# UPDATE ON THE TEMPORARY CLOSURE OF CHARTRIDGE WARD AT AMERSHAM HOSPITAL

## FEBRUARY 2020

**Ben Collins, Deputy Director of Integrated Elderly and Community Care**

## 1. Summary

In response to the CQC imposing conditions of registration on BHT's community wards, Chartridge ward has been closed to admissions since 1 July 2019. A suite of service improvements have been introduced to ensure a high quality service can be provided with our community inpatient capacity reduced by 22 beds.

Stakeholders including primary care, Bucks Clinical Commissioning Group, Frimley Health Foundation Trust and Buckinghamshire County Council have been engaged throughout the process. Public workshops were held in October 2019 and January 2020.

This paper proposes that the current service model - with no inpatient beds in Chartridge ward and improved care in the community and enhanced therapy and geriatric consultant support to the acute site - continues. In addition, a rehabilitation service will be considered as part of an engagement process from which will take place during Quarter 1 of 2020 around plans for delivering community health and social care services across Buckinghamshire.

## 2. Background

Buckinghamshire Healthcare NHS Trust is on a journey to achieving an 'Outstanding' overall rating from the Care Quality Commission (CQC), and we are particularly proud that the CQC has rated us as 'Outstanding' for being caring.

However, the CQC identified the challenges of providing sustainable safe, effective care in the Trust's community inpatient wards in its 2019 report.

In response to this, on 1 July 2019 the Trust temporarily closed Chartridge ward in Amersham Hospital to concentrate staff across two community inpatient wards, rather than three, to deliver a safer and more effective model of care.

The aim is to help people avoid a hospital stay, or, if they do need to be admitted, to help them to return home as quickly as it is safe to do so, to continue their recovery in the comfort of their own homes.

Whilst we have continued to try to recruit staff to enable us to reopen Chartridge Ward, we have also been working with members of the public and other health and social care providers to develop a safe, effective and sustainable alternative model of care, should we be unsuccessful in our recruitment drive to reopen the ward. This paper describes the outcome of this work, and our current thinking about the future based on:

- What is best for patients from a clinical and patient experience point of view;
- What is best for staff;
- What is best for the system as a whole;
- What we have heard from our stakeholders; and
- How we make the best use of the resources we have available.

This has been developed within the context the NHS Long Term Plan[1] which outlines improvements to urgent community services over the next five years in the following areas:-

- Expansion of Urgent Community Response services to operate seven days a week 24/7;
- Delivery of the new national standards for Urgent Community Response (within 2 hours for urgent care and 2 days for accessing intermediate care/reablement services); and
- Partnership working with Primary Care Networks to develop new service models of Anticipatory Care to help people stay well and fully implement the clinical domains of the ageing well guidance[2] (as provided in the NHS Long Term Plan).

## 3. Service Improvements

The following actions have been taken since the temporary closure of Chartridge Ward to improve patient outcomes and help them to either return home as quickly as possible or to avoid a hospital admission in the first place:

- We have recruited two more therapists and three rehabilitation support workers. This is helping us to provide more comprehensive rehabilitation, including delivery of therapy at weekends. Further recruitment is in progress and shortlisting has been completed for five further physiotherapy posts in community and acute settings.
- We have increased therapy available to patients in their homes:
    - Our Rapid Response Intermediate Care (RRIC) service provides physiotherapy, occupational therapy and care within 2 hours, for up to six weeks. Patients can receive therapy up to three times daily, seven days/week. The RRIC service has had an average caseload of 196 patients at any one point in time during 2019/20.
    - Our Community Physiotherapy Service maximises patients' independence at home, for longer term patients. The RRIC service has had an average caseload of 564 patients at any one point in time during 2019/20.

