



Coastal West Sussex
Clinical Commissioning Group

Community Bed Review

Phase 1: Engagement, research & analysis
Patient Profiling: Audit Results

October 2011

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Introduction

1.1 Background and Context

The NHS is facing one of its biggest challenges for decades, having to find £20bn worth of efficiency savings by 2015 through the Quality, Innovation, Productivity and Prevention (QIPP) programme, which are to be reinvested into patient care.

This follows a significant policy drive to see Care Closer to Home as detailed in Our Health, Our Care, Our Say (2006). Importantly not only must care be delivered locally and closer to home it should be delivered in an integrated way. As Liberating the NHS described, it is 'essential for patient outcomes that health and social care services are better integrated at all levels of the system' (2010).

In West Sussex the over 65 population will grow by around 38% and the over 85 population by 69% from 2001 to 2026 according to A Fair Old Age (2009). These three initiatives seek to tackle rising costs of healthcare delivery associated with this demographic shift, where people are living longer, often with co-morbidities and requiring longer term care and support as a consequence.

It is widely acknowledged by local healthcare professionals that our current community bed provision has some significant issues which are in need of urgent consideration and review.

This includes a lack of consistency in the approach to care such as variable admissions criteria and rights. Significantly there is no agreed patient profile, estate is varied in quality and financial and contractual arrangements are, generally complex.

This leads to a poor strategic fit with current clinical models and service developments across the local health and social care economy, with previous reviews of community beds being inconclusive in their recommendations.

However, the ongoing Service Redesign for Quality process led by Western Sussex Hospitals NHS Trust proposes moving all elderly care beds from Southlands to Worthing and developing community services to accommodate the reduction in 'like for like' beds from 120 to 60. This provides an opportunity which the community bed review can make use of, designing the system of community beds making them reflective of local needs and allocating resources in the right place.

Yet the configuration and provision of Community Beds is potentially highly sensitive. There has been intensive lobbying for the development of Arun Community Hospital since the demolition of Littlehampton Hospital in 2005, and following numerous statements of intent on behalf of the local NHS, as such this process must contribute its views on the business case for this site.

1.2 Purpose and Objectives

This audit is designed to understand the patient profile across CWS Community Beds. An audit is required as diagnosis, treatment and spell details are not captured in a comparable way to inpatient spells within an acute trust.

This aims to support the Community Bed Review stakeholder group to build on the data gathered in Phase 1: Engagement, research and analysis with additional data covering these areas:

- reason for admission
- the patient pathway and potential delays
- patient dependency
- the potential alternative (community) care pathways

This document describes the audit design and its findings with a short summary.

1.3 Audit Design and Documentation

The audit design has been overseen and supported by local clinicians and managers. It involved all stakeholders and was approved by the providers Sussex Community NHS trust and CareUK prior to data gathering beginning.

1.3.1 Audit sample

The audit was in place from 8th August 2011 until 2nd September 2011 (inclusive). The patient sample was all patients discharged (or deceased) from community beds during this period. This included the following sites and wards.

Organisation	Site	Ward	Number of beds
Sussex Community NHS Trust	Arundel & District Hospital	-	20
	Bognor War Memorial Hospital	Don Baines	24
		Leslie Smith	19
	Midhurst Community Hospital	The Bailey Unit	17
	Salvington Lodge	Ferring	13
		Offington	13
	Zachary Merton	Mewsbrook	13
		Swanbourne	13
CareUK	Darlington Court	-	20
Total			152

1.3.2 Audit proforma

Shown below is an audit example. A full-size version is also found in appendix A.

Community Bed Review			Patient Profile Audit		
Site/Ward	Date Completed	/ /	Site / Ward	Male / Female	/ /
MHS Number	Sex				
Age	GP Practice				
Date of Admission	Date of Discharge	/ /			
A. Reason for admission (mail up to two spots only - using 1 and 2 to indicate order of relevance, admitted with medical nursing need. A UTI for example, but does not meet the Complex Elderly with co-morbidities category)					
Sub Acute					
Intensive Rehabilitation	admitted for rehab following a fall or episode of illness				
Stroke Rehabilitation	admitted for rehab following a stroke				
Complex Elderly with co-morbidities	a frail elderly patient admitted for medical and nursing care for a number of diagnoses for a prolonged period				
Neuro Rehabilitation	admitted for rehab for a condition such as MS or Parkinson's Disease				
End of Life or Palliative	admitted to provide their end of life care				
Respite	admitted for a care rather than a medical/nursing need eg. Carer breakdown, support with activities of daily living				
Other (please describe)					
B. Episode details (place one 'x' in the relevant box)					
Primary Diagnosis					
Describe the primary condition which led to the episode of care					
Prior to this episode of care, where did the patient live?	Own Home (no care/nursing package)				
	Own Home (no care/nursing package)				
	Residential (nursing Home)				
	Their own GP				
	The Out of Hours GP service				
	Acute Hospital				
	Community Services				
	Other:				
	Yes				
	No				
Was this patient admitted with a discharge plan or predicted discharge date? If yes, briefly describe in the box provided					
Where was the patient discharged to? If other, please note in the variable space	Own Home (no care/nursing package)				
	Own Home (no care/nursing package)				
	Residential (nursing Home)				
	Acute Hospital				
	Other:				
	Private/Family/Social Care/Local Authority				
	NHS Continuing Healthcare				
	Yes				
	No				
Were there any delays in this patient's discharge? If yes, briefly describe in the box provided					
Audit User Initials			Audit Number (Commissioner Use only)		

C. Patient dependency assessment (place only one 'x' in the relevant box per column)			
Category	Description	On admission	On discharge
Mobility	Free/mobile		
	Free/mobile with the use of aids		
	Needs supervision (1 nurse)		
Washing & Dressing	Needs 2 nurses to mobilise/transfers/position		
	High level of care/complex safety		
	Full independent		
Family needs	Needs supervision/guidance		
	Needs help		
	Full dependant		
Communication	Minimal		
	Minimal eg. Psychological support		
	Communicates freely		
Eating & Drinking	Complete medical communication eg. Deaf - Severe		
	No assistance required		
	Needs minimal supervision or assistance		
Skin Integrity	Needs to be fed or requires PEG or line feed		
	Subcutaneous feeds		
	Inset but regular assessment (water/wet/dry)		
Dressings	At risk (water/wet/dry)		
	Breakdown in skin integrity		
	Simple (<10 mins)		
Elimination	Complex (>10 mins OR requiring 2 nurses)		
	Minimal intervention		
	Assisted intervention eg. suppositories/enema		
Psychological status	Catheter in situ/assistance/supervision		
	Cobwebs/blebs/colic/haematuria		
	Incumbent of tubes/lines OR constant night toileting		
Breathing	Anxious/needs occasional reassurance		
	Anxious/needs constant support		
	Low in mood		
Sleeping & Resting	Terminally ill		
	No intervention required		
	Physiologically unstable/minimal intervention		
Other	Physiologically unstable/significant intervention		
	Sleep well (no sedation)		
	Sedation is used		
	Confused/ restless/ wandering - requiring observation		
	Requires isolation barrier nursing for infection control		

D. Alternative pathways		Yes/No
Is it possible that this patient could have been supported by a community team?		
Community Nursing Team	Virtual Wards - with supportive nurse	
Fall Prevention	In-reach at home services/supporting frail patients	
Heart Failure	In-reach at home services/support	
COPD	In-reach at home services/support, pulmonary rehab	
UTI Therapy	In-reach at home antibiotics/subcutaneous infusion/blood transfusion	
One Team (mark all that apply)	Pre-visit assessment service, coordinating care for up to 72 hours ensuring handover to an appropriate service	
Services with Home Care	Provision of personal and social care provided through HSCC	
Other:		

