Appendix A v2

SOUTH ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

Biggleswade Hospital Information Update for Overview & Scrutiny Committee

1.0 BACKGROUND

In way of context: As part of the Governments 'The White Paper Our Health, Our Care, Our Say: A New Direction for Community Services (DH 2006)' sets out government policy for bringing care closer to home. One of the main strands involves delivering specialist care in local settings, particularly near to or in the patient's home, moving away from the traditional outpatient model and towards innovative community approaches that make use of multidisciplinary teams.

As part of regular service reviews, SEPT ensures that they are providing the right care, at the right time and in the right place for our patients. This means that for many of our patients, we are able to provide the best care for them within their own homes. This is also in line with the national agenda of providing 'Care Closer to Home' which is advocating this as the preferred option, where possible and appropriate.

Research demonstrates that individuals have better outcomes when there is a quicker response and rehabilitation and enablement care is provided in their own home when possible. Being an inpatient is not a neutral state and patients lose 5% of their functionality each day. Inpatients are also more at risk of hospital acquired infections and therefore supporting patients in their own home will always be the preferred option. We can already demonstrate that patients who require confidence building after a fall respond better when receiving these services at home instead of spending 4-6 weeks in an inpatient unit only to then have to have separate kitchen and stair assessments in their own home. The performance scorecard for Rehabilitation and Enablement services indicates that in 2013/14, 79% of patients receiving intervention from Community Therapy services required no further support and were independent after 6 weeks. This reduces the need for on-going packages of care. The patient and carer feedback and experience has been extremely positive. This was demonstrated by the Net Promoter score averaging 9.3 out of 10 in February 2014 and a 'Friends & Family' test of 100% in January 2014.

The Intermediate Care Team - IMC (part of the Rehabilitation and Enablement Team) manage rehabilitation programmes for patients at home who have been either discharged from an acute setting following an inpatient stay (early supported discharge) or who would otherwise require hospital admission. The patients that the IMC team manage have very similar health and therapy requirements to those patients who are admitted to Biggleswade hospital. The recent integration of the Rapid Intervention Nursing Team with the Rehabilitation and Enablement team allows the IMC patients to not only receive their therapy support at home, but also the non-complex nursing care that patients receive at Biggleswade hospital, giving patients opportunity to recover at home rather than in an inpatient setting, leading to improved patient satisfaction and outcomes.

To put into context the volume of care that is delivered to patients at home compared to the care delivered to patients in Biggleswade hospital in the table below:-

Area	Average number of admissions to caseload/month	Percentage of total caseload
Biggleswade Hospital	6	7%
IMC team Mid	31	37%
IMC Team South	45	54%
Total	82	100%

Please note that this activity does not include the work that is undertaken by the other Community Health Service Teams such as Community Nursing, Rapid Intervention Team, or Specialist Nursing Services which also support patients at home.

As a result of increased rehabilitation care packages at home, beds at Biggleswade Hospital have not been utilised as much.

There was some confusion around the increased provision of care at home and the bed reduction at Biggleswade Hospital and SEPT was issued a contractual performance notice by the Bedfordshire Clinical Commissioning Group (CCG). This was thoroughly investigated and the outcome was there was no case to answer for SEPT. However, there was recognition that communication could have been better. The 'performance notice' was removed and a joint action plan put in place.

2.0 ADMISSION CRITERIA

The admission criteria for Biggleswade Hospital were further reviewed in partnership with the CCG and local GPs. The CCG undertook a bed review which was to ascertain the inpatient bed requirements moving forward. This has now been superseded by the Healthcare Review currently taking place for Bedfordshire and Milton Keynes.

The admission criteria for the inpatient unit are attached in Appendix B.

The criteria was flexed over the winter period to include none weight bearing patients who require a longer rehabilitation period of rehabilitation from 4-6 weeks to 4-18 weeks. The flexed criteria also included patients waiting for continuing healthcare assessments, patients waiting for residential or nursing home placements and patients with a mild confusion.

The 2011 criteria are currently under review with commissioners to establish 2014 criteria to include patients who require lengthier periods of rehabilitation.

