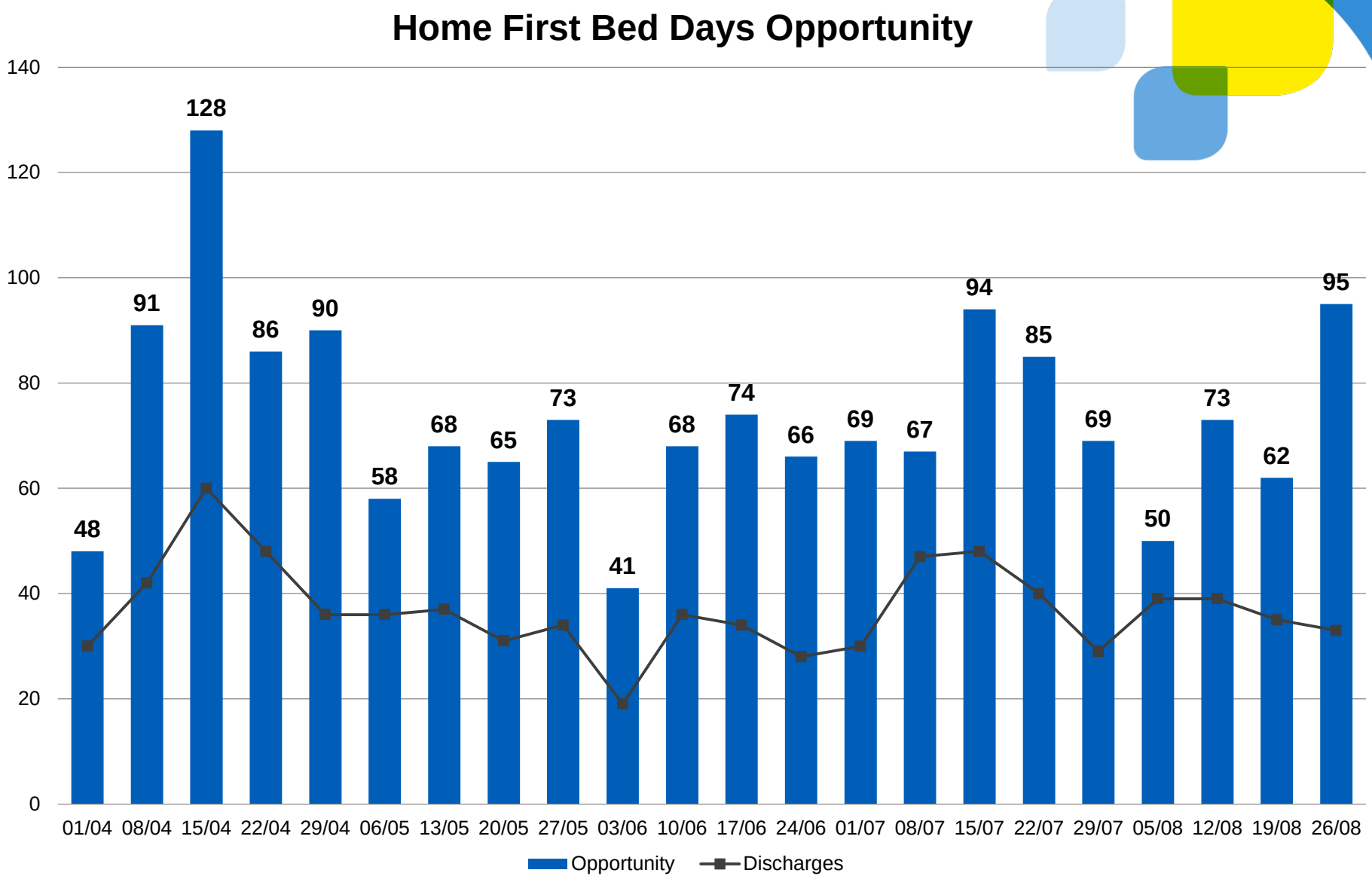
Think Home First

Assume Home First

Why Not Home First?


Collaborative Working
Department
Guide

Home First Regional Winners in The Excellence in Urgent and Emergency Care Award category of the NHS70 Parliamentary Awards.


Home First Bed Days Opportunity
140
120
100
80
60
40
20
0
48
91
128
86
90
58
68
65
73
41
68
74
66
69
67
94
85
69
50
73
62
95
01/04
08/04
15/04
22/04
29/04
06/05
13/05
20/05
27/05
03/06
10/06
17/06
24/06
01/07
08/07
15/07
22/07
29/07
05/08
12/08
19/08
26/08
Opportunity
Discharges

Integrated Discharge Service

Agreed system wide AIM - To maximise processes and communication across the RUH and the community to ensure that complex patient discharges are as efficient as possible.