1.4 List of Contributors

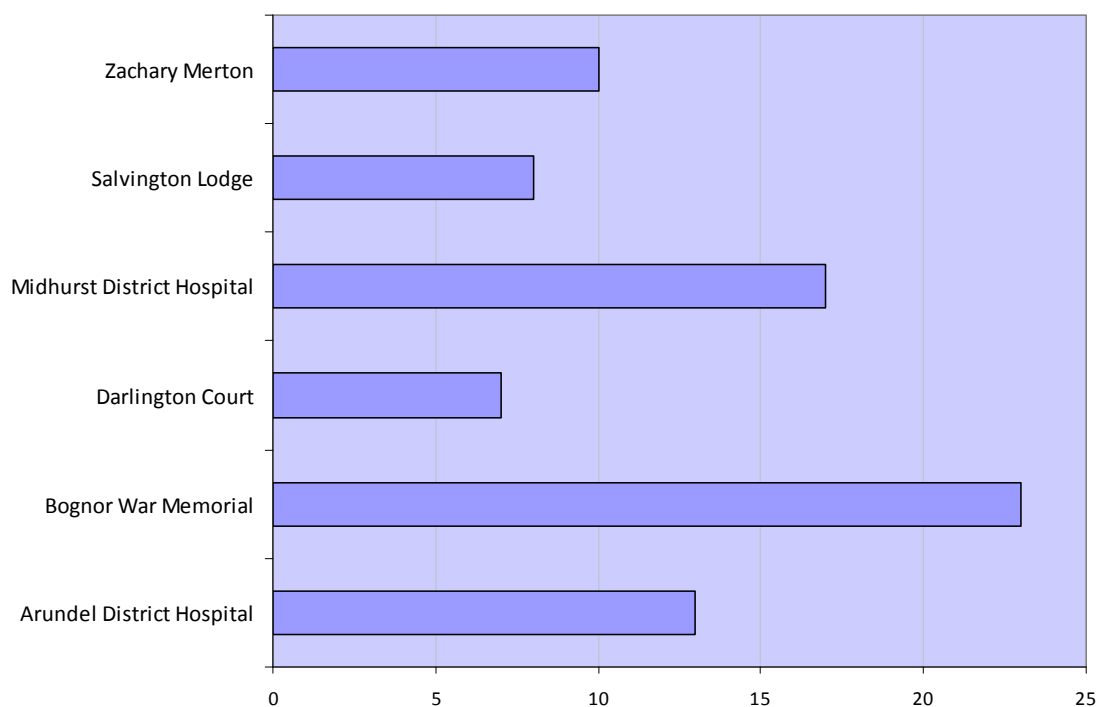
Members of the Community Bed Review stakeholder group supported the design and delivery of this audit, they are listed below:

Dr Oliver Smith	GP	Lime Tree Surgery
Dr David Hunt	Integrated Clinical Lead	Western Sussex Hospitals
Matthew White	Service Development Manager	CWS CCG
Katie Summers	Lead for Planning	Sussex Community Trust
Louise Mayer	Head of Service	Sussex Community Trust
Simon Neale	Matron	Sussex Community Trust
Mary-Jane Bosley	Matron	Sussex Community Trust
Lucie Brumder	Matron	Sussex Community Trust
Linda Clements	Darlington Court Manager	CareUK
Linda Currie	Darlington Court Deputy-Manager	CareUK

Thanks also to all the Ward Sisters and Staff Nurses involved in gathering data.

Data and Results

2.1 Sample

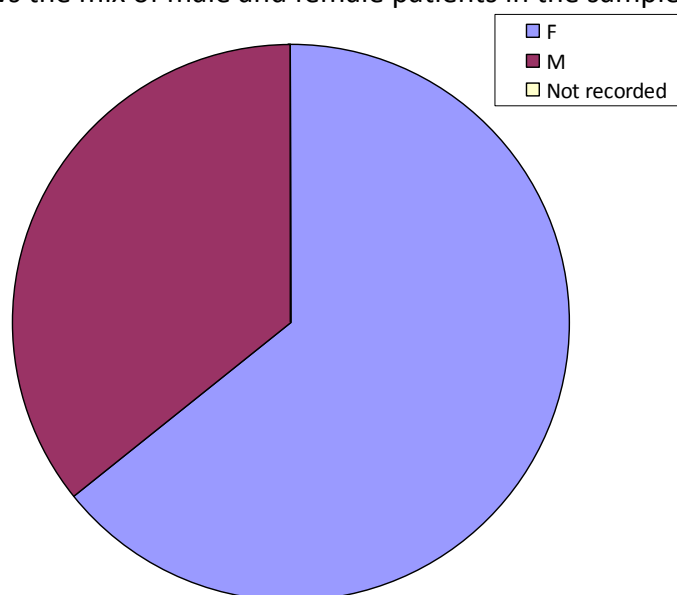


Total number of audits carried out	78
Rate of audits per 100 beds	51.3

2.2 Demographics

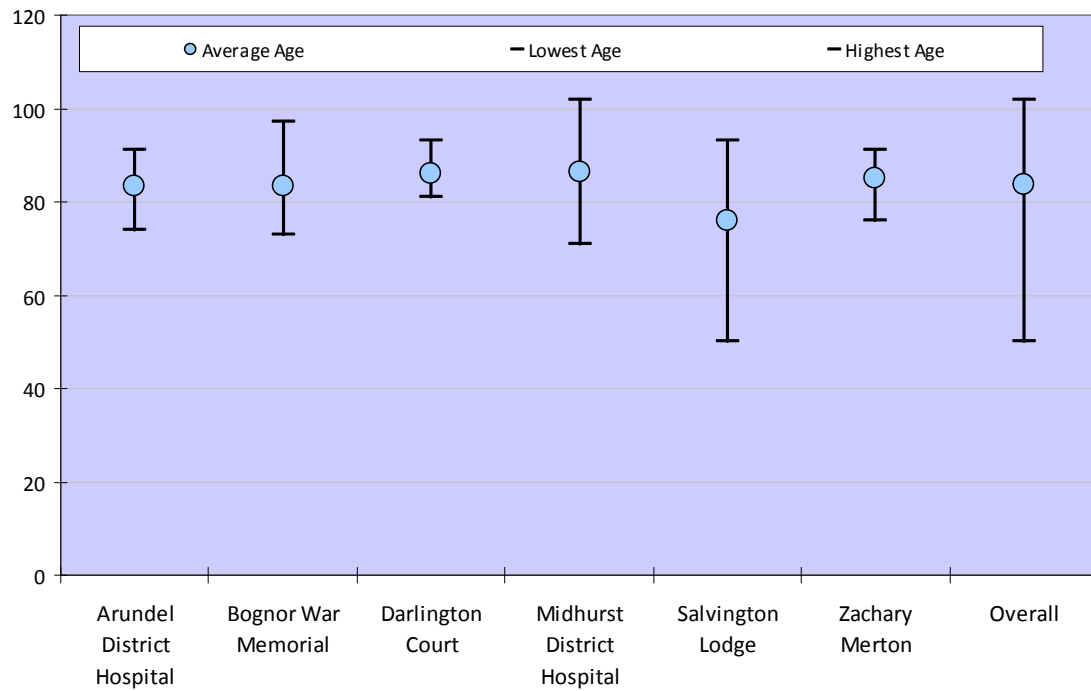
2.2.1 Patient sex

This chart shows the mix of male and female patients in the sample.



