Improving the Community Beds and Inpatient Pathways in Oxfordshire

A clinical review of the community beds model in Oxfordshire and proposal for new pathways

Introduction

- As part of the Oxfordshire community services strategy, a clinically led review of community beds was completed Oct-Dec 2021
- Two workshops were completed with clinical leaders and healthcare partners from across Oxfordshire
- This presentation summarises the outputs of those workshops and subsequent work to review the current clinical model and proposed community bed pathways as well as how they fit with wider community services

- Community beds provide rehabilitation and recovery for patients who no longer require treatment in an acute hospital
- Community beds aim to enable the majority of people to resume independent living more quickly
- The review considered two types of community beds in Oxfordshire;
    - inpatient wards in Community Hospitals
    - care homes short stay hub beds
- It did not include consideration of other beds based within the community such as long-term residential or nursing home placements, respite beds and hospice beds

Oxfordshire's current community beds

Community hospital beds Short stay hub beds

As of December 2021, the following community beds were provided within Oxfordshire:

Community Hospitals	Bed numbers
Abingdon	38
Abbey Ward – General	12
Abingdon – EMU (subacute)	6
OSRU (stroke rehab)	20
Bicester – General	12
Didcot – General	18
Oxford (City Comm) – General	15
Wantage (temporarily closed)	0
Wallingford	18
General	16
End of life	2
Witney	33
Linfoot – General	8
Linfoot – Bariatric	4
Wenrisc – EMU (subacute)	4
Wenrisc – General	16
Total	134

Short stay hubs	Bed numbers
Banbury Heights	17
Chacombe Park	12
Henry Cornish House	14
Isis	20
Albany	12
The Close	15
Chiltern Court	7
Total	97

It is important to note that the number of beds 'open' on a ward and the corresponding staffing ratios of medics, nurses and therapists per patient fluctuate by a small amount each week and are continuously monitored and adjusted to ensure patient safety.

How are community beds currently used

The community bed census

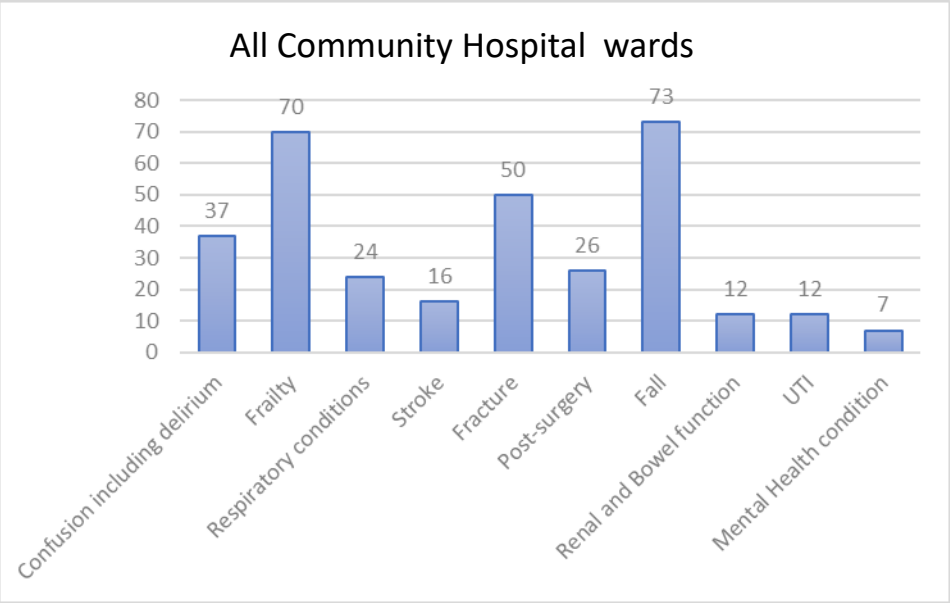
As part of the clinical review a snapshot review (census) of patients across all community hospital wards & hub beds was completed to understand:

