Oxford Health NHS
NHS Foundation Trust

NHS
Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

Proposals for future services at Townlands Hospital

Answers in Response to Questions from the Townlands Steering Group 9 June 2015

Question 1

What are the current bed usage figures for Peppard Ward?

What happens to patients who would have been admitted to Peppard when the new model is implemented?

Currently in any one month, there is an average of between six and seven people from the Henley area in beds in Peppard ward This number varies from four (July 2014) to 14 (August 2014)

This analysis is based on postcodes RG4, RG8 and RG9 and represents the combined number of patients transferred from the John Radcliffe Hospital and the Royal Berkshire Hospital to Townlands Hospital.

More detail on these calculations can be found on page two of the document *'Modelling Step-Up and Step-Down beds in Henley'* .

Data from Abingdon and Witney EMUs shows that providing a model of care similar to that proposed for Townlands resulted in:

80% of patients being supported to go home the same day

10% being admitted to a step-up bed similar to those proposed for Henley

10% of those seen were so ill they needed to be admitted to an acute bed.

Our calculations lead us to believe that we are likely to need between five and eight step up/step down beds to support the new ambulatory model of care in Henley. Should the proposed model be taken forward, we would expect there to be a further level of more detailed analysis and modelling as we would normally do in the development and commissioning of any new service

A more detailed explanation is in the paper we have provided.

Types of Bedded Care

It may be helpful to explain here the different types of bedded care and how that will change as the ambulatory care model helps us to prevent more people from needing to be admitted in an emergency situation.

The type of care currently provided in the Townlands Hospital is called **General Rehabilitation/Re-ablement** – this is care provided following a period of treatment in an acute hospital (such as the John Radcliffe or Royal Berks). The care a patient receives is designed to prepare someone to be able to continue their recovery and function at home following discharge.

To support the **Ambulatory Model** we will need **Step Up beds** that will provide care for patients experiencing a new episode of illness, who are in crisis, are unsafe to be cared for at home and need a short period of bedded care as to aid their recovery.

We will also need **Step Down beds** for people on a discharge pathway of care from an acute setting.

These types of bedded care also need to be distinguished from **Intermediate Care beds** that provide basic nursing care for people who are too ill to manage their own illness at home and need observation and support for a short period to promote their recovery.

We would anticipate that initially we will be using more step down beds than step up beds but, over time, as we see the benefits of the new model that will change and we anticipate we would need more step up than step down care.

Examples of how the new model might work:

Mrs B

MrsB, is 82 and lives alone with care package support 2 times a day (getting up and dressing, helping to bed and administering medication. Neighbour and family help with meals). Becoming more frail. Up until a week ago was able to get up round the house and make herself a cup of tea. Now she is very reluctant to get out of her chair. GP visits and can see that Mrs B's situation is deteriorating. House smells strongly of urine. He arranges for her to be seen next morning in the RACU. A dedicated ambulance comes and collects her. Tests done in the unit reveal that she has a urine infection. Blood tests analysed on site show that she is dehydrated. The consultant reviews her and stops some of her medicines as they may be making her more prone to dehydration. She commences a course of antibiotics and is given some IV fluids by drip. As the day goes on and she rehydrates, she feels much better and wants to go home. The clinic arranges return transport and the integrated locality team arranges for her to be reviewed that evening by a nurse. The social care team linked to the clinic temporarily increase her care package to three times a day for the next week. Provision is made to bring her back to the RACU in 2 days' time for review if necessary. In the event, it is not necessary as she is feeling much better.

Mrs P

Mrs P, 92, is visited by her GP. She lives with her husband but she has been falling almost daily and he is concerned that it is unsafe for her to remain at home. The GP arranges for her to be seen the next day by the RACU. Blood tests are normal but

her blood pressure is very low. The consultant at RACU finds that while her blood pressure is normal when she is sitting down, it drops when she stands up. He stops some of her medication and arranges for her to be admitted to one of the beds in the neighbouring care home for observation. 2 days later he finds that her blood pressure no longer falls when she stands and that she has lost that feeling of being light headed when she stands up. There have been no more falls. She returns home and is reviewed twice in the next week by the district nurse from the integrated locality team. She remains well.

What is the rationale for not considering the option of locating the 18 bedded ward on the 2nd floor

Our proposal for ambulatory care, the way this model will use beds and our calculations for how many of these new types of beds will be needed mean that an 18 bedded ward would not be needed as part of this new model.

We are confident that we can provide the ambulatory care model from the 1st floor along with the step up/step down beds that we plan to commission from the Order of St John Care Home

In the period from the closure of Peppard until the Order of St John care facilities are ready for use (April 2016) we will ensure that patients receive the care they need from the provider that is most able to meet their individual need.