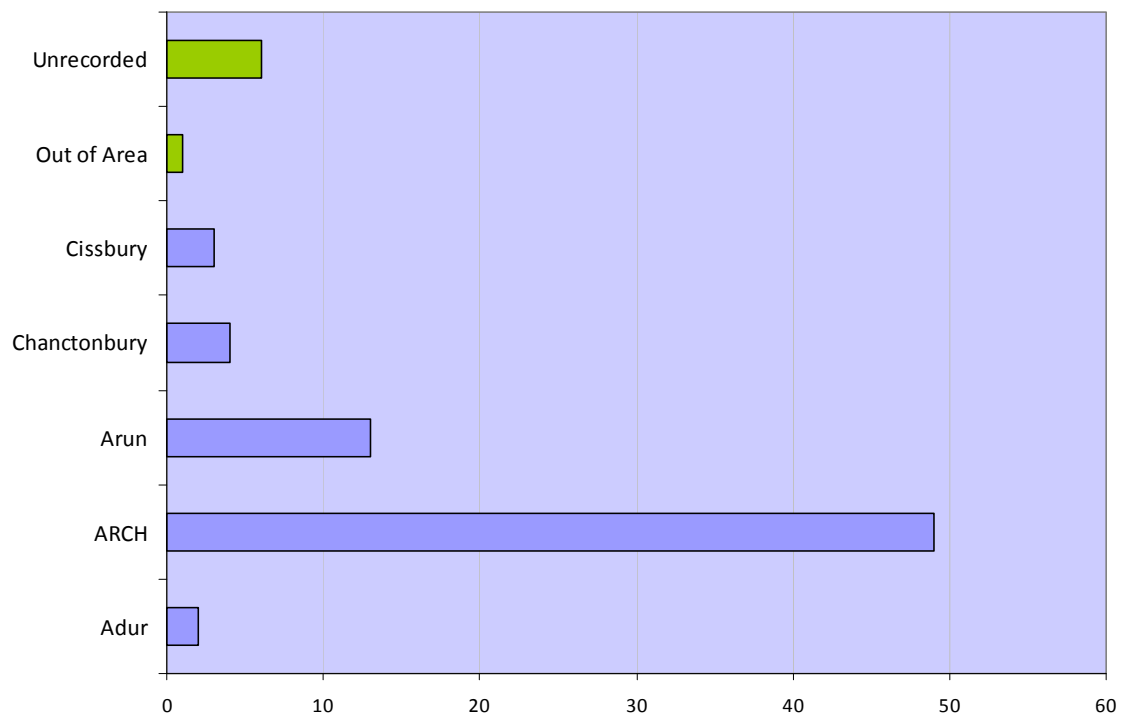
2.2.2 Patient age range

This chart shows the age range of patients within the sample as well as the average age by site.



2.2.3 Patient locality

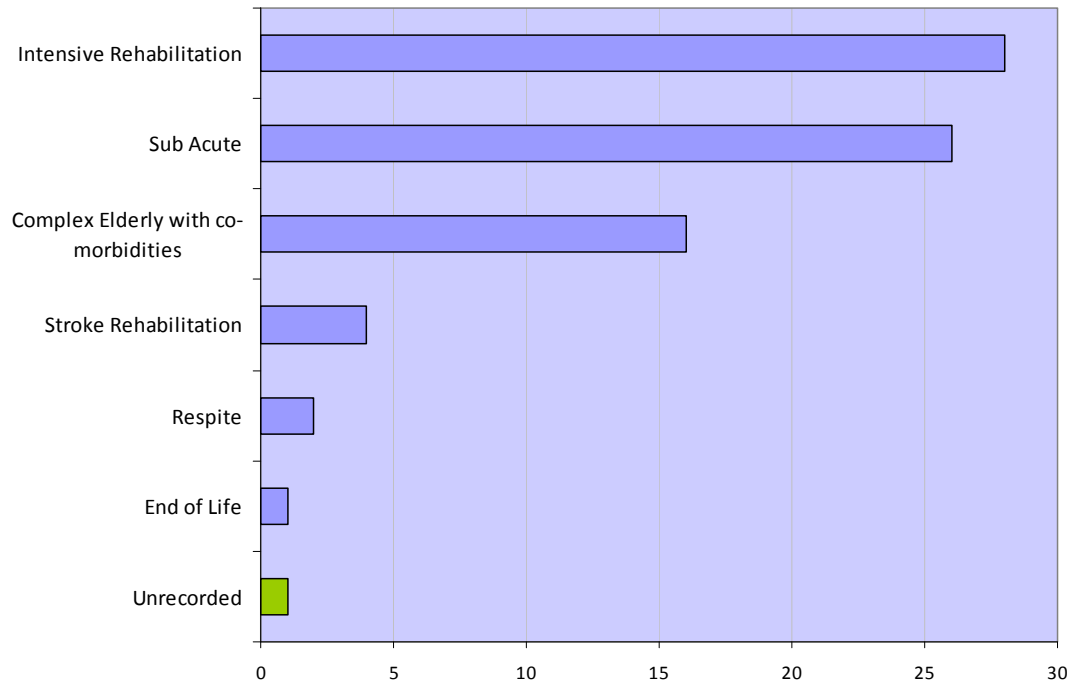
This chart shows the how the sample was distributed amongst the Coastal West Sussex Consortia.



2.3 Patient Profiling

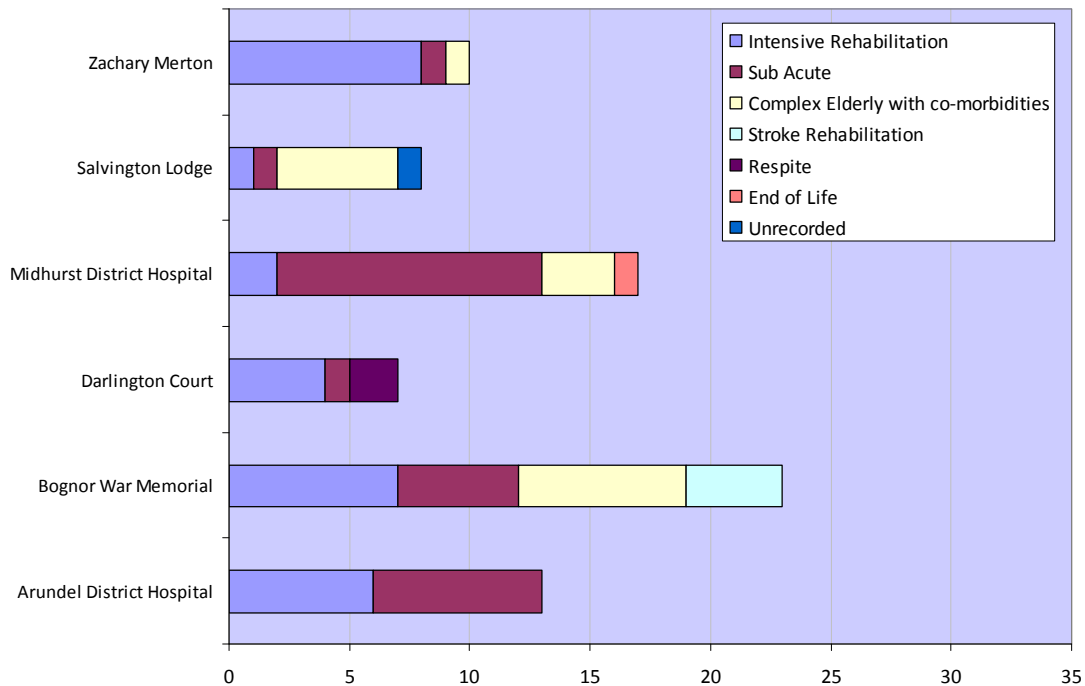
2.3.1 Primary patient profile

This chart shows the mix of primary patient profiles within the sample. The profiles were predefined, using best practice guidance and categories, with added 'Respite' and 'Other' options to be used as required.



2.3.2 Primary patient profile by site

This chart shows the mix of primary patient profiles within the sample by each site.



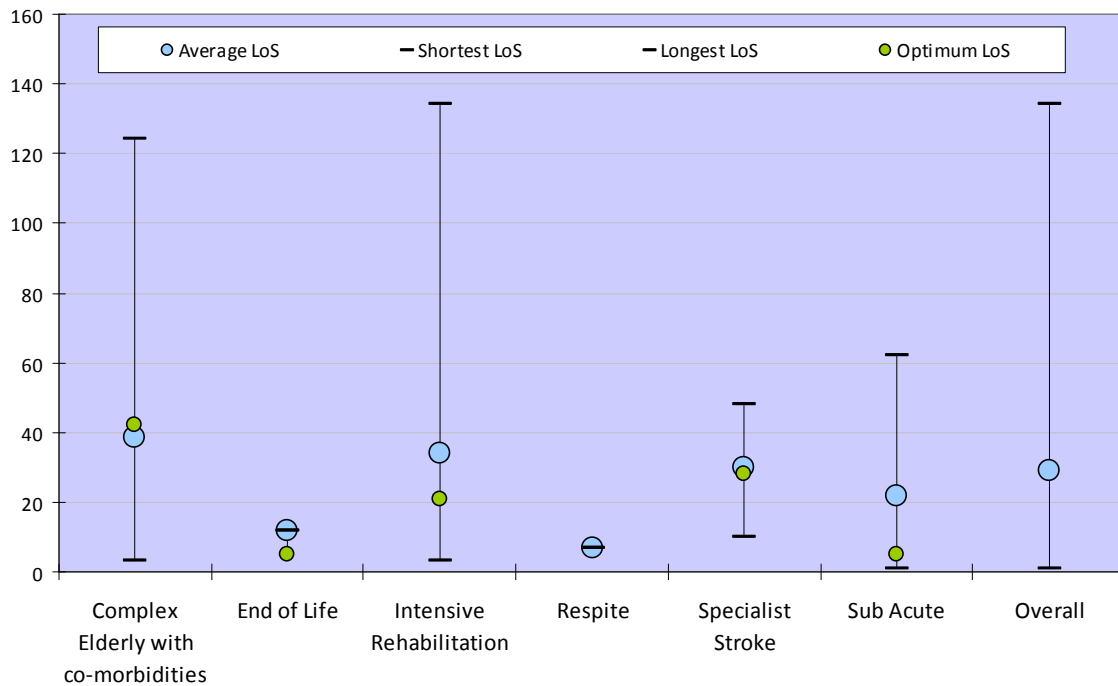
2.3.3 Primary patient profile vs Secondary patient profile

This chart shows the link between the primary and secondary patient profile.