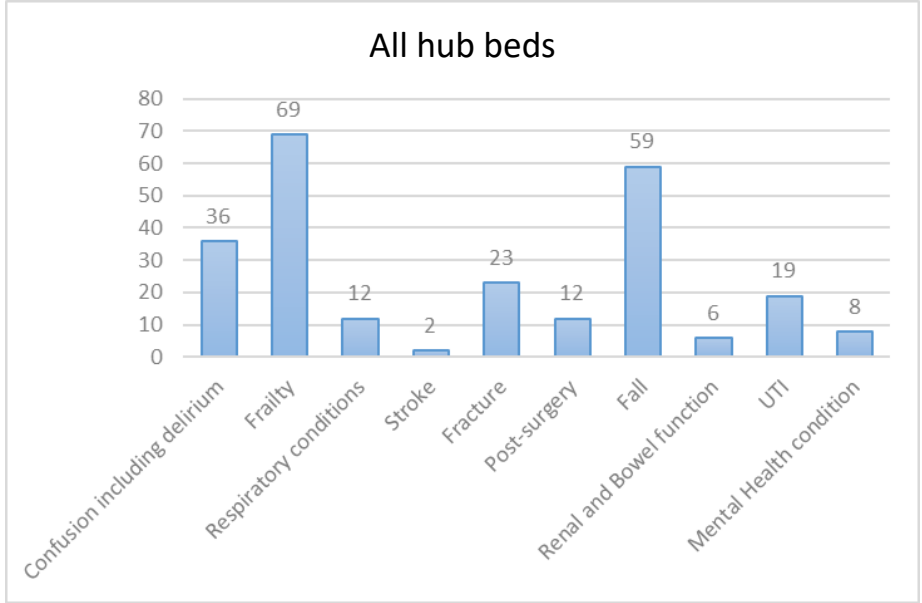
- Admission reason
- Types of need, diagnoses & complexity
- Who is supporting the patient and how
- Optimal use of beds and alternative settings for patient care

The census was carried out October to November 2021 across all community hospital wards and hub beds within Oxfordshire.

The community hospital wards were reviewed by clinical leads including the Community Services AHP lead and area service manager for hospitals and the hub bed review was completed by Liaison Hub Senior Nurses and Therapists.

Reason for admission – main clinical diagnosis



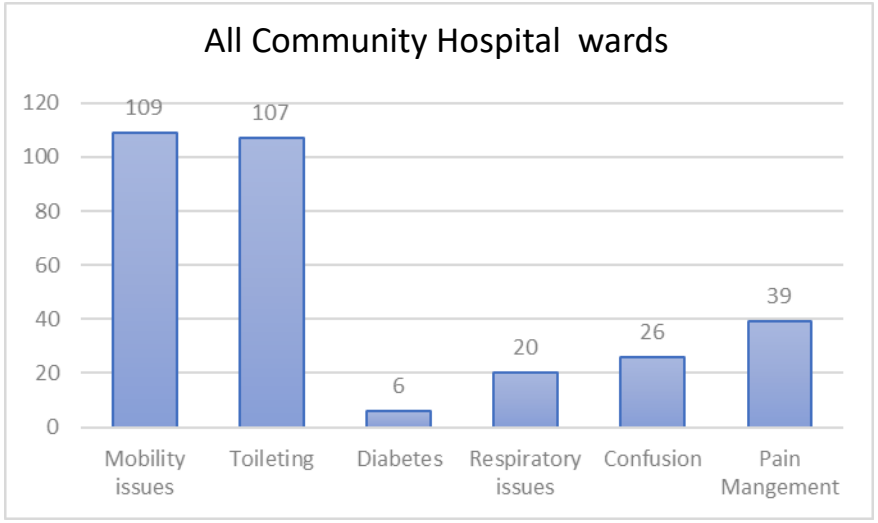


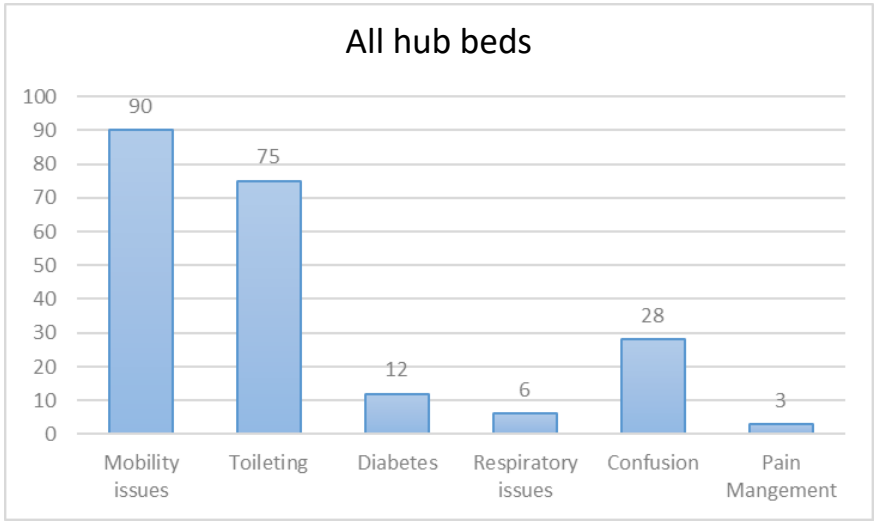
Across both community hospitals and hub beds the most common clinical diagnosis was frailty followed by falls. In community hospitals there were also a high proportion of patients with fractures. Patients in both settings also had a high level of confusion.