What evidence is there of the benefits of Emergency Medical Units (EMUs) in Oxfordshire (e.g. Witney, Abingdon)

Evaluation of the first year of the Witney EMU showed that the number of patients being referred doubled.

The average age of patients being treated through the EMU was 70 - 80 years old, with the majority of referrals from primary care (76%). The second largest referrer was South Central Ambulance Service (8%).

The four most common conditions people were referred for were:

- Heart failure
- Skin infections
- Anaemia
- Acute Chest infections

Those who were part of the ambulatory model attended for:

- Infections such as urinary tract infections (UTIs), cellulitis, pneumonia, gastroenteritis
- Anaemia

The service has proved popular with patients with 88% of those being seen being extremely likely or likely to recommend the service to friends and family.

GPs too have found the service works well with 33% of GP's likely and 67% extremely likely to refer patients through this system in the next month.

Initial analysis of the data to 2014 indicate that practices referring to an EMU have not seen an increase in older (65+) patients being admitted to medical specialties at the John Radcliffe Hospital, compared to practices in other parts of Oxfordshire such as Oxford City and the North East of the county.

For this particular analysis, we compared annual admissions post EMU with the year prior to the start of EMU. The increase in other areas varies between 28% and 17%, whereas for the EMU referring practices the increase is just 5%.

Based on this evidence it appears that EMU model of care helps to minimise the rise in acute admissions (consistent with data from other areas e.g. Plymouth).

However it is important to understand that we are not looking to fully replicate the EMU model in Henley rather we are proposing to deliver the Rapid Access Care element of an EMU service through the new hospital.

There is ongoing evaluation of the EMUs that will help us shape the ambulatory nature of the Townlands care model.

Question 2

How will adult social care respond to this new model of health care?

Social care working with health care in Henley

Oxfordshire County Council has prepared a paper to help describe the way that social care services and professionals will support the proposed new model of health care in Henley.

Oxfordshire County Council and the Oxfordshire Clinical Commissioning Group fund and support a wide range of services which people can use to stay safe and independent at home. At different times and for each individual, these will be the right services for people who are receiving health care in the new ways proposed for Henley. As the Integrated Locality teams develop across Oxfordshire, professionals working together around each person will become simpler.

Examples of these services are:

Discharge to Assess - a service which can help a person get home from hospital without waiting to have a full assessment first.

Good Neighbour Schemes - groups of volunteers, supported by the council, who provide all kinds of informal help for people, such as transport, or visiting for a chat.

Community Information Networks - people who can tell you what is available locally

Assistive technology - for example alarms to call for help in an emergency; talking food labels; GPS (satellite) devices to help find somebody who has got lost.

Crisis Response service - gets out to people straight away to help them avoid going into hospital or a care home.

Support at home - help with day-to-day tasks such as washing, eating, dressing and using the toilet - now bought by the council through block contracts with agencies so that it is more secure.

Carers Oxfordshire - information, advice and support for people who care for a family member, friend or neighbour.

Re-ablement - a service to help people relearn how to manage independently after an illness or injury.

Rather than describe in detail how each of these services work from the point of view of the service we have prepared some stories about how it could work for you or your family, friends or neighbours.

They are not stories about real people but they might help to picture how the new way of providing health and social care could work. The full paper has a number of examples but let me take you through one example.

Mrs Smith

I live on my own. I had a fall a few months ago and I ended up being admitted to hospital in Reading. I developed a urinary infection and it took me a few weeks to get back home. I am lucky I have a neighbour who looks out for me and she popped in with a meal every day for the microwave, but I have never felt quite my old confident self since then.

Then last week I fell and broke my wrist outside the supermarket. I felt dizzy and disorientated and I lost my footing and fell. I had been having a lot of dizzy spells recently and had been feeling quite nervous about going out on my own. It was a very different story this time. Someone from the supermarket came out to help me, and he walked round to Townlands with me. We went straight to the Minor Injuries Unit where my wrist was x-rayed and treated. The doctor there suggested I should go to the Rapid Access Care Unit to see if there was more going on and causing my dizziness. The Unit is also in Townlands so I went straight there. They did some tests straight away and found that my blood sugar was very low and my blood pressure was high - both of these things could have explained the dizzy spells and there is a possibility I have diabetes. They sorted out treatments there and then and arranged for me to see my GP next week to monitor everything.

I was introduced to an Occupational Therapist who is based at Townlands. She came to my house later that week and we talked about what might help me be safer at home - I've got some material to stop the rugs slipping on my floor, some rails are going to be fitted by the stairs and in the bathroom. I have an alarm with a button to press to let someone know if something goes wrong. I feel so much more confident. I

thought I would have to wait to see a social worker to find out if I can have any help at home, but the Occupational Therapist was able to ask me about my needs. It turns out I am able to have support and care arranged through the council (I am 'eligible').