  Both of these services work in close partnership with Buckinghamshire County Council's Reablement and Adult Social Care teams.
- We have an additional elderly care consultant in A&E for two hours every day to identify those patients who do not need to be admitted and to ensure the relevant support is put in place to enable them to go home.
- We are introducing seven complex care managers to community nursing. These complex care managers specialise in helping patients with multiple long-term conditions to stay in their own homes. In addition to current district nursing staff, these roles will enable us to support and look after patients who need a high level of care in the community. We have appointed to six out of the seven roles planned and these managers are currently developing their caseloads.
- We have provided an additional six hours of specialist elderly care consultant support for our elderly patients on our general surgery wards at Stoke Mandeville Hospital. As well as providing specialist geriatric support to emergency laparoscopy patients, these consultants are also part of a multi-disciplinary ward round, which has been

[1] NHS England Long Term Plan: https://www.longtermplan.nhs.uk/
[2] NHS England Long Term Plan Ageing Well: https://www.longtermplan.nhs.uk/areas-of-work/ageing-well/

shown to improve outcomes and reduce mortality. This contribution has been described as 'vital' by the surgical leads. As a direct result of this, BHT has some of the highest levels of postoperative elderly care support in the Thames Valley Region, and is a positive outlier according to the National Emergency Laparotomy Audit (NELA).

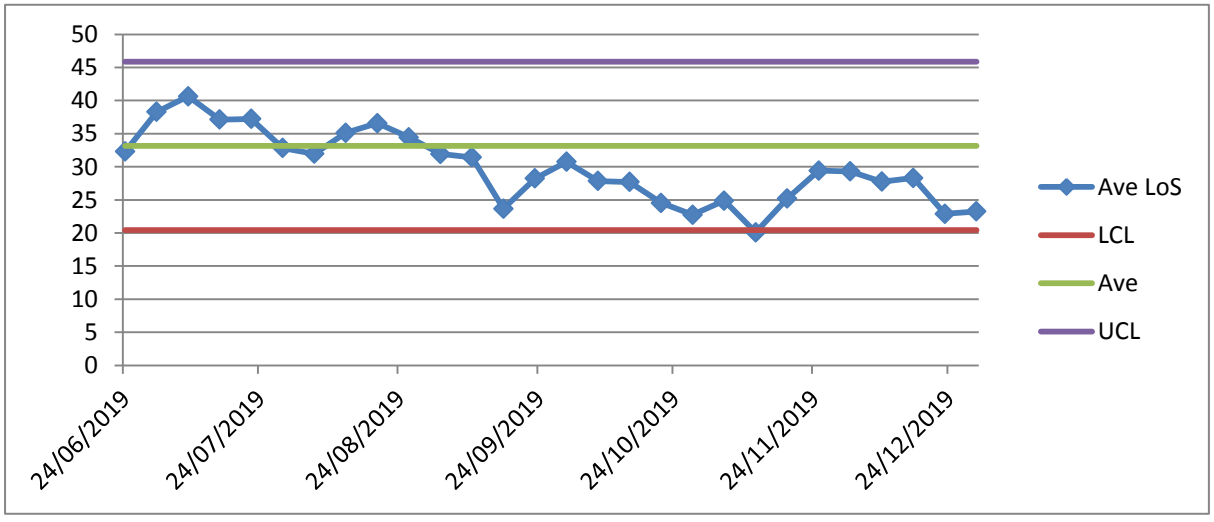
- We have established a Community Assessment and Treatment Service at Amersham two days a week. This service assesses frail, elderly patients in the community and puts in place additional support to enable them to remain independent and at home, avoiding a hospital admission.
- We have extended the hours that GPs and other health care professionals can contact a specialist geriatrician and receive immediate advice and support to help patients receive appropriate care in the community.
- We have recruited to one of the two additional physiotherapist posts to enhance the Early Supported Discharge Orthopaedic Service and are actively recruiting into the second post.
- To enhance our support for patients over the winter, we have:
    - Provided 6 beds for non-weight-bearing patients in Lakeside care home;
    - Supported Adult Social Care to provide rehabilitation beds in Fremantle care home; and
    - Opened 10 temporary rehabilitation beds in Wycombe Hospital for patients who are stepping down from acute care.