In addition to the main diagnoses noted here there were for all patients a total of:

- 218 additional community hospital diagnoses recorded
- 118 additional hub bed diagnoses recorded

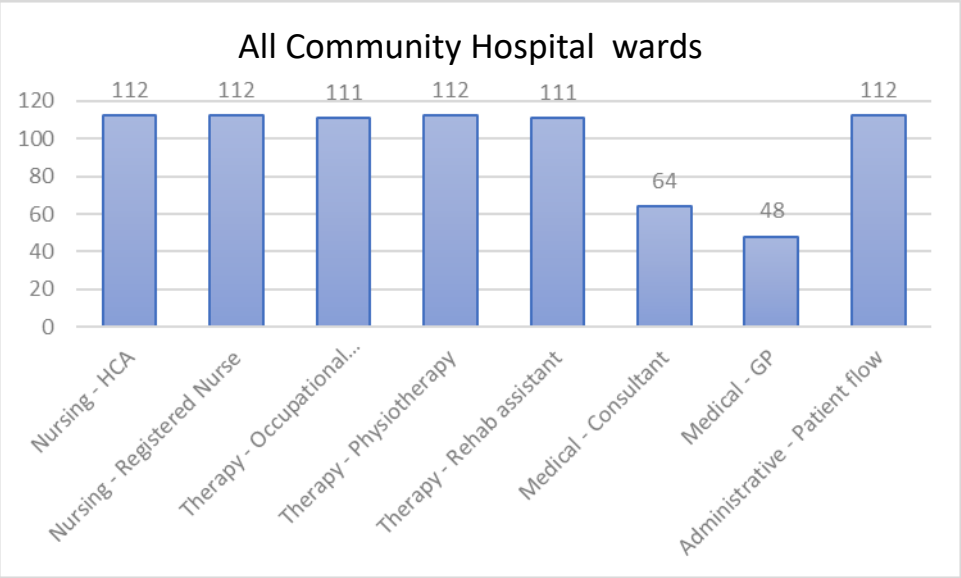
What are the main needs patients have?

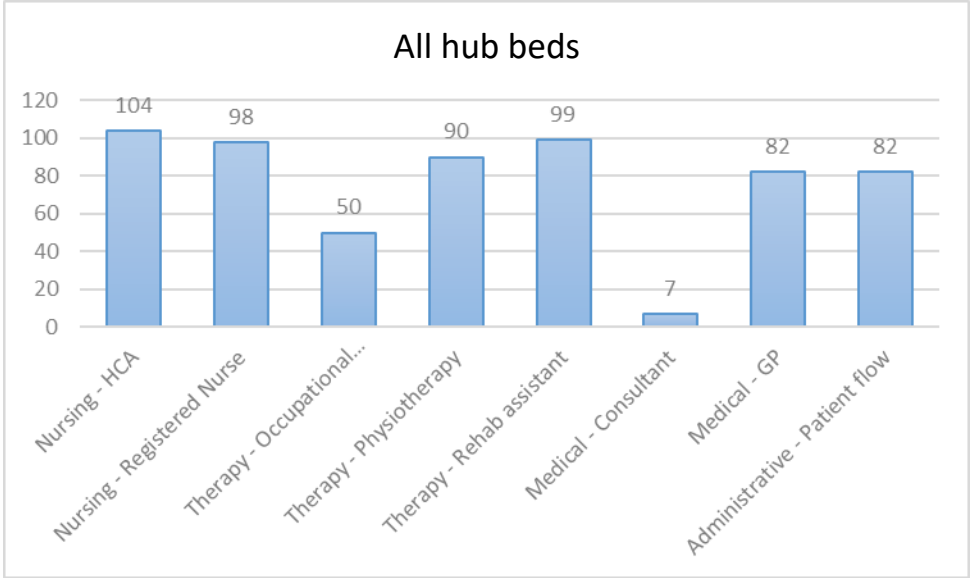




- In addition to the main diagnoses noted here there were for all patients a total of:
  - 31 additional community hospital needs recorded
  - 36 additional hub bed needs recorded
- In all settings the most common patient needs were relating to mobility and toileting.
- This aligns rehabilitation most commonly provided to address mobility and personal care to enable functional independence.

