Oxford University Hospitals NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee Meeting

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Title	**Plans for acute bed and service reconfiguration at the Oxford University Hospitals NHS Foundation Trust**

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Plans for acute bed and service reconfiguration at the Oxford University Hospitals NHS Foundation Trust

1. Introduction

1.1. This paper sets out how the Oxford University Hospitals NHS Foundation Trust (OUHFT) plans to further develop an ambulatory model of care to improve patient experience and outcomes. The aim of this programme of work is to deliver care to patients in the most appropriate environment for them. It also provides the opportunity to optimise the use of beds across the organisation and improve aspects of the estate which will enhance the quality of the environment for patients and staff.

1.2. This paper details the current work programme undertaken to move patients to more appropriate care settings while they await further care and which enabled the release of beds within the Trust.

1.3. Plans for further acute bed and service reconfigurations are also outlined. These will utilise and expand the already established Liaison Hub and further develop ambulatory approaches, thereby enabling the release of a further 118 beds across the Trust.

2. Background: Implementing an ambulatory model of care

2.1. Evidence has shown that many patients, in particular frail older people, have better outcomes and experience when an in-patient stay is avoided and when they instead are treated with appropriate, integrated support as an outpatient, as a day case patient, or through outreaching directly into the patients' own homes[1].

2.2. There are times when patients who are frail, develop acute illness or have long term conditions which requires care within a hospital setting. However, there are risks with an in-patient admission, particularly for this cohort of patients. There is evidence to support a responsive and rapid assessment of frail patients followed by treatment, supportive care and rehabilitation closer to or in patients' homes. This is associated with lower mortality, greater independence and a reduced need for long term care. This growing confidence to safely assess and manage 'frailty' patients in their own environment requires effective co-ordination between secondary and primary care.

2.3. Patients have also expressed a clear preference to be treated in the community, whenever possible[2,3,4]. There is real mutual benefit to be gained, therefore, by providing care closer to home. The need for inpatient beds can be reduced by introducing innovative approaches to care, as outlined below supported by:

- the deployment of rapid diagnostic tests (eg. point-of-care blood analysis),
- improved imaging facilities (CT, MRI),
- an advanced ambulatory emergency care capability,
- improved clinical coordination of health and social care services, and
- improved network support for specialist conditions.

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[1] Future Hospitals Commission (2013) Future Hospital: Caring for Medical Patients A report from the Future Hospital Commission to the Royal College of Physicians

[2] ibid (pages 49-62)

[3] Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R (2009) Hospital at home early discharge. Cochrane Database of Systematic Reviews

[4] Fearon P, Langhorne P, (2012) Early Supported Discharge Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews

2.4. Reflecting contemporary evidence, the set of pervasive, patient-centred care principles which underpins this care model include:

- Embedding pragmatic, evidence-based preventative interventions as 'business as usual' during all planned and unplanned patient encounters
- 'Ambulatory by default' (a set of patient-care principles, the most prominent of which is minimisation of overnight hospital admission)
- 'Assess to admit' (capable clinical assessment, often multidisciplinary, before a decision to admit to hospital is made)
- 'Enhanced recovery' (a set of enabling care principles that de-escalates care rapidly as the patient improves, minimising iatrogenic or hospital-induced illness and the 'post-hospital syndrome' of physical and mental debility)
- 'Discharge to assess' (an early move from hospital closer to home to deliver enabling care and determine ongoing care needs).

3. Initial stage of development November 2015 – March 2016

3.1. 'Rebalancing the System' initiative

3.1.1. In November 2015, Oxfordshire health and social care providers agreed to work together to develop a joint plan to enable patients who no longer needed acute medical care to move from the hospital setting into a nursing home. This enabled their needs to be met more appropriately while they waited either to be transferred home with community-based support or to a permanent care home placement.