The Occupational Therapist gave me a form to fill in about my finances and my neighbour has helped me with it. I might have to pay towards my care. While the care is arranged I have some carers coming in for a few weeks to help me do things I can't do with only one arm working, and to help me get back my strength and confidence, and learn to manage while my wrist heals. ('Re-ablement'). I might not need to continue to have care when my wrist gets better. If I have diabetes there are a few appointments to make at Townlands. There is a clinic for people with diabetes and a group meets to talk about how to manage your diet. There is a podiatry clinic I can go to - it's important that I look after my feet.

Quantify the impact on community health – are more district nurses, physiotherapists required?

Experience in Witney and Abingdon shows that existing teams were able to pick up and manage the care of those patients discharged home following treatment.

The type of care proposed for Townlands provided aims to detect complications early before they become critical so those referred to the community teams would be seen at an earlier stage of their illness enabling us to maintain their independence better.

The patients cared for through the proposed model of care will not be as sick or dependant as those seen in the current EMUs across Oxfordshire

Some of the staff who are providing inpatient care in Peppard ward, in Henley, will be re-skilled to concentrate on supporting the ambulatory care model in the hospital, in the community and in the care home alongside the appropriately qualified staff appointed by Order of St John.

This will be further complimented by the newly established Neighbourhood Teams one of which is based here in Henley. These teams enable us to deliver integrated care for people working through a core group of multidisciplinary health and social care staff linked to a specific group of practices.

Question 3

Please provide detail of the transition plan to include:

Estates Plan

Preparing for opening of the new hospital

The plans for the build have a number of key contractual dates that are set out in the building contract which need to be adhered to.

- Practical Completion & Handover (when construction work is complete and the building is handed over to NHSPS) Current programme date – 6th November 2015
- Following Practical Completion there is a 4 week 'decant' period where the building is equipped and prepared for the services to move in ready for patients to use.
- Based on the above the anticipated earliest opening date would be early in December. However this will be subject to discussion and agreement with providers once we are clear on the model of care.

It should be noted that currently we are planning that the Maurice Tate room will be re-provided on the 2nd floor

Preparing for closure of current buildings

The building contract sets out a number of key dates by which the current buildings need to be vacated by. This is to allow the commencement of Phase 2 of the new hospital development, which includes the provision of car parking and access roads to support the hospital.

All of the current buildings, Outpatients, Peppard and Maurice Tate will require, as part of the building contract, to be vacant in the old Townlands building by the 7th December 2015 at the latest. The diagnostics, MIU and rehab services will all be moving into the ground floor of the new hospital whilst the outpatients will be provided on the 1st floor.

Transition Plan for Peppard Ward

A month before the closure of Peppard Ward, Oxford Health will stop admitting patients to the current Townlands Hospital. From that time people discharged from Oxford University Hospital and Royal Berkshire Hospital will be referred to their nearest community hospital or appropriate care setting. Of the patients already in Peppard efforts will be made to conclude planned care where possible and discharge those that are fit and well. Of the remaining patients Oxford Health will work with patients and their families to develop a detailed patient by patient plan for their continued care.

Question 4

What other options are there for the 2nd floor?

The CCG and National Health Service Property Services are working closely together to develop a range of options for utilising the 2nd floor of the new hospital. These include the provision of a range of health services which would be

complimentary to the new model of care. At present it is not possible to provide more detail due to commercial confidentiality. But further information will be provided when it is appropriate to do so.

Question 5

What are the parking and transport implications of proposed new services and will this require a review of planning permission?

Once we are clear about the services that will be provided in the new hospital NHSPS will review the car parking and transport implications. This review will assess the impact of any changes to the model of care and the health services being delivered in the new hospital.

Question 6

What happens after the consultation ends e.g. governance , development of detailed plan details, further consultation/engagement

Following the closure of the consultation on 15th June 2015, the CGG will be reviewing the feedback from the public. Information from the consultation will be used to inform a paper that will be presented to HOSC on July 2nd 2015.

The CCG will also be using the consultation feedback to review its new model of care and prepare recommendations to be presented at its Governing Body meeting on Thursday 30th July 2015.

As part of the project structure for the commissioning of services for the new Townlands Hospital, Oxfordshire CCG, working with Oxford Health, Royal Berkshire Hospital and Oxfordshire County Council will refine the details of the model and ensure smooth transition

Oxford CCG will ensure stakeholder engagement is secured as the programme progresses and will ensure patient and public representation on working groups as appropriate.

As part of this process we will be developing a robust plan to evaluate the new model to ensure that we have evidence that the people of the Henley area are deriving maximum benefits from the new model of care.