Staffing support



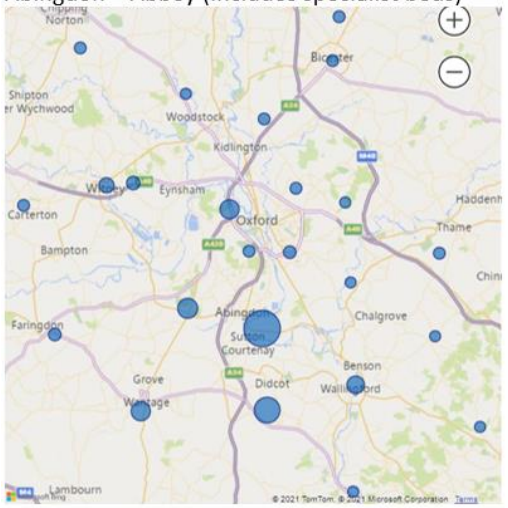


- All Community hospital patients were receiving support from Health care assistants, Registered nurse, Occupational therapist, Physiotherapist, Rehabilitation assistant & Patient flow team.
- Medical cover was divided between GP & consultant. In addition, but not captured in the census, medical cover is also provided by Advanced Clinical Practitioners in Didcot, Bicester and City.
- Due to staffing limitations, Therapists within Hub beds are expected to work across disciplines e.g. Physio providing Occupational Therapy and vice versa
- All Hub bed medical cover is provided by GPs however some patients are supported by Ambulatory Outreach Team or the Ambulatory Units at the JR and Horton

Which patients are using community hospital beds?

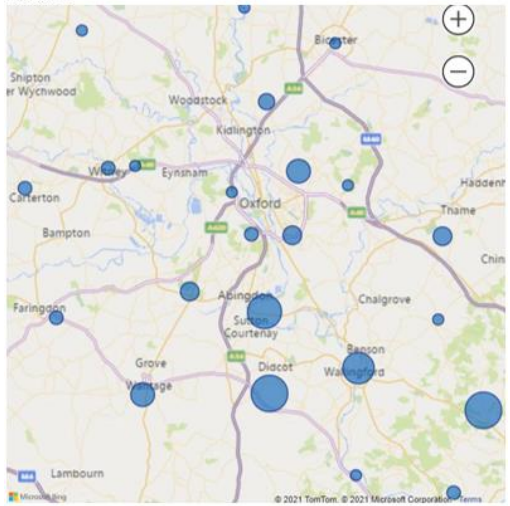
The location patients are admitted to is currently determined based on their needs combined with the availability of a bed within their local community hospital. Preference will always be given to a patient being placed closer to home, however, there are a number of factors which may influence which ward they are admitted to. The below maps show the home location of those admitted to community hospital beds between April and October 2021.

Abingdon – Abbey (Includes specialist beds)