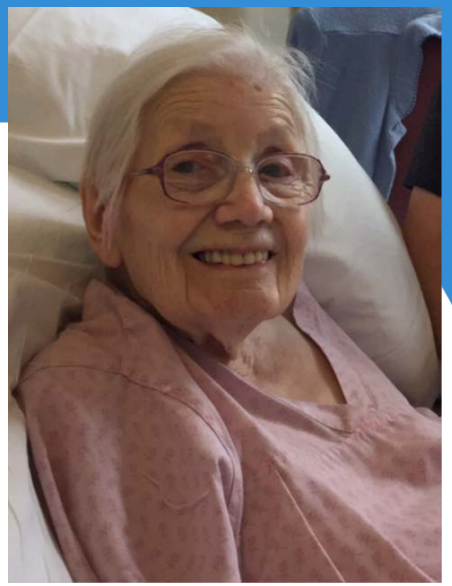
The Integrated Discharge Service (IDS) is a truly collaborative service bringing together employees from the RUH Bath, and the stakeholders from both health and social care from our partner organisations.

This model is primarily focused on providing a service to the wards of the acute hospital through expertise and advice to promote the safe and effective discharge of patients with complex needs and to act as an expert on discharge planning for the wards.

Integrated Discharge Service (IDS)

- The IDS staff represent Wiltshire, Bath and North East Somerset, Mendip, Somerset and South Gloucestershire.
- The professions involved are social workers and in reach discharge staff for Health plus the RUH Discharge Team.
- If the hospital ward multidisciplinary teams decide that, at that point in time, a patient is not able to leave the hospital with Home First, they refer to IDS. The role of IDS is to then combine the skills of professionals from both health and social care to plan the appropriate discharge pathway and support the patient, their family and the ward through the process.
- IDS will always promote discharge to the patients home if at all possible.
- We would also promote making a decision about a move to a Care Home from home rather than the hospital. However if this is not possible, the IDS social workers will support this move from the hospital.

UNDERSTANDING DISCHARGE



Patient Story

Anne is 91 and was admitted with a chest infection.

She has some memory problems but was managing fine at home before she became unwell.

Her chest infection made her delirious and knocked her off her feet. She lives on her own and she was found on the floor by her daughter and brought in to hospital.

When she was over her infection she was noted to be “a little bit muddly”, deconditioned and fatigued and she had lost her confidence and was worried about going home. She could only stand for short periods and she had been given a walking frame to get mobile again.

The team were concerned that she wouldn’t be able to manage her personal care and meals. She needed some help getting in and out of bed and washing and dressing herself – these are things that Anne was managing well at home before her admission but now she’s struggling and tires really quickly. Her daughter had been doing Anne’s shopping before she was admitted to hospital and is happy to continue to do it, and can pop in a couple of times a week but she has a family and works part time and didn’t feel she could take on any more to help her mum. The multidisciplinary team felt that Anne would benefit from Home First and referred her to the service.

Patient Story

Anne went home with Home First Transport to make sure she got home before 10:00.

The community team came to visit her at 11:00 and assessed her at home. They found that Anne could manage to get in and out of her own familiar bed without any difficulty, but she was struggling with the toilet. They also identified that she was not taking her medicines at the right time, was getting very tired and not managing to cook for herself.

The community team went back that afternoon and brought a frame that helped Anne manage the toilet.

They visited twice a day and helped and encouraged her with her washing and dressing, meals and prompted her to take her tablets, getting Anne to do a little bit more every day and get her balance and stamina back.

Anne settled in well at home and within a week she was walking without a walking frame and the team only needed to support her once a day.

Within ten days Anne was much less muddled and her confidence and stamina had improved and she was able to look after herself again at home. The team also gave Anne and her family some information around telecare including a falls alarm “just in case”.

Without Home First, Anne would have been waiting in hospital for a care package, this means being “looked after” rather than given the encouragement and support she needed to get her confidence back and to regain her independence. The ward would have identified that she needed help three times a day and so she would probably have waited over a week in hospital for this to be set up. Staying in hospital would put her at risk of catching infections, or falling.

Anne was really happy with the experience she had from Home First. Anne is still thriving at home.

Thank you.

Questions?