## 4. What The Benefits Have Been For Patients

### 4.1. Length of Stay

Length of stay on Waterside Ward has dropped significantly, with 8 data points[3] since 23 September being below the average. The increased number of permanent staff, including therapy provision at weekends, has supported patients to be discharged and return home sooner compared to the previous model. The average length of stay for our patients in July 2019 was 37.2 days and in December 2019 it was 26.3 days.

**Chart 1. Average Length of Stay of patients on Waterside Ward, measured weekly.**




[3] No data was available for the week beginning 18 November 2019.

## 4.2. Community Beds Waiting Lists

Charts 2 and 3 show the number of patients waiting for community beds in Buckinghamshire. Chart 2 shows the number of BHT patients waiting and Chart 3 shows the number of patients in Wexham Park Hospital waiting for community beds in Buckinghamshire.

**Chart 2. Number of patients in BHT waiting for Bucks community beds.**

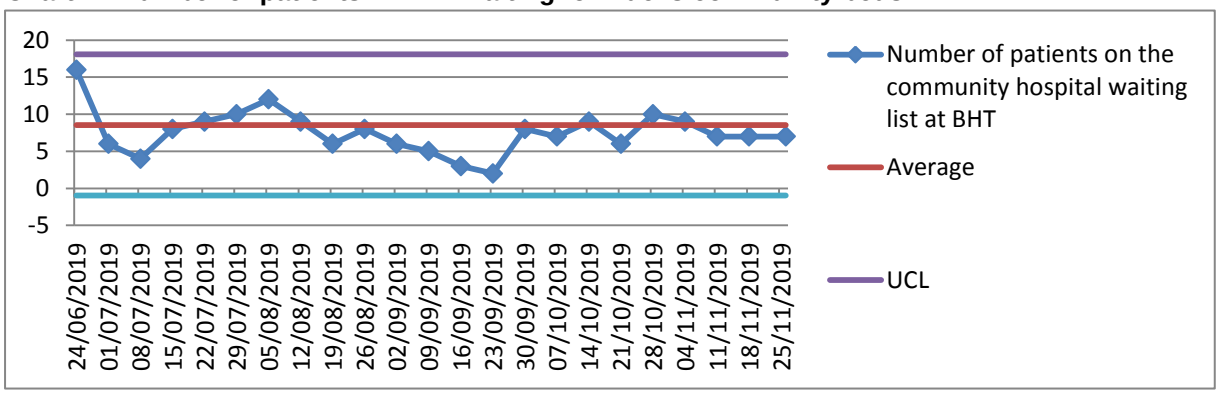
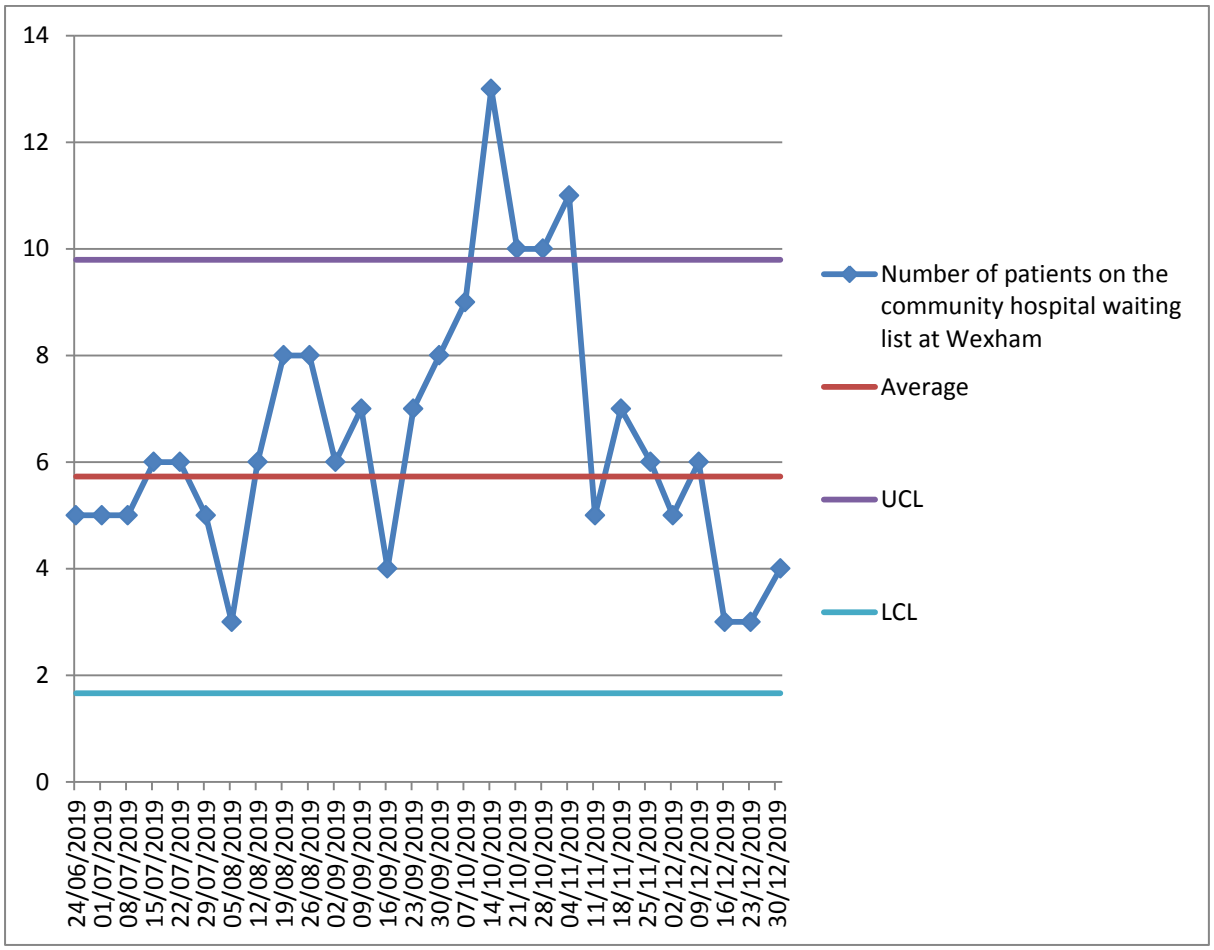