3.1.2. The central aims of this initiative (entitled 'Rebalancing the System') were to:

- Ensure that patients who were medically fit to be discharged from hospital, but awaiting non-acute health and social care support, were cared for in the right environment.
- Linked to this, reduce avoidable patient deterioration caused by delays in bed-based care.
- Reduce the number of patients delayed.
- Enable the shift to ambulatory (as opposed to bed-based care) thereby supporting the management of the expected increase in hospital admissions due to winter illness affecting the elderly and those with chronic conditions.

3.2. The development of a Liaison Hub

3.2.1. In order to coordinate and manage the needs of the patients being transferred to nursing homes, a multi-agency Liaison Hub, located in OUHFT, was established in December 2015. This included involvement of the three provider organisations (OUHFT, Oxford Health NHS Foundation Trust and Oxfordshire County Council).

3.2.2. At this time, 76 acute beds were released which included 23 beds in the Post-Acute Unit (PAU). A number of staff from PAU, capable and experienced in complex discharge planning moved to the Liaison Hub in order to focus on this activity.

3.2.3. The hub acts as a key liaison point supporting patients during this transitionary period. In particular it:

- Ensures safe and proactive discharge planning for patients who are transferred
- Administers arrangements with nursing homes, social workers, therapists, GPs and hospital clinicians.
- Manages the logistics of communication with patients and families and escalates any concerns and issues.
- Maintains a tracking system via a virtual ward of all patients who have moved and their onward destination.
- Actively liaises with Community Hospitals to ensure good patient flow from OUHFT to CH beds
- Provides day to day support to nursing homes to proactively support patient management.

3.2.4. The Liaison Hub's multi-disciplinary team (MDT) consists of qualified nurses with acute medical experience and expertise in complex discharge planning with discharge planners working alongside them, the OUH lead for discharge planning and an administrator. The hub works closely with staff from adult social care, therapy staff, consultant Geriatricians and senior interface Physicians.

3.2.5. Careful and detailed planning is undertaken to ensure that the move for patients, many of whom are frail with complex needs, is well managed. This includes the following processes:

- Each patient has a long term discharge destination and a therapy plan (where necessary) targeted at maintenance or rehabilitation.
- Once determined as medically fit for discharge, patients and their families are informed of the move and have an opportunity to discuss this with staff.
- Each patient and their family/carer is provided with a personalised letter explaining the reason for the move and a contact number for the Liaison Hub.
- The patient's GP is also informed by letter that the patient has been transferred to an intermediate care bed whilst discharge planning continues.
- Each patient is transferred with an information pack which contains the following:
    - Nursing Summary
    - Medical summary (EiDD) with list of take home medication
    - If relevant a completed Do Not Attempt Resuscitation (DNAR) form.

3.2.6. Importantly, arrangements are made for each nursing home to have an assigned Multi-disciplinary Team (MDT). This includes a named nurse from the Liaison Hub, social worker, therapist where required and medical staff member. The contact details for each one are made available to the Care Home Support Service, Adult Social Care and the Liaison Hub team.

3.2.7. A weekly MDT review of all patients is put in place to review the progress of those transferred and ensure that onward transfer is expedited.

3.2.8. As of the 30 August, 483 patients have been transferred from an OUHFT bed or an OHFT community hospital bed to a nursing home.

3.3. **The Acute Ambulatory Unit**

3.3.1. The Adams Ambulatory Unit, situated on Level 5 at the JR Hospital plays a crucial role in providing a responsive, multi-functional hub, delivering three main pathways of care, seven days/week.

- **Next day assessment:** this builds on the existing day hospital function, delivering next day MDT assessment, diagnosis and treatment on an ambulatory basis following initial assessment and referral from primary/community care, OP attendance and EAU/ED attendance.
- **First Assessment:** primarily focused on Geratology Rapid Access for patients deemed as requiring urgent assessment on the same day, but not deemed as requiring emergency/blue light review. This service will concentrate not uncommonly on patients with complex needs.
- **Immediate streaming of patients from Level 1:** largely older, frail patients where assessment can be done on an ambulatory basis. The very early filtering from Level 1 of this cohort of patients helps to de-congest Level 1 and prevents overcrowding of the Emergency Department.