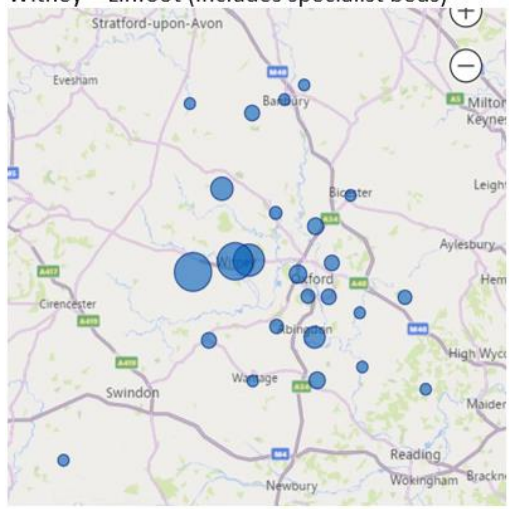


Bicester

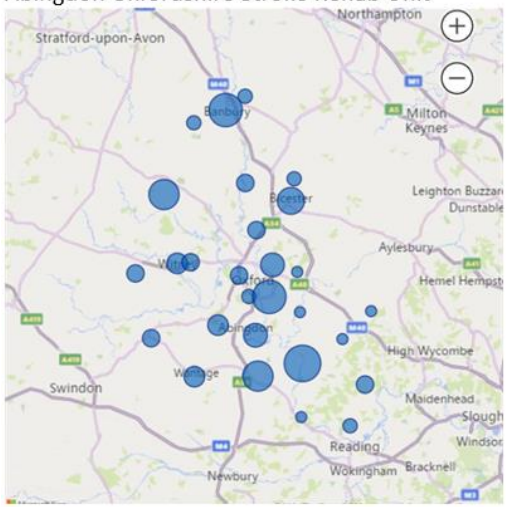
Didcot



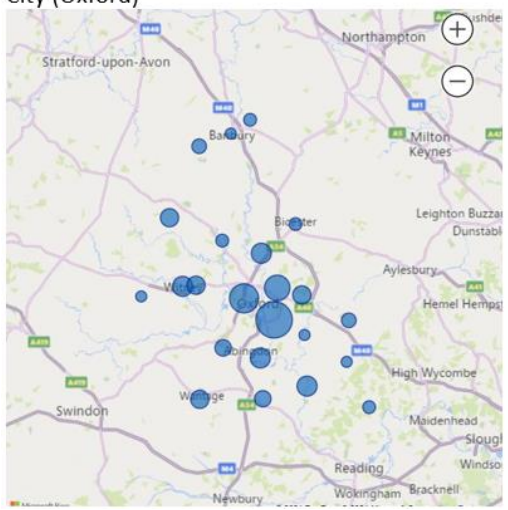
Witney – Linfoot (Includes specialist beds)



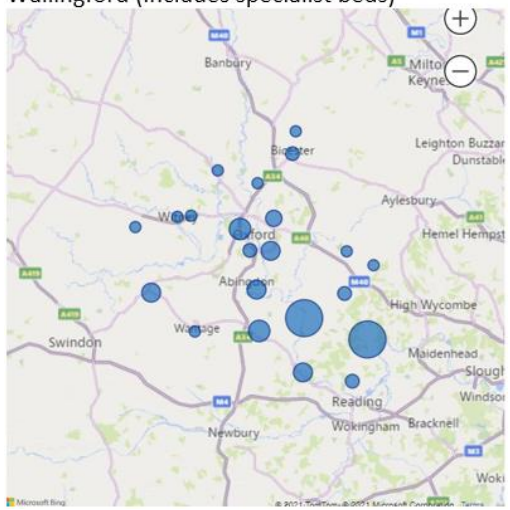
Abingdon Oxfordshire Stroke Rehab Unit



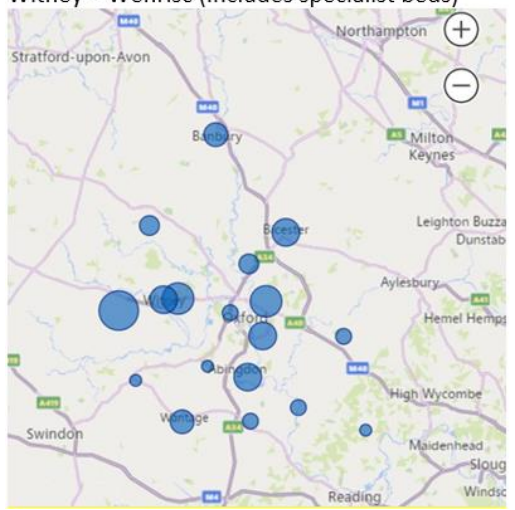
City (Oxford)



Wallingford (Includes specialist beds)



Witney – Wenrisc (Includes specialist beds)



National best practice and evidence on the role of community beds

Home first

- ‘Home First’ is the national NHS policy ambition to help older people receive care and assessment in their own homes wherever possible.
- A study carried out by the Better care support programme (available at reducingdtoc.com) found that on average, 27% of the 10,400 individuals studied were declared to be medically fit for discharge yet remained in hospital. When these patients got discharged, in 92% of these cases, the setting was providing a more intense level of care than required to maximise the individual’s independence.
- It is widely accepted that most people want to leave hospital as quickly as possible and return to the living arrangements they enjoyed prior to their admission with the highest level of independence, wellbeing and quality of life possible, given the circumstances.
- Staff caring for people also want them to be discharged to the right place, in the right way, at the right time.
- A hospital is a good place to be when you are acutely unwell, but it can also bring its own risks. In every hospital admission, there is a risk of picking up an infection. For the more vulnerable, being in hospital can mean:
    - losing confidence in the ability to live independently
    - losing the continuity of whatever care packages are in place
    - losing mobility
- Older patients can often experience confusion and disorientation in an unfamiliar environment so the home first approach proposes where an individual is able to return home safely, they should be supported to do this rather than remaining in a hospital bed.

John Bolton pathway principles

Professor John Bolton completed a review across seven health and care communities between July 2020 and June 2021 to improve their local arrangements on hospital discharge with a focus on the needs of older people. Building on this he identified shared learning to consider how to bring together services to improve patient discharge processes.

Oxfordshire healthcare system is committed to meeting targets around patient discharge as set out by John Bolton.