Primary Patient Profile	Secondary Patient Profile
Intensive Rehabilitation 28 patients	11% Complex Elderly with co-morbidities
	39% Sub acute
	4% Investigations
	46% <i>No secondary profile</i>
Sub Acute 26 patients	12% Complex Elderly with co-morbidities
	62% Intensive Rehabilitation
	4% Respite
	23% <i>No secondary profile</i>
Complex Elderly with co-morbidities 16 patients	50% Intensive Rehabilitation
	6% Respite
	6% Sub acute
	6% Investigations
	31% <i>No secondary profile</i>
Stroke Rehabilitation 4 patients	25% Intensive Rehabilitation
	75% <i>No secondary profile</i>
Respite 1 patient	100% Sub acute
End of Life 1 patient	100% Respite

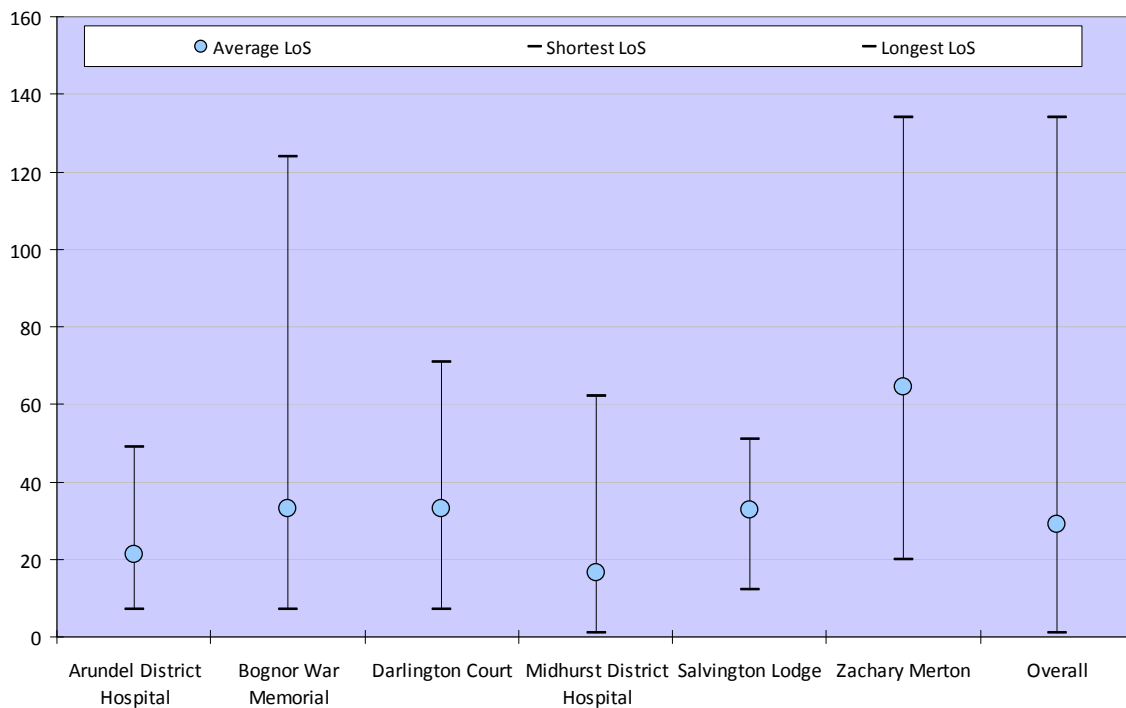
2.3.4 Length of stay by primary patient profile

This chart shows the how length of stay (days) associated with a patients primary patient profile, sits against the 'optimum' length of stay as described in best practice guidance (Review of Community Hospital/Intermediate Care Provision: Good Practice Guide,2008).



2.3.5 Length of stay by site

This chart shows the how length of stay (days) varies across sites.



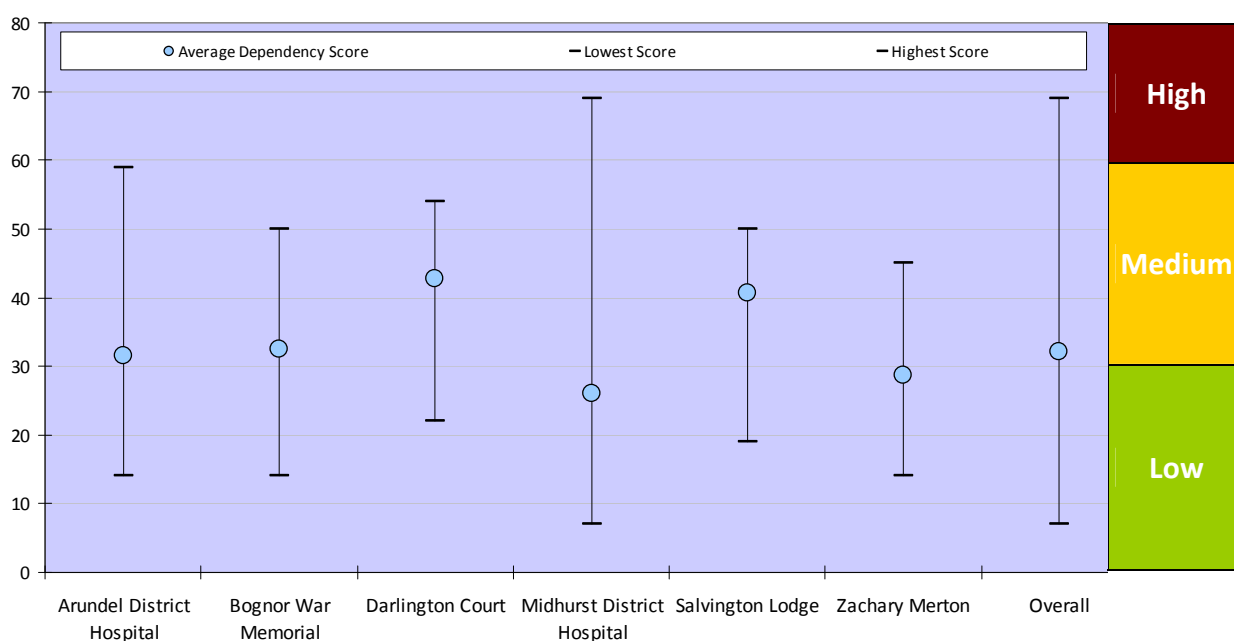
2.3.6 Primary diagnosis

This chart shows the patients Primary Diagnosis (the condition which led to this episode of care), listed against their Primary Patient Profile.