4. Next steps in releasing beds and increasing ambulatory provision

4.1. In order to move from a dependency on bed based care to bed and non-bed based care, the Trust needs to continue to develop an ambulatory model of care which provides continuing care/treatment for patients, in their own home. This release of inpatient beds only becomes viable with the continued implementation of the following developments, which release staff to deliver patient care in an increased ambulatory way. This includes the following:

- Acute Hospital at Home (AHAH): providing ambulatory care in-reaching into patients' homes delivering acute care for a defined time period
- Continuation and expansion of the role of the Liaison Hub
- Implementation of a Trust wide Discharge Liaison Team
- Expansion of the Supported Hospital Discharge Service (SHDS)
- Refurbishment of Level 7, John Radcliffe Hospital
- Increasing capacity in Ambulatory Care, Level 5.

4.2. **Acute Hospital at Home**

4.2.1. This is a service that provides acute care into patients' homes for a defined time period. This can be achieved either by assessing the patient in their home using point of care testing or transferring them to the hospital for assessment only but continuing to provide care /treatment in the patient's home, where feasible.

4.2.2. The service aims to achieve two goals: to avoid hospital admission and to support the safe transfer of patients from secondary care to the patient's own home where care can be safely continued. This will include patients who require ongoing treatment, monitoring, nursing care, therapy support, and who would otherwise remain in hospital without this intervention.

4.2.3. The Acute Hospital at Home service will accept referrals from General Practitioners (GP's) and other health care professionals within the community setting e.g. District Nurses, heart failure and respiratory specialist nurses, Palliative care teams, South Central Ambulance service and carers. To enable early and safe transfer of continuing care from hospital to home, it will

also accept referrals from acute medical physicians, ward sisters, specialist nurses and other specialist services.

4.2.4. Patients with the following conditions will be those most able to benefit from this service in the first instance:

- Community acquired pneumonia
- Cellulitis
- Volume depletions/dehydration
- Urinary tract infection/urosepsis
- Deep vein thrombosis and pulmonary embolism
- Acute decompensating heart failure

4.2.5. Patients not included are listed below:

- Patients under the age of 16yrs
- Patients with resolving alcohol or substance misuse issues which would prevent them from engaging with Multidisciplinary case management
- Patients with acute/severe mental health problems
- Patients who decline this service

4.2.6. The types of treatments delivered by AHAH will include:

- Administration of parenteral therapy:
  - IV Antibiotics (to include 2nd dose) IV or S/C Diuretics
  - IV or SC Fluid (S/C to include full range of approved s/c crystalloid preparations).
- Supplemental oxygen via O2 concentrators – monitoring and further titration if required of O2 via appropriate delivery device.
- Palliative medication to be administered where appropriate via s/c syringe driver or prn injection.

4.2.7. Patients will be discharged back to the care of their GP within 5-7 days after transfer home and patients ongoing medication will be prescribe for up to 14 days following discharge to the care of the patients GP.

4.2.8. The team delivering the service will consist of senior registered nurses, supported by clinical support workers, therapists, pharmacists and Geratologists.

4.3. **Continuation and expansion of the role of the Liaison Hub**

4.3.1. As described in Section 3.2 above, the Liaison Hub provides a valuable and crucial role in coordinating the transfer of patients with complex discharge needs.

4.3.2. This allows time to complete the discharge planning thereby releasing an acute bed. The cost of the ongoing running of the hub is part funded by the Clinical Commissioning Group (CCG). Its role has expanded to include support and management of the following (a total of 134 beds):

- 55 transitional beds in Care Homes
- 18 Interim beds
- 49 intermediate are beds
- 12 CHC beds.

4.4. Implementation of a Trust wide Discharge Liaison team

4.4.1. The Medicine, Rehabilitation and Cardiac Division (MRC) are in the process of developing the existing Discharge Liaison (DL) team to enable them to support all sites within the OUH Foundation Trust. The existing team is being expanded to focus on a further reduction of avoidable delays.

