Townlands Hospital
A dossier of facts, arguments & requirements

Prepared by the Townlands Steering Group (a sub-committee of Henley-on-Thames Town Council) for its final consultative meeting with the OCCG on 15th September 2015 and updated for the 24th September Governing Body Meeting.

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Contents

1. Summary
2. TSG Concerns over Ambulatory Care Proposals for Townlands
3. Royal Berkshire Foundation Trust Concerns
4. GP and other Clinician Views
5. Patient Safety and Risks
6. Justification for beds
7. Proposal for Combined RACU & Intermediate Beds in Townlands Hospital
8. Specification and Comparison of Bed and Nursing care specifications
9. Points on which the TSG's negotiating sub-group still needs to be satisfied.

1. Summary

This document captures the concerns the TSG has over the CCG's plans to implement an Ambulatory Care/RACU model when the new Townlands building opens in December.

The TSG recognises that it is impossible to prove that a model will be successful, and that operational issues will inevitably arise which will require refinement of the plan over time.

The TSG accepts that the Ambulatory Care model has considerable potential to improve the delivery of health care to the community in and around Henley. It is however clear that the current proposals are unsound, under-prepared, and that insufficient evidence has been provided to support the CCG's proposals.

The TSG has made an alternative proposal which allows both RACU and intermediate care beds to be provided in the new Townlands hospital from its opening in December.

2. TSG Concerns Over Ambulatory Care Proposals for Townlands

Bed Requirement Data:

- There has been no computer modelling by the NHS to assess the need for beds & to test the sensitivity of the bed requirement to changes in admissions, healthcare needs.
- The figures used do not take into account some needs and use a South East Oxfordshire catchment area (RG4, RG8 & RG9 postcodes) which excludes in-patients from Berkshire & Buckinghamshire, despite these being a population as big as that in the South East Oxfordshire and being as close or closer to the Townlands site by car or by public transport. The OCCG state that there are responsible for the whole of Oxfordshire and only for Oxfordshire, so must exclude neighbouring counties. The TSG & the local community (who live in three counties) do not accept this artificial and unrealistic catchment area restriction which seems to have been introduced without consultation in 2012, and mentioned by the OCCG only in the middle of the consultation, not at the outset, and only when requested by the TSG. [Note 1]
- The average length of time patients currently waiting for a home care package is 10 days. (Anne Brierley) which the CCG said on Sep 1st was "management time". Exactly how much of this is caused by lack of Adult Social care resource remains unclear.
- The RBFT's submission to the consultation process puts the case well, has not been refuted by the OCCG, and has been confirmed by them since: i.e. "cohort of elderly patients who will require admission to an acute hospital and also will then require inpatient rehabilitation following acute hospital episode". 47% of Townlands patients come from the RBFT therefore their view and needs must be taken into account.
- The new model must be implemented in the context of a county wide plan. There is no evidence of this. Stuart Bell stated in April that this would be the subject of further design and a subsequent consultation, but this has not so far been in evidence.
- The 18 existing beds appear to have been used by patients from outside Oxfordshire until 2012, at which time they were reduced to 14 and patients from outside Oxfordshire appear to have been excluded – although our requests for numbers from before 2012 have been denied on the grounds that they are not available to the CCG.
- DToCs from Oxfordshire hospitals are not included in the CCG numbers.

Our own computer modelling indicates a current need for 18 beds, rising to 36 when the local over 70 population has increased by the 70% which the CCG say they expect over the next 10 years.

OSJ

The local community has expressed severe doubts about the wisdom & practicality of placing non-elderly people – which includes those in their 70s or older who are fit and do not see themselves as elderly - in beds in a care home designed for elderly people. Specifically:

- The Service Specification for the OSJ does not make any specific requirements for Registered Nursing Provision for the Intermediate Care Beds, only that a Registered Nurse be available to the beds. It provides a guidance of one Lead Registered Person and 2 Care Assistants to 13 patients. It was suggested by HM in one of the meetings the Intermediate Care beds would have a Registered Nurse and 1-2 care assistants. This is not reflected in the Service Specification. We read from the the subsequent statements from the CCG that the OSJ will determine staffing and the Registered Nurse could be responsible for large numbers of patients. The concerns are compounded by the April 2015 CQC report on the OSJ Care Home in Chiltern End where the OSJ were found to inconsistently demonstrate safe staffing levels.
- The TSB believe a dedicated RN Band 6 registered nurse is needed for overnight care, and ideally in the daytime too.
- The Service Specification to include an expectation that OSJ will staff to national guidelines on best practice applicable to their service type, which we expect to be published soon.
- The OSJ are to have discretion as to whether they accept admissions after 5:00 p.m. or delay them until the next day. Thus if a patient is still receiving treatment in the RACU at 5:00 p.m. e.g. IV Rehydration, which falls outside the scope of the Intermediate Care beds, they will be in limbo.