Primary Patient Profile	Primary Diagnosis
Intensive Rehabilitation	Falls # Neck of Femur # Pelvis # Wrist # Unspecified Chest Infection
Sub Acute	Cancer Chest Infection DVT Fall # Pelvis # Unspecified Vertigo Constipation Cellulitis Low Sodium Pneumonia UTI Poor Mobility Parkinsons
Complex Elderly with co-morbidities	End Stage Heart Failure Leg Ulcers Amputation Falls # Neck of Femur
Stroke Rehabilitation	Stroke
Respite	Diabetes Epilepsy
End of Life	Cancer

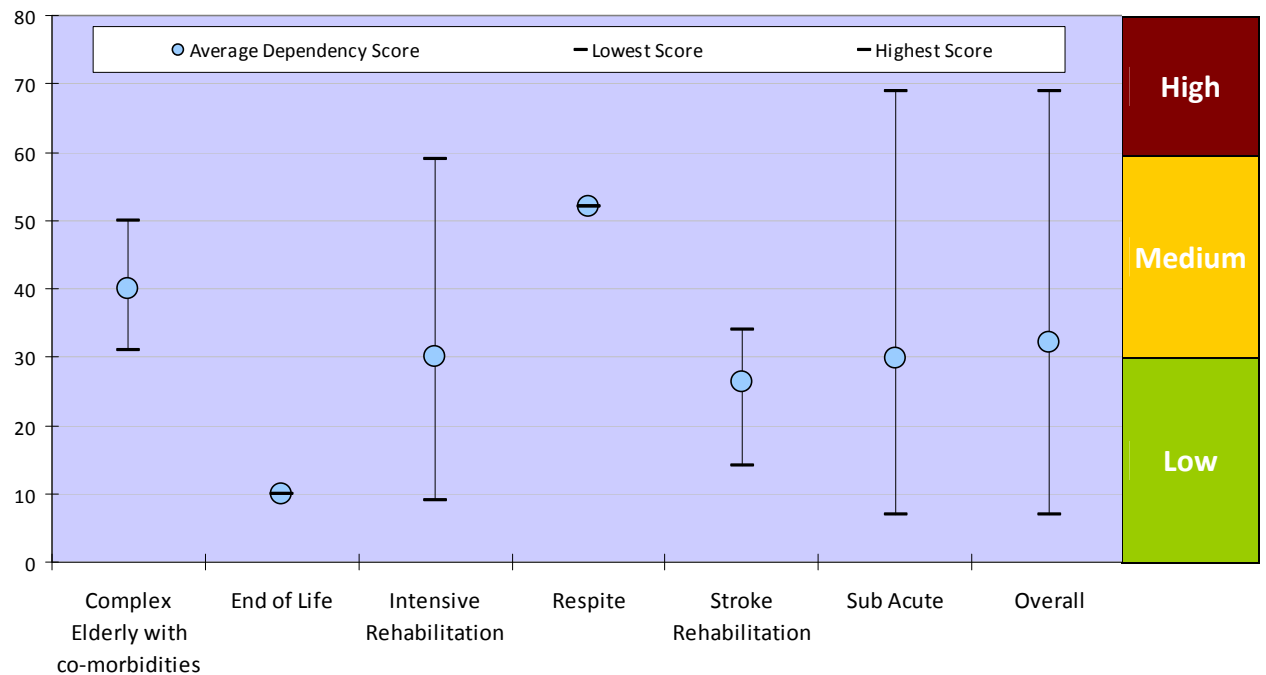
2.3.7 Dependency score by site on/near admission

This chart shows the how patient dependency (scored using a series of criteria based on the Northwick Park and a local tool) varies across sites upon or near the date of admission.



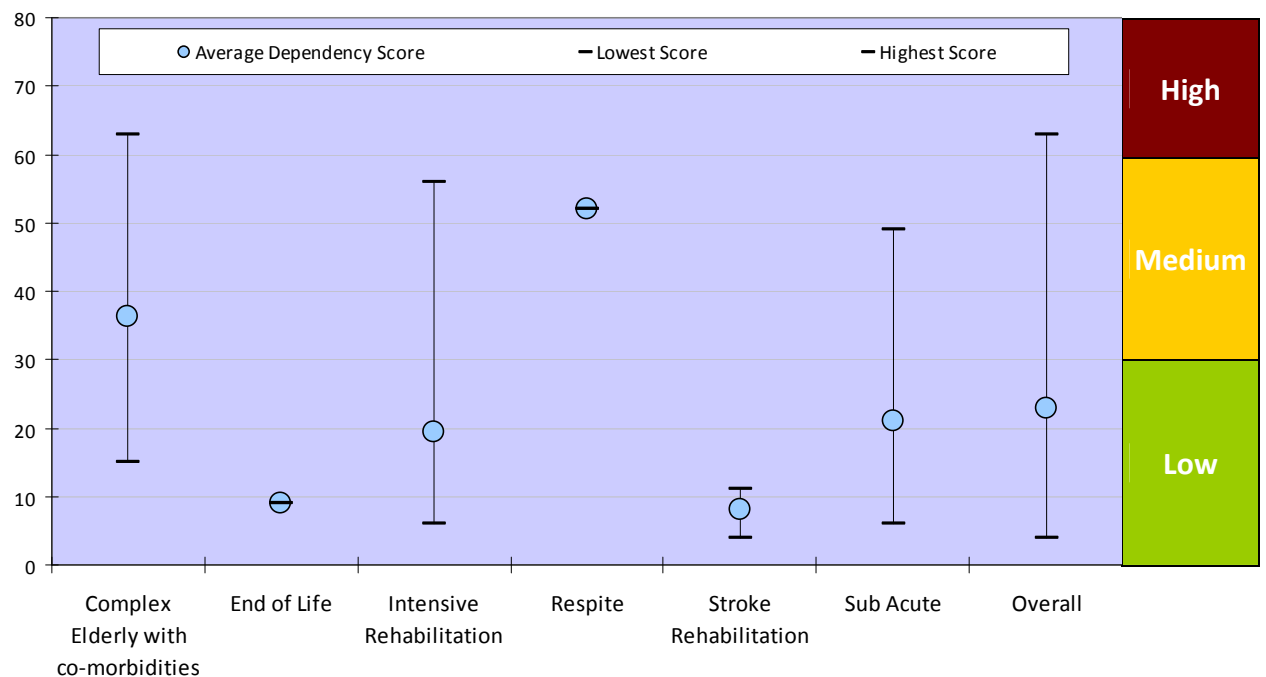
2.3.8 Dependency score by primary patient profile on/near admission

This chart shows the how patient dependency (scored using a series of criteria based on the Northwick Park and a local tool) associated with a patients primary patient profile upon or near the date of admission.



2.3.9 Dependency score by primary patient profile on discharge

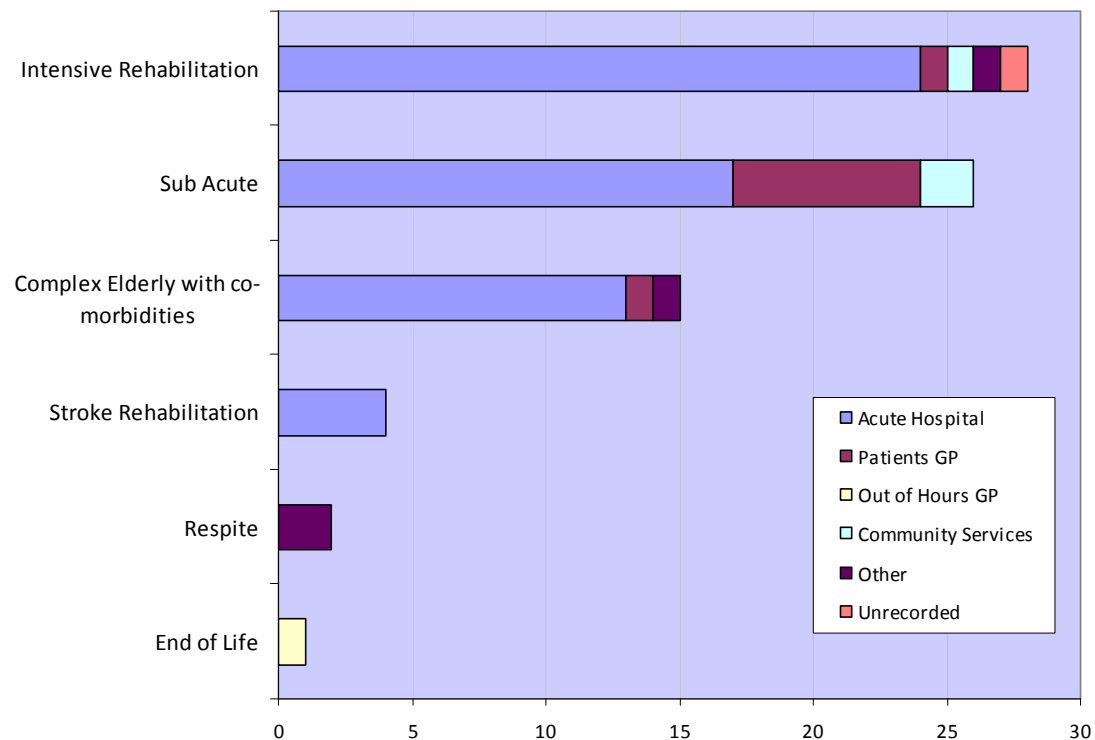
This chart shows the how patient dependency (scored using a series of criteria based on the Northwick Park and a local tool) associated with a patients primary patient profile upon discharge.