Within this work he concluded that the bedded facility whether in a care home or a community hospital should have as its main purpose the support for people to return home. Without this focus there is little prospect of Pathway 2 delivering desired outcomes and short-term placements are likely to become permanent.

As a guide he identified the following proportions for each 'discharge pathway':

- Pathway 0 (Patient returns home with no support) - 50%
- Pathway 1 (Patient returns home with additional support) - 45%
- Pathway 2 (Patient admitted to community rehabilitation bed) - 4 %
- Pathway 3 (Patient admitted to long term care) - 1%

https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

Ageing Well: Urgent community response

- Another national NHS programme, this is focused on reducing avoidable admissions.
- Preventing admissions and providing care at home is critical to managing hospital capacity over the Winter & pandemic period and to improve outcomes.
- Many people with frailty currently admitted to hospital through A&E don't need inpatient care – estimates range up to 30%.
- The 2018 National Audit of Intermediate Care recommended that intermediate care capacity needed to double to meet demand and that waiting times for crisis response were on average 5.1 hours and for reablement were 5.6 days.
- Care Quality Commission (CQC) research (2018) has shown that investment in lower-level preventative services can lead to a reduced need for care and support and cost saving equivalent to £880 per person.
- Therapy led reablement is proven to reduce need.
- Further details are available on the NHS England website (https://www.england.nhs.uk/community-health-services/community-crisis-response-services/).

Recommended role of community beds

Constraints on the use of community beds

1. **Flexibility of bed numbers to meet needs**
    - Based on seasonal demand there has tended to be an increase in demand for bedded care over the winter period.
2. **Sustainability of staffing for small rehabilitation wards and challenges around recruitment**
    - Where a ward has only a small number of beds it is much harder to provide sustainable staffing which can impact on the ability of that ward to provide optimal care
    - The Lord Carter review (2018) noted that "a much clearer idea of 'what good looks like' is needed but one thing is certain – an isolated 10-bedded inpatient facility is unlikely to be clinically or financially secure". The review also showed that smaller units have significantly higher running costs on average.
3. **Limitations relating to the physical estate including parking, building size, shared space requirements**
    - Need to review the physical estate constraints for each ward as well as consideration of any capital works which could be completed to mitigate these as well as any travel impacts for patients having to travel between wards if smaller wards are seen to be less viable.
4. **Interest of providers to deliver short stay hub beds**
    - Where hub beds are identified as preferable to community hospital beds to meet the needs of patients, consideration needs to be given to whether there is sufficient interest from local providers to deliver hub beds in this area.
5. **Delayed discharges impact on capacity to return people home**
    - Shortage of capacity to support people to return home results in delayed discharges, which in turn mean that more community beds need to be kept open to support those who cannot yet safely return home.
    - Across Oxfordshire between 20 and 30 people are impacted by delays on most days. Recent reviews of home based reablement have identified this as a significant challenge.

Improving the model for community inpatient care

- As a general principle, Community Hospital beds are best used to provide therapy and care which can't be delivered within a non-bedded environment in the community.
- The working group agreed that admission to a community bed should be based on:
    - The identification of a care, reablement or therapy need that cannot be met in the patient's usual home environment
    - The frequency and intensity of health care needs, i.e. how often the individual needs care
    - Diagnostic certainty and relative medical stability, i.e. how confident professionals are that the needs of the patient are understood and likely to remain consistent
- The following approach to determining whether someone's needs are best met within a community bed is recommended:
    - We will always consider first whether someone can return home and if their needs could be better met within the community.
    - No one whose care and health needs can be met at home at the time of discharge should be placed in a community bed. To inform this decision making, it is recommended that a frailty score could be used to assess the needs of each patient.
    - We will minimise wherever possible delays which result in people remaining in the bed when it is not the right place for them.
- A 24-hour 7-day reablement approach should be implemented. This would reduce the extent to which discharges would be affected by the time and day on which a patient is due for discharge.

Recommended community bed pathways

Rehabilitation and recovery - Community Hospital inpatients

A bed-based assessment and rehabilitation offer, most commonly required by people with significant frailty, disability or co-morbidity. The type of rehabilitation and recovery varies between locations based on the complexity of the patient need.

The need:

A proportion of people who have had a significant period of illness or immobilisation, or who are recovering from injury or surgery, need expert inpatient rehabilitation and/or nursing to reach strength-based goals within a target timeframe.

Location:

A period of bed-based reablement or rehabilitation is required by approximately 4% of all acute hospital discharges according to national models and should be made available to patients in all Network Areas of the county through a series of well-resourced, equipped and suitably staffed Community Hospital inpatient units.