4.4.2. There are some 350 beds at the JR, 220 beds at the Churchill and 130 beds at the Nuffield Orthopaedic Centre (NOC) that have very limited input from the DL team. The team will be expanded to improve focus and input and will be managed by MRC to ensure consistency in practice and robust cross cover for leave and sickness.

4.5. Expansion of the Supported Hospital Discharge Service (SHDS)

4.5.1. In order to improve the discharge of patients waiting for reablement or domiciliary care in their own homes, an analysis of this provision (conducted in February 2016) identified that the system needed to provide an additional 1,600 hours of home care each week.

4.5.2. The decision was taken in March 2016 for the OUHFT (as a registered social care provider) to directly recruit and train up to an additional 50 reablement staff to increase the overall availability of reablement and home care delivery in Oxfordshire. This development will support discharging patients directly from the Emergency Departments, Emergency Assessment Units and Ambulatory Care in addition to supporting inpatient clinical areas across the Trust. This has not been without its challenges due to the well-known recruitment and retention issues associated with this staff group in Oxfordshire however an additional 42 staff have been recruited.

4.6. Refurbishment of Level 7, John Radcliffe Hospital

4.6.1. It is recognised that Level 7 in the main John Radcliffe hospital requires significant refurbishment to continue to deliver care in a suitable environment for older patients who require admission to hospital. Patients are increasingly presenting with cognitive behavioural challenges and high care needs (acutely unwell and require continuous monitoring) and ward environments need to reflect the demands placed upon them. Likewise for patients who choose to die in hospital, an improved environment conducive to good end of life care needs to be provided for them and their families.

4.6.2. The four wards on level 7 will be refurbished and integrated into two 30 bed wards releasing 26 beds.

4.7. Repatriation Policy

4.7.1. In order to help underpin the developments described earlier the Trust has also reviewed its mechanisms for the timely transfer of patients back to their referring hospital and to this end a revised Repatriation Policy for the Thames Valley is being trialled.

4.8. Summary

4.8.1. In summary, this programme of change supports the following:

- Single point of access to medical review, specialist opinion and diagnostics.
- Reducing long waits for medical and ‘frailty’ patients in the Emergency Departments.

- Improved access to senior, expert decision makers seven days a week between 08:00 and 20:00hrs, in late 2016 this will be extended to 08:00 - 22:00.
- Ambulatory care pathway managed by a single MDT and supported by psychological medicine.
- Patient and carer involvment in decision making.
- Prompt discharge planning within 24hrs unless hospital treatment is necessary.
- Post discharge support.
- Effective and appropriate rehabilitation and reablement after acute illness.

5. Details of Ward Relocations

5.1. In total, supported by these ongoing developments, the MRC and NOTSS Divisions are aiming to release 118 beds in General Medicine, Orthopaedics, Trauma and the West Wing. The key changes are:

- The current Acute Ambulatory unit has relocated to a larger facility on Ward 5B.
- Ward 5B (stroke) has relocated to ward 6B.
- Infectious diseases inpatients will relocate from John Warin ward on the Churchill site to the Bedford end of Adams and Bedford ward on level 4 in the John Radcliffe Hospital. John Warin ward will decrease from a 20 bedded ward on the Churchill site to occupy 11 of the existing beds on Bedford ward, four of which will be negative pressure rooms with access to the garden.
- Vascular inpatients, which are expanding linked to the transfer of emergency and elective inpatients from Buckinghamshire, will transfer from Ward 6A to released inpatient capacity in the West Wing.
- The option then exists to transfer Renal inpatients from the Churchill to either Ward 6A or Ward 7F at the John Radcliffe.

5.2. **Surgery and Oncology and Children's and Women's Divisions**

5.2.1. In addition to the above, it is essential the Trust achieves the integration of elective and urgent/emergency Urological Services on the Churchill site. The Surgery and Oncology Division has identified the ability to release 8 beds in the Cancer Centre which can then be reallocated to create inpatient capacity and a triage facility to support the transfer from the JR to the Churchill. This means the change can be achieved on a cost neutral basis.