At the previous OSC meeting it was agreed that any anecdotal information would be forwarded to Stuart Mitchelmore, Associate Director CBC to discuss and investigate with Helen Smart, Director Adult Services. To date nothing has been received.

3.0 CURRENT POSITION

Irrespective of having reviewed and agreed the criteria and process for admission the use of the beds has remained low. SEPT and partners undertook an audit of patients who had a prolonged stay at Bedford Hospital to establish if the beds could be utilised better for a different cohort of patients based on need. At this point the criteria for admission were flexed further but the beds continue to be underutilised. The increased activity for caring for patients in their own homes is now stabilising at an increase of 38%.

A common theme in both local acute trusts is patients exercise choice and decline a bed at Biggleswade Hospital mainly due to its location and poor transport links.

Our view is the current bed capacity outstrips the current demand. It was hoped the commissioned bed review would establish requirements and changes moving forward.

	Nov 13	Dec 13	Jan 14	February 14	March 14
Patients admitted	9	8	11	19	12
Patients offered but refused bed at Biggleswade	5	1	2	7	6

As part of recent developments in relation to Winter Planning we have further reviewed admission criteria with all partners and flexed the criteria even further to include Local Authority patients however the bed utilisation still continues to be low.

4.0 CONCLUSION

As a provider SEPT are keen to provide services that are required and based on patient need.

Report prepared by: Richard Winter, Executive Director of Integrated Services, SEPT

April 2014

Appendix B

Bedfordshire Community Health Services

ADMISSIONS POLICY FOR IN-PATIENT UNITS

January 2011

Lead Post: Head of Service
Policy approved by: Clinical Governance and Risk Committee
Date Approved:
Recommended By Integrated Governance Committee
Ratified by NHS Bedfordshire
Review Date: December 2011

CONTENTS

Introduction

This policy sets out the required processes and standards for admission to the Bedfordshire Community Health Services (BCHS) in-patient units:

- Biggleswade Hospital
- Archer Unit
- BCHS funded beds in Tamar and Knolls Nursing Homes

It sets out the criteria for admission and promotes safe and clinically appropriate placement of patients within the Units. The objective is to ensure admission which is appropriate to the case mix, within the capacity and capability of the nursing and support teams, and safe to the individual.

This policy should be read in conjunction with other policies (see section 0)

Scope of this Policy

The purpose of this policy is to ensure that the community hospitals/intermediate care beds are used appropriately within the health economy.
This policy sets out the criteria and processes for admission to ensure effective working with partner agencies and clinicians, particularly General Practitioner (GP) and local acute hospital referrers.

This policy supports the role of the Clinical Services Manager and Bed Manager in the safe and satisfactory placement of patients, and the management of Bedfordshire Community Health Services (BCHS) bed capacity.

Key Principles

The following principles underpin the implementation of this policy.

- The safety, comfort and quality of care for the patient is the primary concern.
- BCHS has a responsibility to ensure that clinical accommodation is appropriately staffed and equipped to support available beds.
- BCHS is committed to ensuring that service users have a timely, appropriate and service user focused entry to BCHS services. The admission process is fundamental to achieving this aim.
- BCHS are committed to eliminating racism, sexism and all forms of discrimination. We will not discriminate on grounds of age, colour, disability, sexuality, ethnic origin, gender, gender reassignment, culture, health status, marital status, social or economic status, nationality or national origins, race religious belief.

Responsibilities

- Bed Manager acts as a link for all acute trusts and rapid intervention services regarding bed availability. Admission to beds in relationship to the Pending List, and is responsible for managing any delayed discharges within bedded units.