Examples of patients supported:

People with multiple care needs and diagnoses (co-morbidities) who require full time care & therapy to rehabilitate, this might include:

- Admitted to hospital following a fall which caused multiple fractures admitted for rehabilitation. Rehabilitation limited due to pain and postural hypotension
- Admitted to an intensive care unit and is recovering from post ICU deconditioning, also has general frailty

Rehabilitation and recovery – care home reablement (hub beds)

A bed-based assessment and rehabilitation offer, most commonly required by people with significant frailty, disability or co-morbidity. The type of rehabilitation and recovery varies between locations based on the complexity of the patient need.

The need:

People who require a short and less intensive period of focused bed-based reablement or assessment before transfer to home reablement (Pathway 1) or no further reablement (Pathway 0) or who may need a permanent placement in long term care (Pathway 3).

Location:

A period of bed-based reablement or rehabilitation is required by approximately 4% of all acute hospital discharges according to national models and should be made available to patients in all Network Areas of the county through a series of well-resourced, equipped and suitably staffed Community inpatient units.

Examples of patients supported:

- A person who is unable to put weight on their hip following surgery for a fracture but is unable to return home as they need additional support
- A person where there is clinical uncertainty over whether they will respond to rehabilitation and would benefit from a period of bed-based care outside acute hospital that will allow an assessment of their needs.

Sub-acute care and stabilisation

The need:

People who become unwell, injured or whose health deteriorates and who have frailty, multimorbidity or complex needs, may require an actively managed period of stepped-up monitoring, medical treatment, nursing care or therapy until they are stabilised but don't need the facilities of an acute hospital

Location:

Patients in this pathway require rapid assessment in an ambulatory care or same day emergency care unit, following by a period of monitoring and treatment from a suitably trained multi-disciplinary team of medical, nursing and therapy professionals. They also require access to diagnostic and imaging services, such as x-ray, and so these facilities should be co-located together. Because of these essential needs, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.

Examples of patients supported:

- An older person who is unable to walk due to unexplained weakness and has become slightly confused
- A person with multiple health conditions who has become gradually more breathless and fatigued over the past week
- A person with frailty who has been seen in an acute hospital and is well enough to return home, but requires a specific treatment and re-assessment by clinical team the following day

Bariatric

The need:

There is an increasing number of people with a high BMI who require specialised equipment, facilities and professional input to enable them to experience safe care and rehabilitation, so they can return home and access appropriate weight management support

Location:

This cohort requires use of specialised equipment, premises adaptations and staff trained in providing care for plus-sized people. As a result, it is necessary to provide this care on a limited number of specialised Community Hospital sites with appropriate staffing and facilities.

Examples of patients supported:

- A person with a BMI of 40 who has had a fall causing toe fractures and is immobile. Previously transferred with pivot transfer but unable to do so with fractured toes so needs significant support.
- A person with a high BMI who is recovering from a below knee amputation.
- A person with a high BMI and complex diabetes and a skin infection

Stroke rehabilitation

The need:

A significant proportion of people who have had a stroke require a period of targeted rehabilitation in an environment with specialised staff and facilities, in line with national stroke guidance.

Location:

Specialist stroke care is provided at the Oxfordshire Stroke Rehabilitation Unit (OSRU), located at Abingdon CH

Examples of patients supported:

- A person who has had a stroke and needs intensive therapy to help them to regain the ability to eat, speak and move themselves. This might include speech therapy, support from a dietitian and therapy to improve movement.
- A person who needs 2:1 care following a stroke to support them with eating drinking, washing, dressing, toileting and overnight needs. They also may need dietitian and specialist support to feed including starting up Peg feeding and NG tube feeding and support to learn to feed themselves prior to returning home.

Specialist Care towards the end of life

The need:

Most people prefer to die at home when nearing the end of life and this aim will be supported through enhanced community-based end-of-life-care services and primary care, in partnership with the hospice charities. Much care for people in the last year of life will continue to be provided in Community Hospitals with the aim of restoring their independence and enjoyment of life at home for as long as possible. However, a small number of specialist palliative care beds is necessary to support some people at the end of life when it is not possible to provide them with adequate symptom control at home or when other factors mean an admission is necessary to ensure safety or minimise distress. Not all patients admitted to one of the specialist palliative care beds will die there; some will have a planned return home once stabilised.

Location:

Specialist end-of-life care is best provided in a purpose-built facility that provides a calm environment, enables family members to stay on site and where staff can develop specialist skills in palliative care.