**Chart 3. Number of patients in Wexham Park hospital waiting for Bucks community beds.**

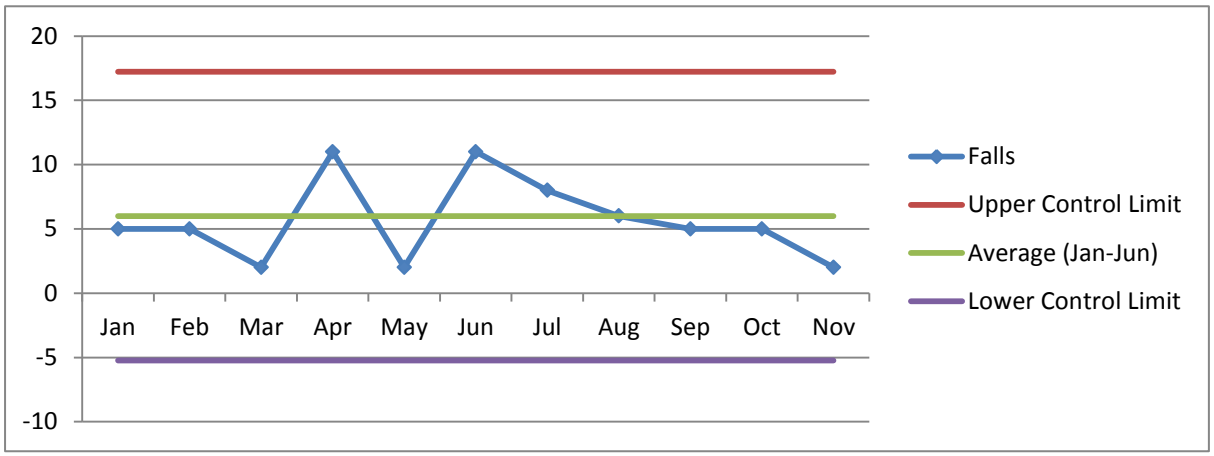


### 4.3. Safety

- **Pressure Ulcers.** No Grade 3 or 4 pressure Ulcers have been deemed Serious Incidents since March 2019.