2.4 Pathways

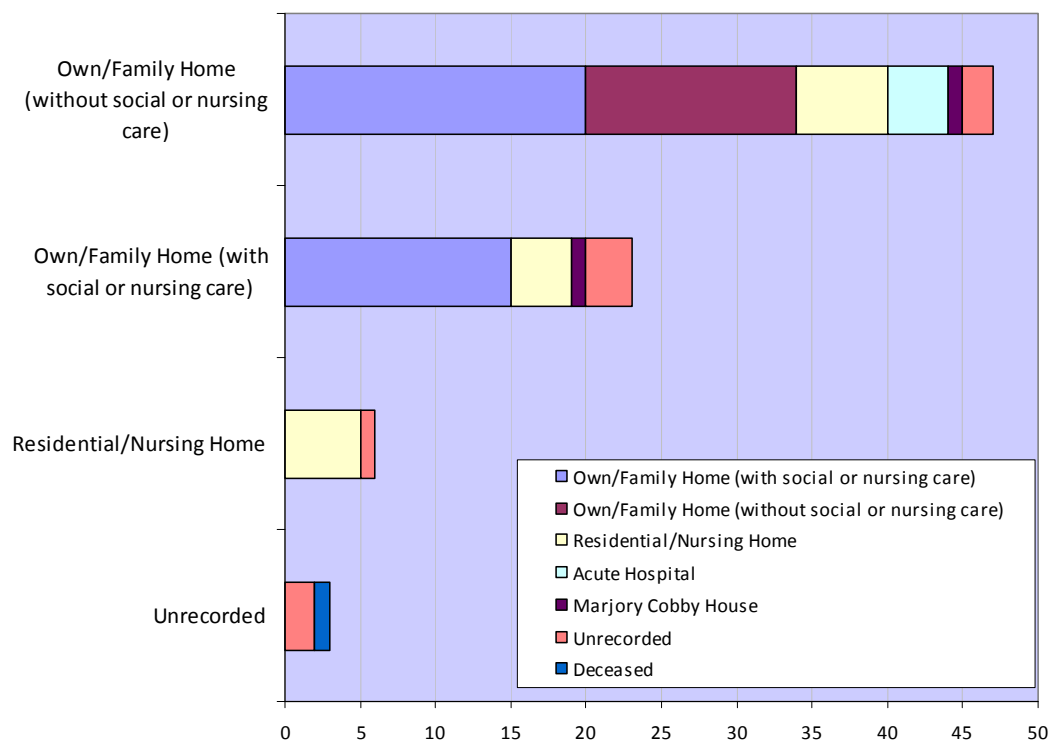
2.4.1 Admission source

This chart shows the admission source of the sample, linked to Primary Patient Profiles.



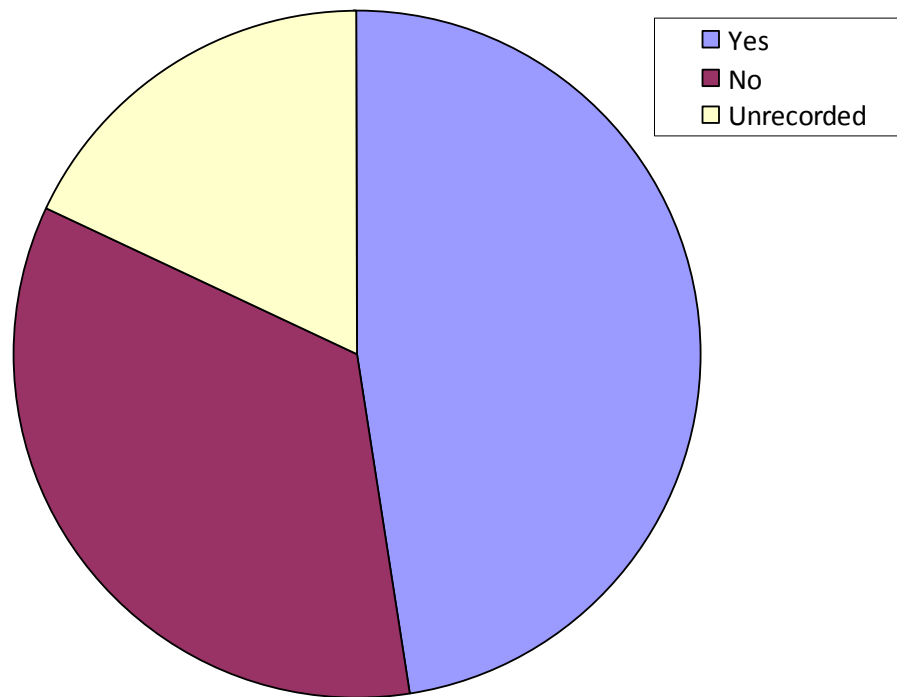
2.4.2 Patient destinations

This chart shows the patients place of residence at the start of their episode of care (vertical axis) and on discharge from a community bed.



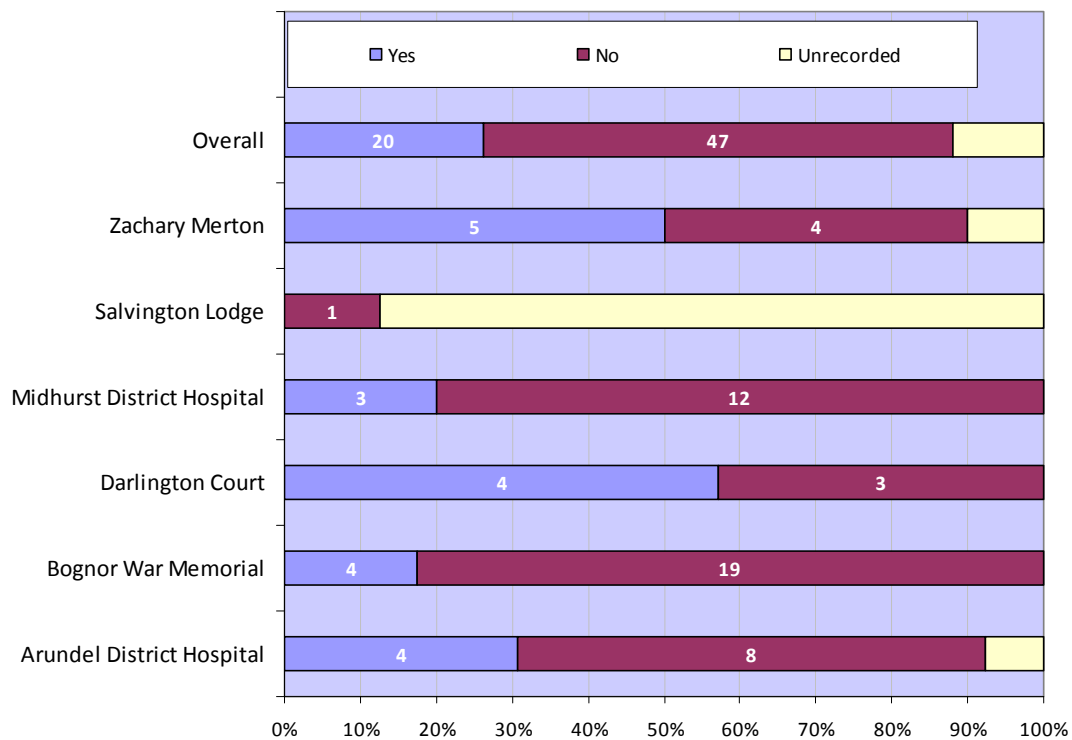
2.4.3 Patient admitted with a discharge plan

This chart shows the percentage of patients admitted with a discharge plan.