Examples of patients supported:

- A patient for whom a period of in-patient care would be preferable to care at home. The reasons for this can include carer fatigue or distress; the patient lives alone without support between carer visits; the patient may be a parent of young children and prefer not to live their last days in the family home; there may be symptoms which could be more easily stabilised in an in-patient environment; or a patient requiring additional support or treatment in their last days.

Additional pathways identified

In addition to the pathways identified above, it was agreed that consideration should be given to the development of the following pathways which are not currently provided. Further detailed work is required to agree the optimal way to deliver these pathways.

Specialist neuro-rehabilitation

- **The need:** Inpatient care and rehabilitation for those with level 2 neuro-rehabilitation needs (as defined in national guidance) alongside the existing stroke pathway
- **Location:** This provision would ideally be co-located with Stroke rehabilitation to enable sharing of specialist resources, facilities and expertise and a more sustainable staffing model

Acute confusion

- **The need:** People with an acute confusional state of delirium (which is often caused by a combination of acute illness and dementia) who are sub-acutely unwell require specialist staff and resources, as they are often unable to engage successfully with therapy in a traditional ward setting and can wander, be at increased risk of falls, or exhibit challenging behaviours. An acute ward environment is often suboptimal as it can cause additional confusion and distress for the person and their family. Skilled assessment is often required to provide evidence that the delirium will resolve with treatment and to establish clear goals to enable people with permanent confusional states (e.g. advanced dementia) to move onto appropriate long-term care placements.
- **Location:** This service would be best developed at a site with suitable facilities, layout and staffing to provide the appropriate environment for people with acute confusion to receive effective care and maintain their dignity. A site with close links to Adult Mental Health expertise and support would be ideal.

Implementation considerations identified by the workshops

Dependencies

Expanding the community therapy and nursing offer ;

- Community beds make up only a small part of the community services offer. Any future model of beds needs to consider the way in which beds fit into the wider community therapy and nursing offer which support people to remain well at home.

Night sitting and live in carers;

- A number of patients are currently admitted to a community bed because they are not safe to return home and be alone during the day or overnight. Development of a night sitting offer and strengthen live in carers would reduce the number of community beds required.

Urgent community response 2-hour support to improve admission avoidance;

- The urgent community response programme (as mentioned in the evidence base above) is a national programme to reduce the number of people who require admission to a bed. This will therefore have a significant impact on the way in which people are supported within their own homes and so reduce the need for community beds.

Access to specialist support such as hospital at home;

- Community based interventions such as hospital at home which is a service to enable people with complex health needs to remain at home, have a significant role in enabling admission avoidance.

24/7 rapid decision making in the community;

- One reason why people might be admitted to a community bed would be challenges around the ability to make urgent decisions within the community. Strengthening of decision-making processes within the community will therefore reduce the number of patients needing to be admitted to beds.

Dependencies (cont.)

Domiciliary care & respite beds and support for informal carers;

- By strengthening both the domiciliary and respite care within the community the number of people needing to be admitted to a community bed and also the length of stay of those who have been admitted can be reduced.

Primary care support/intervention;

- While patients remain within the community they are supported by their local GP (primary care) and so the level of support and intervention which can be delivered within the community will impact significantly on the number of community beds required.

Community staff equipment;

- This includes areas such as IT, PPE, transport, medical equipment. The equipment available within the community is central to determining how much care can be provided within the community.

Community patient equipment;

- The availability of equipment for patients such as hospital beds, pressure relief, toileting equipment, mobility equipment, is a key dependency for community beds as it is a significant contributing factor to patients being admitted to a bed rather than remaining at home.

SCAS and patient transport;

- The ability to move patients around the community in a timely way and the capacity to provide this, both through the South Central Ambulance Service and wider patient transport, impact on the time taken to arrange for a patient to return home and so increase the length of stay within a community bed.

Wider system changes/enablers

- Flexibility of support from each area;
  - Consider opportunities for sharing resource and learning from other teams through shadowing
  - Workforce planning – approach to strengthening our teams both within community beds and services
- Culture change
  - Focus on returning patients home and always considering how we can join up support with a shared vision
  - Increasing confidence in the community (at all levels) to move away from risk-averse decision making to consider the long-term benefit for the patient and how their needs can best be met
- Shared discharge team
  - Pilot a discharge hub to share decisions on how we can move patients through the system and identify opportunities to reduce delay
- Embed use of systemwide frailty score
- Explore a whole system approach to equipment manual handling requirements so there is consistency of expectations between staff in acute and community on how a patient can be supported
- Night sitters, live in carers (alternative short-term housing for those without space)
- Increase advance care planning/End of life planning as needed
- Clearer relationship with respite beds joining up the offer between adult social care and community services.