- **Falls.** Chart 4 shows a downward trend in falls on Waterside ward since staff from Chartridge were redeployed there:

**Chart 4. Falls on Waterside Ward.**




### 4.4. Flow

The two community wards in Amersham – Waterside and Chartridge – had a combined capacity of 46 beds, of which 10 were allocated to Wexham Park hospital for the step down of south Bucks patients, and typically 6 beds were occupied by amputee and non-weight bearing (NWB) patients. These patients typically have a very long length of stay.

Closing Chartridge to admissions reduced the capacity by 22 beds to 24. The amputee and non-weight bearing admissions were redirected to Ward 8 (Therapy and Nursing Led Unit) in Stoke Mandeville, effectively freeing up 8 beds in Amersham.

The impact this has had on patient flow in BHT, is a reduction in step down capacity of c.11 patients/month, when comparing Sept-Dec 2019 to the same period in 2018 (Table 2).

**Table 2. Patient Flow through Amersham Hospital Community Wards.**

| | Waterside and Chartridge, Sept-Dec 2018 | Waterside, Sept-Dec 2019 |
|---|---|---|
| **Average monthly inpatient admissions** | 30.75 | 20 |

Furthermore, readmission rates among the group of patients who would most likely be referred to a community inpatient ward as part of their care have shown a downward trend from 17.7% in the three months prior to the temporary closure of Chartridge Ward, to 15.7% in the three months since the closure.

## 5. Stakeholder Engagement.

### 5.1. Work with Health and Social Care Partners

Our aim is to help patients to return home as quickly as it is safe to do so following an inpatient stay. A Discharge Coordinator and Social Worker attend the Daily Facilitated Meetings (DFMs) on the ward – a forum where doctors, nurses, therapists and social care staff meet to plan each patient's care and discharge arrangements. Actions are reviewed in weekly meetings along with the next steps required to move the discharge plan forward. Social workers are present at Buckingham Community Hospital ward twice a week, with one of these being the weekly discharge meeting.

Waterside is covered medically by a consultant geriatrician and GP trainees and Buckingham Community Hospital ward by GPs provided by the Swan Practice. There are good working relationships between the medical and non-medical staff. Out of hours, GP cover is provided by the 24/7 primary care services across Buckinghamshire.

