The Patient Experience Cycle

A number of complaints were received by the Trust relating to patients being admitted to wards outside of the Trust's geographical area and management.

1	2	3	4	5
What did we take from this?	**What did we learn?**	**What changed in practice?**	**How did we disseminate this?**	**What happened as a result?**
PALS feedback, complaints and staff feedback that patients are not receiving optimal care on wards outside of our control. That the impact on the patient and their family was detrimental to recovery. That care coordinators did not have a 'grip' on the plan of care and treatment for our patients. We recognised that AWP are encountering issues with bed capacity in line with the national picture	That the most acutely unwell patient must be admitted locally. That transferring a patient who is ready for discharge or approaching this is less disrupting to care pathways. That 'grip' and clinical oversight of patients admitted out of area was absolutely critical to ensure the quality of care they were receiving was good. There was a need to repatriate patients as soon as possible.	An Out of Area Placement manager was appointed to review patients and to assist teams in moving patients back to local beds. Greater clinical oversight of the care provided to patients placed out of area. Wards identify the three people that are closest to discharge, and suitable to be moved, to allow a more unwell patient to be admitted. This information is provided twice weekly to Bed Management teleconference. Greater oversight of bed usage and the patient population using them.	A procedure was developed and sent to wards. It described the actions required by the wards and the way in which this new process would be monitored by Locality Management teams and Executive Team.	The numbers of people placed in beds out of area reduced. Better patient and carer experience, families no longer dealing with being miles away from loved ones. Complaints about out of area reduced from 7 within January to June to 2 from July to date. However, complaints about transferring patients and this being detrimental to recovery and unsettling for patients and families began to be made to the Trust. 5 complaints about this were received in Q2 15/16.

The Patient Experience Cycle

A number of complaints were then received about transferring patients between AWP wards and that the reason for this was for bed management purposes and not clinical care

1 What did we take from this?	2 What did we learn?	3 What changed in practice?	4 How did we disseminate this?	5 What happened as a result?
That the new policy had not been 'heard' by staff in the way intended. Staff needed support and guidance about how to implement the new policy and the reasons for it. That patients and families were distressed by the moves between wards. That communication with families and carers about potential moves needed to be improved.	Any decision to move a patient must be clinically led. If people need to be on the ward then that's where they should be. The protocol as a whole needed a programme of review. A communication plan was needed to get the right message to staff that if there is no one who should be moved, then that is fine.	The protocol was reviewed after a month and will continue to be reviewed by clinical directors every three months. Fortnightly Trust wide telephone conferences are also held with the inclusion of the intensive team to help resolve issues with finding beds for service users and accelerate this process.	Patient information was developed to inform patients and families that a transfer towards the end of their inpatient journey may be a possibility. Regular discuss at the Quality Huddle. The monthly Chief Executive briefing to all staff redirected with the correct information on when and how to use the protocol. An Ourspace message was out on line to inform all staff of when and how to use the protocol.	The Trust are also in the process of trialling a new bed status system that will highlight more clearly where action is required and when beds are available. Staff are encouraged to use these resources wherever possible to reduce the amount of time spent arranging transfers. Complaints about transfers between wards continue to be monitored and 2 have been received so far in Q3 15/16. Close performance monitoring Reports to Board.