Note:

RCN advocate that for Intermediate Care Beds within Nursing homes care must be taken to ensure staff are able to meet the increasing complexity of care needs. They have noted that contracting for simply for 24/7 nursing "presence" is not an acceptable way forward. Registered nurses should be taking an active and participatory role in the care of those people using intermediate care facilities, not simply providing a cover for services by being "present". A nurse employed by a home to provide care in another part of the facility is not providing adequate accountability and oversight by the simple fact of their presence in the building.

As such, they would expect to see at least one registered nurse operating, at a minimum, at level 6 of the Nursing Career Framework[3] providing clinical oversight at all times for those beds being purchased. It also underlines our call for a Level 6 nurse to be involved in all care as an employee of the care home, to ensure that they can bring their clinical expertise to managing the relationships between the various healthcare staff required to ensure full re-enablement.

Social Care

- Availability of community care staff is "yet to be tested" (CCG slide) yet the CCG wishes to take the risk of removing beds before such testing, despite the current lack of social care staff. The CCG claims that experience at OHFT indicates the implementation of an ambulatory care

pathway does not increase demand on community services: patient demand does not increase, patients are instead seen earlier in the care pathway – but OHFT's situation, particularly with regards to DToCs, is very different from that of the RBFT, who have made their distrust of this assumption clear in writing, and have reiterated it within the past week.

- The current financial modelling for the RACU does not make provision for additional community staff to support delivery.

Thus we are forced to conclude that discharge to community care may be longer than the current 10 days, in which case our modelling shows that the bed requirement will be between 12 & 18. Recent national information about the lack of staff for social services and the poor integration of social services with healthcare services indicate that this is not merely a local problem.

Transition:

- You have told us that the new plan is has not been designed yet [Note 3]: we find it astonishing that you intend to discard a newly-designed and built hospital space without clear plans about how you will manage without it.
- You have also told us that the costs of implementing the 18-bedded ward have not been calculated. So we are unable to make a comparison with the original proposals approved in 2012, and you are unable to make a comparison with your proposed provision of beds in the OSJ.
- You will not provide details of how the locality teams will work until 24th September. [Note 4] The plans are clearly incomplete because Social Care plans are incomplete.
- No risks register of the transition to the new plan has been presented to the TSG, despite repeated requests: the plan is therefore also incomplete in this regard.
- No training of existing staff to operate the RACU has yet taken place.

3. Royal Berkshire Hospital Trust Concerns

The issues raised by RBFT came to light as a result of the TSG's Freedom of Information request, made because the OCCG did not provide this information when requested. The key concern was expressed by RBTF CEO Jean O'Callaghan in a letter to the CCG during the May/June OCCG consultation: she wrote:

"We would therefore strongly recommend that the commissioners re-provide Peppard Ward in the new build". (The full text of the letter is attached).

Jean O'Callaghan confirmed to us on 9th September that, until the RBFT's discussions with the CCG are concluded, *"we do remain concerned about impact of the proposals."*

The CCG initially concealed and later made light of these serious reservations on the part of a main source of patients for Townlands hospital.

4. GP and other Clinician Views

Discovering the views of local GPs has been problematic throughout this process. Only one GP contributed to the consultation – a fact we were forced to discover through an FoI request.

As far as we can ascertain:

- Henley Town GPs continue to have the reservations which two of them expressed orally at the CCG's 9th June consultation in Henley Town Hall. However, the negotiations with them referred to in the Governing Body paper for 24th September presumably affect this.
- We have not seen evidence of the views of other South East Oxfordshire GPs – apart from those of Andrew Burnett - despite requests to the CCG to provide this.

5. Patient Safety and Risks

It is clear that the new model of Ambulatory Care based on a RACU represents a very significant change from the existing service provided in Peppard Ward. The RACU model appears to be an innovation which is so far unproven. The time to design this new service is very short. The CCG have stated that the design of the physical layout or the RACU has not yet started, neither has the (re)training of staff to service the RACU. We understand that provision of Adult Social care using Integrated Locality Teams is set to begin in September.