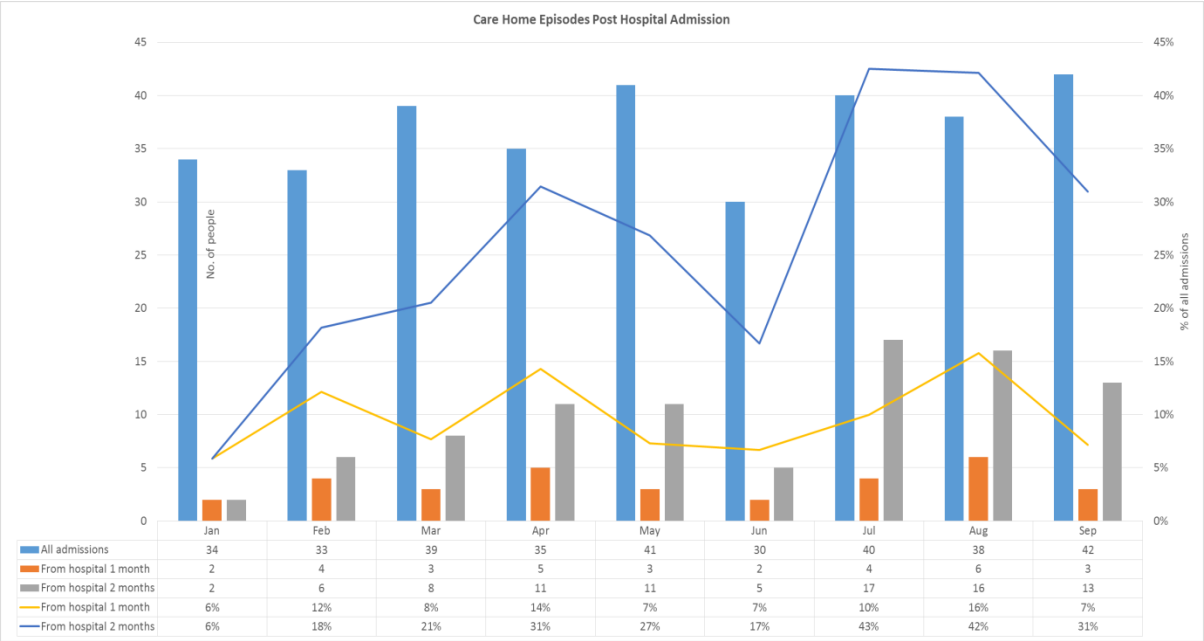
In addition to this work, Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council (BCC) are working closely together on a number of areas to improve services for our patients. These include:

- An Integrated Discharge Team, based at Stoke Mandeville Hospital, where the hospital social workers and BHT discharge team are working as one team to support patient discharges and flow through the hospital;
- An Integrated Single Point of Access (SPA) to make it easier for community health and social care services to work together. The team within the Integrated SPA will be staffed by Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council;
- Social workers are permanently based at Amersham hospital and at Buckingham community hospital ward twice a week. This is a strength-based approach with a 'home first' philosophy.

Chart 5 shows that there is no particular trend for people being admitted into long term residential or nursing placement on discharge from a hospital setting or within 30 days of their hospital episode.

However, it does show that since January 2019, there has been an increase in the number of people being admitted to long term residential or nursing care post a hospital episode; up from 5% in January to 30% in September and in some months in excess of 40%.

**Chart 5. Post Hospital-Admission Care Home Episodes**




| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
|---|---|---|---|---|---|---|---|---|---|
| All admissions | 34 | 33 | 39 | 35 | 41 | 30 | 40 | 38 | 42 |
| From hospital 1 month | 2 | 4 | 3 | 5 | 3 | 2 | 4 | 6 | 3 |
| From hospital 2 months | 2 | 6 | 8 | 11 | 11 | 5 | 17 | 16 | 13 |
| From hospital 1 month | 6% | 12% | 8% | 14% | 7% | 7% | 10% | 16% | 7% |
| From hospital 2 months | 6% | 18% | 21% | 31% | 27% | 17% | 43% | 42% | 31% |

## 5.2 Public Engagement

### First Public Workshop, 9 October 2019

We held a workshop attended by 33 people and a wide range of participants. Participants were asked to consider the challenges and opportunities of the following scenarios:

> **Scenario 1.** Continue to try to recruit staff to enable us to re-open Chartridge Ward, returning to the previous model of care.
> **Scenario 2.** Continue to develop the model of care, which has been put in place since the temporary closure.
> **Scenario 3.** Open some beds on Chartridge Ward for patients who are well enough to go home but are awaiting onward care or improvements to their home.

The consensus was that people should be supported at home and in the community. There was recognition that staffing challenges mean that reopening the ward at Chartridge is not an option at present, and therefore Scenario 2 - enhancing the services already under way - was the preferred option.

Additional concerns were expressed regarding the availability of acute beds for seriously ill patients at Stoke Mandeville and, with the onset of winter, how additional acute beds could be freed up/created to relieve the pressure on A&E and mitigate the perceived impact of the closure of the ward in Amersham.