- Unit team leader / matron acts as the communication lead contact for patient access to bedded units. Manages the risk assessment process and suitability of patients within the multi disciplinary team. Manages multi disciplinary team meetings and is responsible for the devolution of responsibilities to ward staff in his/her absence
- **Pharmacist** – There is no dedicated pharmaceutical support to any of the inpatient units however Biggleswade Hospital can obtain telephone support from Bedford General Hospital Pharmacy and 3/12 check of controlled drugs and safe disposal of these all ordering is completed through BGH The Archer Unit can obtain telephone support from Boots the Chemist in Bedford. With any major concerns NHS Bedfordshire Pharmacists can offer advice...
- **Taymar and Knolls prescriptions are written by GP and sent to local pharmacist , who provides support** .
- **Clinical Services Manager** - To be responsible for day-to-day operational management of the inpatient services for clinical and non clinical areas of work. To work with the Head of Service to monitor clinical governance, risk management and budgetary control within the bedded units
- **Head of Service**- To be responsible for Strategic and service development, to agree with Partners, targets and monitoring of key performance indicators. Establish appropriate systems for ensuring effective governance systems are in place. To agree and review annual budget and spend to ensure cost.
- **General Practitioner** Biggleswade Hospital provides medical overview / assessment of patients on daily ward round. Prescribing of any medicines
- Archer Unit Service User's GP to be contacted by unit as is deemed necessary out of area patients are medically managed within SLA with local GP practice as deemed necessary.
- **Named Nurse** To provide evidenced based nursing care to a designated group of patients in line with the wishes and intentions detailed in the individual care plan and to regularly take charge of a group of patients in the absence of the person with continuing responsibility where appropriate to be identified named nurse.

Criteria for Admission

The admission procedures specific to each service must include clear, written referral criteria and this information must be available to potential referring agencies and to service users. BCHS will ensure that the key referral agencies are informed of the referral criteria.

Eligibility Criteria

- The patient is over 18 years old.
- The patient is medically stable as defined by clinical assessment and not requiring acute admission.
- The patient is registered with a GP who is registered with NHS Bedfordshire.
- The patient has rehabilitation needs with identifiable rehabilitation goals and the potential to improve functions and/or independence.

- The patient's mix of rehabilitation, medical and nursing needs, cannot be met in the range of services available in the community.
- The patient and family/carers have agreed to admission.
- The patient has the mental capacity to participate in and/or is able to benefit from the rehabilitation programme.
- Patient must be motivated to participated to take part in a rehabilitation programme.
- Clear discharge arrangements must be identified for the patient prior to admission.

All patients referred will be assessed against criteria.

Referral Process

Referral to the inpatient unit is either through:

- An acute hospital via discharge planning team.
- A General Practitioner for step up care
- Through an emergency presentation eg Onecall
- The BCHS Rehabilitation & Enablement Team
- Via Accident and Emergency department to avoid acute admission
- Via Community Matron
- Via Rapid Intervention Team

Referrals can be made by telephone and email, followed by letter and single assessment process (SAP).

Referrals are made to the Bed Manager, who must check whether there are any special requirements needed for the patient's admission. All referrals must be logged, including the date, time, referrer and patient details including diagnosis.

The Bed Manager has the right to refuse admission where he/she has assessed the unit as full, or the patient does not meet the criteria set out in section 5.

Documentation required for admission

From community setting

- Single Assessment Process (SAP) and Contact Assessment Form.
- Referral letter outlining current episode giving rise to admission.
- Summary of medical history including current conditions.
- Full current medication list.

From acute setting

- Comprehensive reports from Occupational Therapist/Physiotherapist
- Discharge summary, including infection status[1]
- Summary of medical history including current conditions
- Full current medication list on appropriate documentation
- SAP and Contact Assessment Form

[1] In line with infection control reporting policy, all uninformed infections will be reported back into acute hospitals via incident reporting and the infection control lead

Unplanned Admissions
All unplanned admission must have been triaged through the Onecall process, and a bedded unit assessed as the appropriate place of care.

When an inpatient admission is unplanned and relevant information is not available, a member of staff must be nominated to gather this information (as above) at the first available opportunity to ensure patient safety.

Procedure prior to admission

Prior to admission, and except in an unplanned admission, a member of the clinical team will be responsible for the referred patient and an assessment will be completed and documented in the patient's notes by the responsible clinical team member. The pre-admission assessment will include the following which the referrer must provide:

- A full medical history.
- Details of medications.
- Nursing and therapeutic requirements.
- Full assessment provided by Occupational Therapy, Physiotherapy and any other clinicians involved in the assessment or care of the patient.
- MRSA/C.Difficile status (Where appropriate)

An admission date will be provided, and if no bed is immediately available, the likely waiting period will be explained to the referrer and the patient/carers.