2.4.4 Patients who experienced a Delayed Discharge

This chart shows the percentage of patients admitted to each site who experienced a delayed discharge from a community bed.



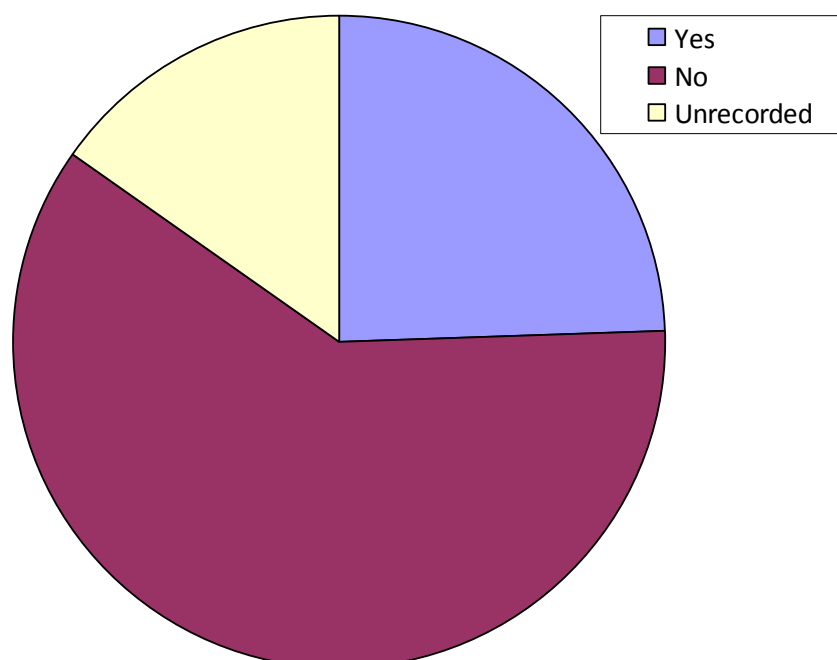
2.4.5 Reasons for delayed discharge

This shows the reasons for delayed discharge as recorded on site.

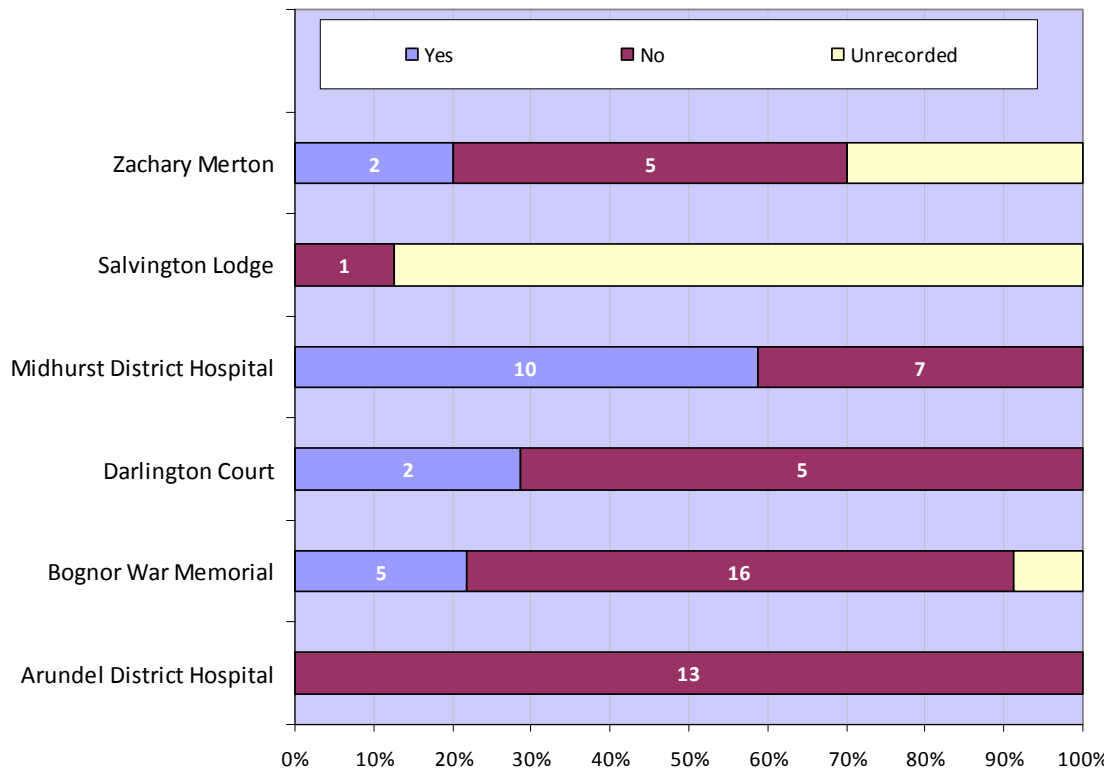
Site	Reason for delay	
Arundel & District Hospital	Delayed care packages x2	Social/Personal problems Delayed placement
Bognor War Memorial Hospital	Delayed care packages x3	Home care (LA) funding
Darlington Court	Awaiting MH Assessment Patient Choice	ICT Support x2
Midhurst District Hospital	Residential Home Equipment (O ₂)	Patient Transport Awaiting Social Work Assessment
Zachary Merton	Residential Home Bed Availability	Delayed care packages ICT Support x3

2.4.5 Alternative pathways

This shows the number of patients who potentially could have cared for on an alternative pathway for some or all of their community hospital inpatient spell.

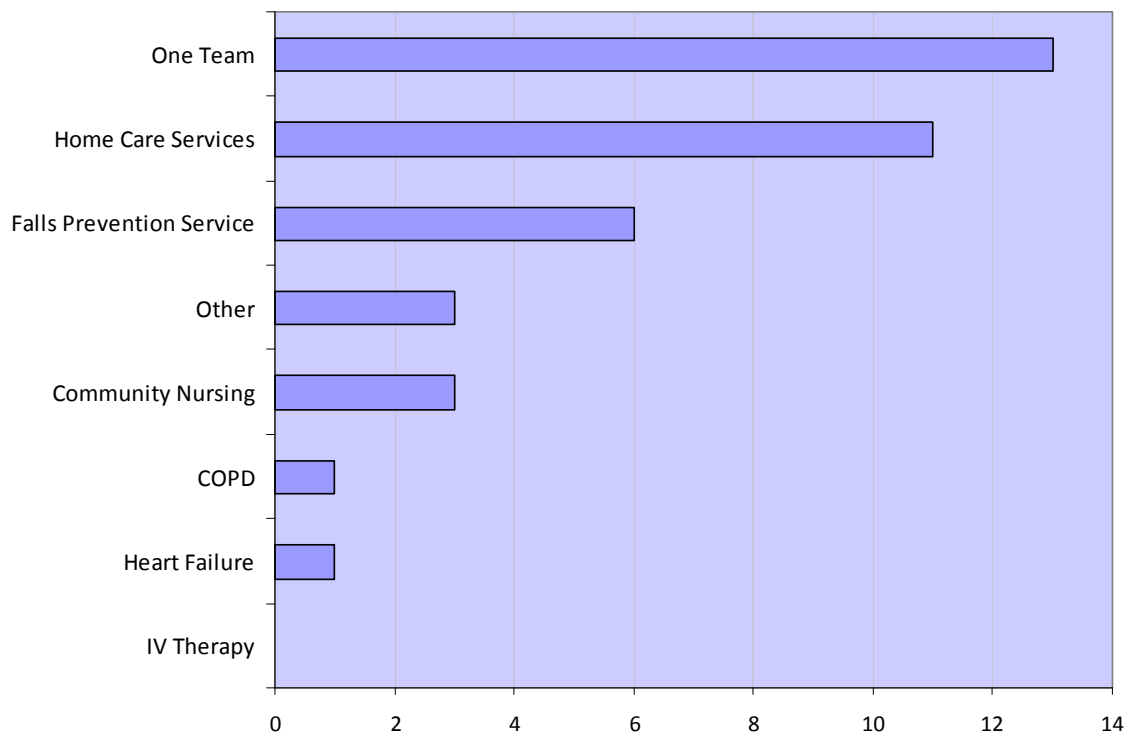


2.4.6 Alternative pathways by site



2.4.7 Alternative pathways by service

This chart shows which services were identified as being a potential alternative to some or all of the patient's community hospital inpatient spell.