### Second Public Workshop, 8 January 2020

The 13 participants were presented with data and outcomes of the work to date. They felt that the Community Assessment and Treatment (CATS) service, along with the enhanced therapy being provided at Amersham hospital, and the care being given to patients at home

was helping patients get out of hospital and back to an environment they were familiar with and more comfortable in: their homes.

Amersham Hospital will continue to offer the CATS service and additional therapy services. Suggestions from this workshop, and further discussions about additional services, will continue internally and with external stakeholders.

Concerns were expressed with regards to transport within the community and ensuring patients had to ability to get to Amersham should they need to. It was suggested more work should be done with Buckinghamshire County Council and the local CCG to address this issue.

It was also suggested that the Trust continues to monitor the impact closing Chartridge ward has on the system in general. Whilst at the moment the data shows positive results in terms of reducing length of stay and maintaining waiting list for community beds, attendees wanted to ensure this continued to be monitored for a longer period of time.

**5.3 What do our patients say?**

A total of 23 recent or current Amersham community ward patients were interviewed in two surveys, in September and December 2019, giving a snapshot of patient experience:

**September Survey**

Prior to the closure

- Most patients felt that they would have benefitted from more physiotherapy.
- Patients felt that short staffing led to delays in staff responding to patients.

Since the closure

- Patients felt that the physio they were receiving was in line with their needs; some felt that a 7 day-a-week service would be better.

Generally

- Patients wanted to be at home, but felt that they needed to be in hospital due to the nature of their condition.
- Eleven out of thirteen patients either had a domestic care package in place, or had one scheduled for their discharge.

**December survey**

- Patients are receiving consistent physiotherapy, which is an improvement from the feedback from our September report where a number of patients who had been discharged had not felt they had received the amount of physiotherapy they needed.
- Most patients felt that Waterside was the right place for them due to the level of injury or illness they had experienced.
- The addition of an activity co-ordinator has been much appreciated by patients, and all patients are encouraged to take part in activities.

- The two areas patients felt could improve the service further were having consistent, prompt response to call bells, and more staff at night.
- Nearly all of the patients we spoke to were, or had been, able to return home with carers coming in to assist.

## 6. Next Steps for Chartridge Ward

Whilst we are continuing our recruitment drive for our community hospitals, there are still challenges in terms of being able to safely and sustainably staff inpatient care in Chartridge ward. However, there are still options for using the clinical space to give patients a better experience and outcomes, whilst supporting acute services. A new CATS service in the Chartridge space is currently operating for two days/week, and is seeing a steady increase in activity, helping people to avoid a hospital admission.

In addition to the CATS service, the following options are being considered to develop Amersham as a specialist rehabilitation centre:

- **A joint Community Neuro Rehab Service (CNRS)/Community Head Injury Service (CHIS) clinic:** This could also offer efficiencies by being co-located with Bucks Neuro Rehab Centre. CHIS needs a South Bucks base to improve access for patients and work more jointly with CNRS as part of overall service development.

- **Out Patient Antibiotic Treatment (OPAT) clinic:** A clinical setting where patients can receive IV antibiotics could benefit our community OPAT team by cohorting patients in Amersham, and also provide an environment to which SMH inpatients awaiting IV antibiotics could be safely discharged more quickly.

- **Explore community rehabilitation services:** We will continue to explore whether some bedded facilities can be provided at Amersham subject to the ability to recruit staff.

## 7. Conclusion & Recommendations

Since closing 22 beds in Amersham hospital, care closer to home has developed and the number of therapists has increased. The overall quality of care continues to improve: services are safer than before the closure and length of stay has decreased on Waterside Ward. In terms of flow, step-down admissions have decreased by only 11 admissions/month, but we are providing a better patient experience, reduced length of stay, and no increase in community bed waiting times.

The changes described here have provided a platform for wider and sustainable changes in the model of care across Buckinghamshire. The Integrated Care Partnership will be engaging partners and the population on the future shape of primary and community services during Quarter 1 of 2020.