Admitting decisions will remain with the units. This will ensure that dependency remains within safe parameters allowing the identified health needs of the new admission to be met without compromising both the existing patients and staff on the unit.

It is the referrer's responsibility to arrange transport to the unit.

It is the referrer's responsibility to ensure that the client has all relevant medications with them on admission.

Information for the patient

Patients must be given information about their planned assessment and treatment. It is responsibility of the admitting nurse to ensure this is done. This information will be given verbally and supported with written information. The information will include:

- The name of the named professional/key worker.
- Information about the specific condition/diagnosis.
- Information about the assessment process.
- Information regarding bringing own drugs to the Unit
- Information about treatment/management plans, including medication.
- The estimated date of discharge.

Written information may be in the form of leaflets prepared by the clinical team or be provided by an external organisation. In either case the clinical teams

within the service areas must ensure that the information is relevant and up to date.

Information for patients and carers/relatives

Services which operate on an inpatient basis must provide written/ verbal information for service users, their relatives and carers. This will include:

- Information on how to get to the unit by car or public transport.
- Information about visiting times and access to telephones.
- Advice about suitable clothing to bring.
- Advice about electrical equipment (to meet Health and Safety requirements).
- Information on what to do in an emergency e.g. a fire.
- What must not be brought into the unit (e.g. alcohol, illegal substances).
- Discharge process and estimated date of discharge

Process on admission

General procedure

The Ward Manager is responsible for ensuring that appropriate arrangements are made to admit the patient, including any arrangements for special needs, including language, dietary requirements, mobility, cultural or communication needs.

On admission the patient and their carers/relatives, if appropriate, must be greeted by a designated member of staff.

The patient should be orientated to the unit and the staff, including toilets, and the nurse call system. Information must be provided on accessing information, the advocacy service and the housekeeping arrangements.

The ward routine must be explained, including meal times and visiting times, and any arrangements for an emergency.

The policy for screening patients on admission to BCHS inpatient beds for Methicillian-resistant Staphylococcus Aureus (MRSA) must be followed.

Patients with Communicable Infections

Patients with a known or suspected infection, which poses a risk to other patients, must be cared for in a single room with full isolation precautions.

An incident form must be completed, in accordance to NHS Bedfordshire's incident reporting procedure, for all uninformed infections; these will be reported back to acute hospitals via incident reporting and the Infection Control Lead.

Assessment processes, including risk assessment

The assessment of the patient must be conducted using Waterlow score and following local guidelines. to be found in the single assessment process.

The patient must wear a wristband throughout their admission detailing their full name, date of birth and NHS number.
Registered nurses are responsible for initial and continuing assessments of patients, and for recognising and acting upon changes in the patient's condition including:

- Moving and handling assessment .
- Malnutrition Universal screening tool (MUST).
- Morse Falls risk assessment tool.
- Waterlow score.
- Observations including Blood pressure, Pulse, respirations.
- Risk of falls assessment
- Top to Toe assessment.
- Slipper exchange.

Medicines management

General issues

It is the responsibility of the admitting nurse to ensure that the GP is aware of all admissions.

Medicines Reconciliation (ref. 1)
Comprehensive medicine reconciliation must be completed within 24hrs of admission by the admitting GP and any medicines prescribed written up on the patients Prescription & Administration Record chart. This will include a comprehensive comparison of the patients own medicines brought in, the information given by the referrer and by patients relatives or carers.

A pharmacist shall be involved in medicines reconciliation for each patient as soon as possible after admission for each patient.

Any discrepancies found, by the admitting nurse, GP or pharmacist will be confirmed and recorded. Any drug allergies and their effect shall be identified and recorded on prescribing documentation.

Patients will be assessed for their ability to manage their own medication safely where appropriate.

Patients are encouraged to bring their own medication, which must be checked by the GP and the pharmacist, for identity, quality and integrity.

Supply of medication

Further supplies of medication are obtained as follows:

Archer Unit
Prescription is faxed to Boots the Chemist in Bedford and delivered with in 24 hours to the unit. No stock is held on the unit.