5.3. An overview of bed realignment proposals are set out in Table 1.

Table 1 Bed re-configuration programme MRC and NOTSS

Ward	Present bed numbers	Beds Realigned	Beds left
Oak (ground floor)	36	0	**36** based on 18 designed for Trauma and emergency Gynaecology and 18 acute medical short stay aligned with medical assessment.
Laburnum (1st floor)	28	0	**28** Female patients
Juniper (1st floor)	30	0	**30** Male patients, bay in between can flex between either gender
JWW	20	20	**0** ID will occupy 11 of the existing beds on Bedford ward
5B converting to ambulatory Stroke 5B will	18 for ambulatory day time	10	**8** inpatient for those who need to stay overnight

Ward	Present bed numbers	Beds Realigned	Beds left
relocate to ward 6B			
Level 7A, B, C, and D if refurbished will have a reduced bed stock to meet present day requirements: dependant on capital program or charitable funds for older people, whilst works are completed move into 6A or 7F realigning 20 beds throughout the refurbishment which will take a year to complete.			
Combine 7C and 7D	42	12	**30**
Combine 7A and 7B	44	14	**30**
Total MRC	**218**	**56**	**162**
F ward HGH	28	28	**0** See above linked to Oak Ward
Orthopaedic (NOC)	102	12	**90** Close 12 beds on C Ward but keeping 12 day beds on A Ward open 24/7 that currently close at 6pm
Neuroscience	75	0	**75**
Vascular Wards 6A and 5C	22	22(26)	**0** Relocate to the West Wing
Total NOTSS	**227**	**62**	**165**
Total Trust		**118**	

6. Financial consequences and investments

6.1. The estimated savings associated with these changes are provided in Table 2 below.

Table 2 Estimated Savings

Ward	Full Year Savings
F ward HGH	**1288**
JWW	**663**
5B converting to ambulatory	**336**
Combine 7C and 7D into one ward	**1231**
Combine 7A and 7B	**0**
C Ward	**195**
6A/5C to WW	**1197**
Total	**4910**

6.2. The investments associated with the service developments articulated in section 4 of this paper are set out in Table 3.

Table 3 –Service Development Investments

Service	Pay	Non Pay	Total cost
Liaison Hub	1,103,000	24,900	1,127,900
Acute Ambulatory Unit	1,650,000		1,650,000
Supported Hospital Discharge	1,250,000		1,250,000
Trust Discharge Team Expansion	100,000		100,000
Totals	**4,103,000**	**24,900**	**4,127,900**

7. Additional benefits to the re-configuration and release of beds

7.1. In addition to the improvements in patient outcomes and experience of being cared for closer to home, further benefits to be realised from releasing beds includes:

- A reduction in agency spend for all staff groups.
- A reduction in staff from clinical and non-clinical support services.

- That medical cover is easier to deliver where beds are co-located within a defined area.
- The development of ambulatory care that continues after the patient is transferred home will benefit all clinical areas within the Trust.

8. Conclusion

8.1. This paper has outlined the ongoing and proposed service developments that are supporting the development of ambulatory pathways for patients and the subsequent realignment and release of inpatient beds.

8.2. Patients who are complex delayed discharges are better cared for in Nursing homes with the support from the Liaison Hub, which incorporates social care and therapy provision.

8.3. A release of 118 beds within MRC and NOTSS can be achieved by releasing staff to care for patients in non-bed based care (ambulatory care) across Oxfordshire. The expansion of staff within SHDS will support the ambulatory care pathway by providing the domiciliary care required to enable the patient to remain at home. A Trust wide Discharge Liaison team will support all clinical areas within the trust to prevent avoidable delays when discharging patients.

8.4. A Project Risk Register has been developed which identifies potential risks and mitigations for the programme. A risk assessment will be undertaken for each individual service change and a Quality Impact Assessment will be completed for the programme.

8.5. Delivery of this programme will improve the quality of the environment for both patients and staff through bed optimisation; ensuring patients are seen and treated in the most appropriate setting for them, thereby improving their experience of care.