The process of Risk management in the NHS is formally specified in a controlled document dated January 2015, here:

http://www.england.nhs.uk/wp-content/uploads/2012/11/risk-man-strat.pdf.

This document states:

All central team directorates, regions and programme and project teams must have an identified risk lead. They will be responsible for:

- *consulting with teams to identify and assess risks and determine mitigating actions;*
- *the ongoing maintenance of a risk register for their area of the business;*

The TSG have not been provided with such Risk Registers in the past. There is no evidence this

document exists. If it does exist the TSG concerns could be considerably mitigated by successful review of this document. If not, our concerns remain.

6. Justification for Beds In Townlands Hospital

The operational statistics associated with the present Peppard Ward of 14 beds at Townlands Hospital indicate a busy, well used environment of Rehabilitation Beds for mostly local people:

- Consistent annual admission levels at 150 patients per annum
- Stable bed utilisations over 3 years at 97.5%
- Bed free days low at 2.5% so that the probability of Townlands being able to supply a bed is 35% - indicating delayed transfer times from acute Hospitals of the order 3-5 days for any patient request.
- An average length of patient stay of 35 days
- 46% of patients in the last 2 years have an average length of bed stay of 56 days which represents occupancy of 76% of the bed stock in Peppard Ward by long stay patients.
- 90% of the bedded patients are over 70 years with an average age for all patients of 82 years.

After many conversations with the Community - both lay and professionally involved medical people and organisations, the considered majority view is that beds are required within Townlands Hospital for an initial period of two years to support roll-out of the Ambulatory Care Model. During and after this period the need for beds would be reviewed to assess their effectiveness in supporting the Ambulatory Care Model. Detailed justificiation of this is at Note 5. [Note 5]

7. TSG Proposal for Combined RACU & Intermediate Beds at Townlands

Both parties agree that a number of beds is required for future care of patients in the Henley area, but there have been three gaps between the TSG's thinking/objectives and that of the OCCG:

1. Location of the beds – in the hospital building* or in the adjacent care home.
2. Number of beds
3. Degree of nursing care and level of installed equipment for the beds.

We endorse the OCCG's intent to reduce the length and frequency of in-bed hospital stays, and support the idea of caring for people in their own homes with proper support from Social Services and Health Services, but we are not convinced that this will be delivered to the necessary level nor that the planned 18-bedded hospital will not be needed.

Our paper setting out this proposal, submitted on 9th September, is attached at Appendix B.

*We have offered to compromise on this point during the past week, subject to more beds being provided in the OSJ.

8. Specification and comparison of bed and nursing care specifications

The CCGT (HM) indicated in an email there would be a dedicated RN for 5-8 beds, but this is not what the OSJ specification says. We have sought clarification on this from HM and KT, who replied by reiterating the Service Specification, which is to allow the OSJ to determine the right staffing levels. We have sought clarification again on this but have not had a reply.

Despite repeated requests to PM, the CCG has not provided information on the current Peppard staffing levels.

9. Key points on which the TSG sub-group still needs to be satisfied

The TSG cannot support the CCG proposals unless and until the following issues are resolved and agreed:

The CCG's proposed statement of agreement between themselves and the TSG:

- does not use the words "dedicated nurse for the beds leased from the OSJ",
- and does not state the RN band (we have requested Band 6).
- refers to the governing body paper which allows the OSJ to determine staffing.
  states that only 5-8 beds will be leased from the OSJ. The TSG have asked for the initial number to be 14.

There are a number of important but secondary issues which also need to be resolved.

Notes

- **Note 1.** "*SG raised the concern that the Bed Modelling paper referenced a different catchment area. HM confirmed that the Bed Modelling paper in question, was written in a direct response to a question raised by the Townlands Steering Group regarding where Henley patients (e.g. patients resident in RG4, RG8 and RG9 postcodes) access inpatient services and therefore not a representation of the totality of inpatient activity provided at the Townlands Hospital. All inpatient activity since April 2012 – June 30th 2015 has been reflected in the presentation provided on the 18th August*."
- **Note 2** "*HM and AB stated that once the model of care had been confirmed, subject to agreement by the OCCG Governing Body, the exact space requirements and configuration could not be confirmed."*
- **Note 3:** "*The costs of implementing the 18-bedded ward have not been calculated. The costs of the new model and existing 14 bedded Peppard ward are being finalised as part of the additional work requested by the Governing Body 30 July 2015 before making a final decision*."
- **Note 4:** *"Further details on the Integrated Locality Teams will be included in the Governing Body paper to be presented on 24 September 2015.*