Biggleswade Hospital
Stock is ordered weekly from Bedford Hospital Pharmacy and a limited stock is held on the ward including controlled drugs.

Tamar Nursing Home (BCHS funded beds)
Prescriptions are written by GP and sent to local pharmacist

- Prescriptions are copied prior to sending medicines checked by two nurses on return.

Knolls Nursing Home (BCHS funded beds) **prescriptions are written by GP and sent to local pharmacist to supply**

In all cases items received must be checked against the prescription by the named nurse, who must also contact the dispensing pharmacist if any discrepancies are noted.

Storage of medicines

All medicines must be stored in their original packaging, and must never be decanted to another container

All controlled drugs must be entered into the Controlled Drugs Record Book and kept locked in the designated cupboard.

Medicines storage varies at each of the units, and will include bedside cabinets, medicines trolleys/cupboards and medicines fridges. In all cases the storage must be lockable, and kept locked when not in use. Local procedure must be followed within each unit. A registered nurse ensures safe administration of medication to patients and records this, or the reasons for non-administration, on medicines administration chart.

Clinical records

General standards

- Registered nurses must adhere to their professional standards of record keeping.
- Documentation specific to individual in patient units must be completed as required following local policy regarding record keeping.

Procedures in event of local health community bed pressures

Emergency Team Meeting

The Head of Service or Clinical Services Manager may, at any time, convene a meeting of a Bed Emergency Team in order to agree action to be taken to place patients safely and appropriately.

The Bed Emergency Team consists of:-

- Bed Manager
- Clinical Support Managers
- Unit Team Leader
- Head of service
- Discharge Co-ordinator

- Rapid Intervention Team

The role of the team is to agree actions to be taken over the prospective 24 hours period, and beyond, in order to accommodate admissions and to support acute hospital escalation policy. The team will rely extensively on the guidance of the Bed Management Team and their awareness of the overall capacity situation.

The Bed Emergency Team will attempt to balance clinical risks for all patients and across all services, giving particular consideration to prioritising the appropriate care of patients in the A&E Department, AAU and appropriate safe discharge.

Where there is a possibility of avoiding admission from A and E to the acute trust. The community beds will endeavour to offer a bed ASAP. In hours the bed manager will liaise with the units . Out of Hours, A and E should ring the units directly to secure the bed.

Bed Capacity and Bed Closure

It is essential that BCHS keep as many of its inpatient beds open as possible. From time to time it may be necessary to close beds because of such things as infection outbreaks estates issues and staffing shortages below safe levels.

If closure of beds is being considered the BCHS Bed Closure Guidelines must be followed. The policy requires that any closure must be authorised/ratified by the relevant Head of Service or their deputy, and must notify the Chief Operating Officer and Commissioning Lead. The Bed Management Team must be advised of any bed closures immediately.

Before any bed closure all possible solution would have been explored including redeployment of community nursing/rehabilitation staff to the bedded units.

Additional Beds

Where safe to do so, BCHS will support, within a county-wide escalation policy, the opening of additional beds when:

- Delayed discharges are highlighted.
- Staffing levels with the unit are at an optimum level to support safe discharge/care of patients.
- The whole systems escalation policy identifies amber/red status and these beds can safely support discharge of medically fit patients.
- The Chief Operating Officer (or his/her deputy) must authorise the opening of additional beds which are funded above the core contract per open bed day.

Related documents

This policy should be read in conjunction with other BCHS policies and legislations, including:

- Consent Policy

- Data Protection Policy
- IT Security Policy
- Infection Control Policy
- Incident Reporting and Management Policy
- Records Management Policy
- Medicines Management Policy
- Risk assessment Policy
- Service Continuity Plan
- Health and Safety Policy
- Moving and Handling Policy
- Discharge Policy

Document Replaces

Admission Policy for in-patient units 2009-2010

Review of this policy

The range of inpatient beds within BCHS and the way they are used is always changing. Any changes will require that the Admissions Policy is reviewed and updated accordingly. This version of the Admissions Policy (January 2011) should be reviewed no later than December 2011.

Reference

1. NICE & NPSA Guidance NICE/NPSA/2007/PSG001: Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. December 2007