Summary of Findings

Sample and Demographics

- Overall the sample of patients audited, **78, represents around a 50% 'response' rate** against the number of beds within the community bed stock.
- **All six community hospital sites responded**, although the volumes varied, as the audit design required audit upon discharge, variation would be expected due to varying patient conditions and broadly proportionate to the quantity of bed stock at each site.
- The average age and age ranges of those patients within the sample are **very similar to that of the data analysis** completed and displayed within the Community Bed Review: Phase 1 Report of Findings, with the average age being 83.7 years and 83.34 years respectively.
- The **proportions of patients from CWS constituent Consortia, aligns to the volumes of audits carried out on sites**, as the rates vary this is not accurately representing Consortia population use of community beds. Therefore analysis of the Consortia population usage of community beds should be drawn from the Community Bed Review: Phase 1 Report of Findings.

Patient Profiles

- **Locally patients are admitted to community beds for 'Intensive Rehabilitation' more than any other profile.** Followed by 'Sub Acute' and 'Complex Elderly with co-morbidities'. The other profiles, 'End of Life', 'Specialist Stroke', 'Respite' and 'Other' have low representation.
- **All sites see a mix of profiles.** Although Zachary Merton has a larger proportion of 'Intensive Rehab' where Midhurst sees the greatest proportion of 'Sub Acute' patients.
- **Patient dependency varies by patient profile. 'Complex Elderly' exhibits the greatest dependency** as would be expected against this profiles optimum length of stay. The range of dependency for 'Sub Acute' patients was very large and reflects the broad range of conditions these patients presented with.
- A significant number of patients started their episode of care with **falls and fractures**. Other common conditions include many long term conditions and conditions often diagnosed in older people, such as urinary tract infections and leg ulcers.

Pathways

- **Most patients were admitted from the Acute Hospital.** With a small proportion from Primary Care and very few from Community Services.
- As stated by community hospital staff, almost half of patients are **not admitted with any formal discharge or care plan.**
- Of the patients that didn't have any formal social and/or nursing care in their home prior to their episode of care, over **a third went on to require social and/or nursing care** in their home with a further **10% going into long term residential or nursing homes.** Despite this **half returned to their usual home without formal social and/or nursing care.**
- Of the patients who had formal social and/or nursing care prior to their episode of care **most went back to these arrangements** although around **20% went into long term residential or nursing homes.**
- The above two points indicate that episodes of care which include a **community hospital inpatient spell often indicate a transition in care needs** for the patient. Given this, it is likely that the arrangement of care packages or placement, including funding and eligibility assessment, makes discharge complex and potentially requires effective coordination and management.
- **25% of patients experienced a delayed discharge.** Reasons include organising care packages, the availability of social or nursing care packages such as Intermediate Care, funding arrangements and assessments, as well as patient choice. Darlington Court and Zachary Merton experienced the greatest percentage of delayed discharges.
- **Nearly 25% of patients could have been supported for some or all of their community hospital inpatient spell, by community teams.** However both Arundel and Salvington Lodge reported no patients as potentially being supported on alternative pathways, this would require further analysis as their average patient dependency on admission and average length of stay were within normal ranges.
- **One Team is cited as the most likely alternative service to support patients for some of their community hospital inpatient spell,** with home care services a close second place.

Appendices

Appendix A. Audit Questions

Site/Ward		Date Completed	/ /
NHS Number		Sex	Male / Female
Age		GP Practice	
Date of Admission	/ /	Date of Discharge	/ /

A. Reason for admission (mark up to two options only - using a 1 and a 2)

Sub Acute	admitted with medical or nursing need. A UTI for example, but does not meet the 'Complex Elderly with co-morbidities' category	
Intensive Rehabilitation	admitted for rehab following a fall or episode of illness	
Stroke Rehabilitation	admitted for rehab following a stroke	
Complex Elderly with co-morbidities	a frail elderly patient admitted for medical and nursing care for a number of diagnoses for a prolonged period	
Neuro Rehabilitation	admitted for rehab for a condition such as MS or Parkinson's Disease	
End of Life or Palliative	admitted to provide their end of life care	
Respite	admitted for a care rather than a medical/nursing need eg. Carer breakdown, support with activities of daily living	
Other (please describe)		

B. Episode details (place only one X in the relevant box)

Primary Diagnosis Describe the primary condition which led to this episode		
Prior to this episode of care, where did the patient live?	Own Home (wo care/nursing package)	
	Own Home (w care/nursing package)	
	Residential/Nursing Home	
Where was the patient admitted from? If other, please note in the available space	Their own GP	
	The Out of Hours GP service	
	Acute Hospital	
	Community Services	
	Other:	
Was this patient admitted with a discharge plan or predicted discharge date? If yes, briefly describe in the box provided	Yes	
	No	
Where was the patient discharged to? If other, please note in the available space	Own Home (wo care/nursing package)	
	Own Home (w care/nursing package)	
	Residential/Nursing Home	
	Acute Hospital	
	Other:	
Where funding is applicable to this patients discharge or ongoing care, who is the funder?	Private/Family	
	Social Care/Local Authority	
	NHS Continuing Healthcare	
Were there any delays in this patients discharge? If yes, briefly describe in the box provided	Yes	
	No	

C. Patient dependency assessment (place only one X in the relevant box per column)

Category	Description	admission	discharge
Mobility	Freely mobile		
	Freely mobile with the use of aids		
	Needs supervision (1 nurse)		
	Needs 2 nurses to mobilise/transfer/position		
	High risk of falls/compromised safety		
Washing & Dressing	Fully independent		
	Needs supervision/guidance		
	Needs help		
	Fully dependant		
Family needs	Minimal		
	Maximum eg. Psychological support		
Communication	Communicates freely		
	Compromised communication eg. Deaf - Mild		
	Compromised communication eg. Deaf - Severe		
Eating & Drinking	No assistance required		
	Needs minimal supervision or assistance		
	Needs to be fed or requires PEG or line feed		
	Sub-cutaneous fluids		
Skin Integrity	Intact but regular assessment (waterlow <15)		
	At risk (waterlow >15)		
	Breakdown in skin integrity		
Dressings	Simple (<10 mins)		
	Complex (>10 mins OR requiring 2 nurses)		
Elimination	Minimal intervention		
	Assisted intervention eg. suppositories/enema		
	Catheter in situ-assistance/supervision		
	Colostomy/Ileostomy/ Ileal conduit		
	Incontinent of urine/faeces OR constant/night toileting		
Psychological status	Anxious: needs occasional reassurance		
	Anxious: needs constant support		
	Low in mood		
	Terminally ill		
Breathing	No intervention required		
	Physiologically unstable: minimal intervention		
	Physiologically unstable: aspiration risk		
	Physiologically unstable: maximum intervention inc O ²		
Sleeping & Resting	Sleeps well (no sedation)		
	Sedation is used		
	Disturbed sleep – minimal supervision		
	Confused, restless, wandering – requiring observation		
Other	Requires isolation/barrier nursing for infection control		

D. Alternative pathways

Is it possible that this patient could have been supported by a community team?			Yes/No
If Yes, which one? (mark all that apply)	Community Nursing Team	Virtual Wards – with supportive IV service	
	Falls Prevention	In-reach at home, service supporting falls patients	
	Heart Failure	In-reach at home, exacerbation support	
	COPD	In-reach at home, exacerbation support, pulmonary rehab	
	IV Therapy	In-reach at home, antibiotic/subcutaneous infusion/blood transfusion	
	One Team	Rapid assessment service, coordinating care for up to 72 hours ensuring handover to an appropriate service	
	Services with Home Care	Provision of personal and social care provided through WSCC	
	Other:		

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Coastal West Sussex Federation is the clinical commissioning group covering Adur, Arun, ARCH (Association of Regis and Chichester) Chanctonbury and Cissbury (Worthing) localities, currently working as part of NHS Sussex. The responsible statutory organisation is West Sussex PCT.