Appendix A

The reasons for this recommendation are as follows:

1. Statistics
   The statistics for the present Peppard Ward represent a busy, relevant and heavily utilised Townlands Hospital with beds serving the local Community. The loss of a Peppard Ward will be a severe loss both locally and within the Oxfordshire strategy. There is a net loss to the Oxfordshire bed stock despite the promise of further capacity for 8-10 beds at Wallingford. At a time when the Government has announced a 20% increase in demand for beds nationally, the imminent closure of beds at Townlands appears to be a poor decision and an erroneous step in looking after the safety of all patients.

2. Change.
   The effects of human behaviour changes with new systems are well researched. It takes significant time for cultural and operational changes to be bedded into a population of people. Change is never easily assimilated and especially with older people. For people to have confidence in this major change in medical practice, it is essential that there are some "pillars" left in place from the old system to aid the transition to the new – for most people this is represented by beds at Townlands Hospital.

3. Patient Risk to Safety.
   In rolling out the new Ambulatory Care Model there will be operational problems which will take time to develop new solutions and underpinning resources. There are known knowns, and known unknowns, but it is in the area of unknown unknowns that the risk areas will surface and represent a threat to patient safety and lives. The complexity of the rollout will be especially difficult with the new Ambulatory Care Model as it will require major efforts across multi-disciplinary medical and care organisations to develop new ways for working together. This will necessitate beds in Townlands Hospital to underpin and support Ambulatory Care so that the risks to patients are reduced whilst the problems are solved by designing and enabling new cooperative working pathways for multi-disciplinary teams.

4. Patients Treated Locally
   The medical services are dealing with frail elderly patients who need confidence in their environment. It is therefore essential that they are treated as far as possible within their local Hospital Catchment Area, where they are familiar with their local Doctors and Nurses and accommodation. The increased anxiety levels associated with being relocated to Wallingford/Abingdon Hospitals should not be underestimated in the future well-being of patients.

5. Access to Patients
   The CCG has stressed the beneficial effects of enhanced services at Townlands Hospital which will be easier to access rather than the services provided at RBH Reading. The same logic applies for patient beds at Townlands Hospital. They will be easier to access for relatives/friends than a trip to Wallingford/Abingdon. Ease of access to patients will mean more visits from loved ones and a greater stability and therapeutic value for patients

6. Bed Strategy for Oxfordshire

   Despite our repeated requests the TSG has never been offered a view of the strategy for beds within Oxfordshire and how a bedded Townlands Hospital might fit into the overall strategy. It is the considered view of the TSG that a mix of beds should be sought for Townlands Hospital – Rehabilitation Beds, Intermediated care Beds and RACU beds all part of the mix. This would enable a full range of our elderly patients from the local Community to be treated successfully and with dignity and respect in familiar surroundings.

7. RBH Point of View

   Some 47% of the bedded patients using Peppard Ward are transfers from the acute RBH. In a June 2015 letter in response to the Consultation, the CEO of RBH expressed disquiet at the imminent closure of a bedded Townlands Hospital as a step down hospital for some of its patients. The main argument of this letter has never been answered satisfactorily by the CCG, to the TSG's knowledge. It represents a powerful rebuttal of bed closure at Townlands Hospital by their principal supplier of patients.

8. Local Community Expectations.

   Our local Community was promised a bedded Hospital from 2008 onwards. Over a long period of time, residents' expectations have been focused on a local Community Hospital with beds. The CCG has dashed these expectations with an unexpected message of major changes including removal of a bedded ward. Inevitably, this has met with frustration, misunderstandings and disapproval from the local Community. The CCG's public relations in supporting their case for change have been poor throughout the Consultation period and it now needs to reflect on an enhanced bedded option as a way forward in winning back the confidence of the local Community.

Appendix B

Possible Combined Model

- a suggestion

We think that the space in the new building designed for 18 beds could be used in various ways, for instance as follows:

- a 4 bed bay/ward – for new RACU Assessments
- a 4 bed bay – for short stay/step up/down beds (24-48hrs)
- 8-10 longer stay community/rehab beds.

Other combinations of assessment/short stay/rehab beds could of course be considered.

As the integration of social care with health care progresses, and everyone – workers & patients - learns to work effectively with the new model, thus facilitating timely moves to home care, demand for the longer-stay beds will/ought to naturally reduce: the RACU could then utilize the space made available to increase its capacity. The ability to contract from OSJ would offer back up if needed.

One benefit of situating both RACU and beds in the purpose-built hospital (given that the RACU model is untested) is that it is possible, perhaps probable, that patients do not present, or not enough present, early in the pathway: most may seek help only once they are sick, therefore often will not be suitable for intermediate care, and hence will be sent to the RBH, thus contributing to or exacerbating the problems which they have already communicated to you.

It is also the case that more and more people will be living at home with increasingly complex health issues that may not be appropriate for OSJ spec beds.

This hospital-based model would allow staff to uplift their skills to operate more as an EMU, should the local health needs move in this direction. Thus the unit would able to continue to support sicker patients and prevent acute admissions and continue to make full use of a valuable hospital resource. The OSJ model could not offer this, because the building is not equipped to the specification required to allow this. And contractual renegotiation would be required to provide care for more complex needs, e.g. change the staffing specifications, skills, admissions policy etc.

Our justification for this proposal is set out below:

Costs:

Equipment/Capital requirement: additional beds in addition to the planned ones for the RACU - minimal cost in the context.

Staff: This is a complex matter, but the RACU component would remain the same. The other bedded care would not differ greatly from the current provision of staffing for 14 beds.

Overheads: somewhat higher because of operating 24/7 rather than 8-8; however, there will be savings through non-use of the planned OSJ beds and associated overheads.

Medical cover could be as proposed, perhaps with enhanced sessions to optimise longer-stay beds in the first instance.

Savings:

- OSJ beds
- Increased capacity at Wallingford and/or increased pressure on Wallingford beds.
- Contract management protection from future vulnerability and reliance on private providers

Benefits:

- Full utilisation of a brand new 18-bed hospital;
- Flexibility to uplift skills if it is found that patients are generally more ill/more advanced on the care pathway thereby still avoiding Acute Hospital admissions and a more flexible response to seasonal fluctuations;
- Future-proofing for increasing complex health needs managed outside acute setting
- Staff rotation and possible improvements in skills, satisfaction and retention;
- Provides more limited but valuable longer stay beds addressing the (still shared) RBFT concern regarding the cohort of elderly who will still need community hospital beds, regardless of ambulatory care, so at least meeting local need, or most of it;
- Enhanced service with short-term risk mitigation in moving to Ambulatory Care + flexibility to easily upgrade to meet future needs;
- Protection from future vulnerability and reliance on private providers;
- Works very well with the new plans and work done on Social Care;
- Reduction of local resistance, so clearing the way to move forward and avoid delays.

Disadvantages/risks:

- Possible loss of the treatment room function e.g. for blood transfusions: this is not acceptable, and although this could be accommodated elsewhere e.g. RACOP at RBH, or, dependent on actual admission numbers (10% from EMU model) the short stay beds may have capacity, we need to see numbers on expected follow up and treatments which we have requested but which have not been provided.
- Reduction by 4 community beds (based on current 14-bed Peppard Ward provision)
- 'If there are beds they will get used' (Parkinson's Law) problem: this should be dealt with through:
    - clear clinical zones and pathways;
    - competent operational management, appropriate targets and referral pathways;
    - guidance and control of decisions by clinical staff, including GPs, the Gerontologist and nursing staff: for example, patients could move from the assessment bay to home or treatment rooms/short stay, after 24-48 hours. If assessed as requiring a longer stay, & patients were moved to the longer-stay beds, a target* could be set of 10-12 days to discharge to most appropriate home care solution or care home solution.

      *This is a starting point only on targets etc.

Transition plans

The original plan was to have patients move from Peppard Ward directly to the new hospital, save a couple of days. This could still happen:

- Using the capacity within social services home care, hospital at home etc, patients currently in Peppard Ward who could or should be at home should be moved home quickly.
- Staff could take advantage of reduced patient numbers in Peppard for retraining opportunities in readiness for the new model.
- Staff and remaining patients could move directly to the longer stay beds in our proposed remodeled 'combined use' unit.
- If staff, mostly medical, were to be hired soon, the RACU could be in operation in the early new year.