

**INTERIM CHANGES TO ACUTE INPATIENT ELDERLY MEDICINE,
CARDIOLOGY & RESPIRATORY SERVICE PROVISION AT CALDERDALE AND
HUDDERSFIELD NHS FOUNDATION TRUST (CHFT)**

Paper for Discussion at Kirklees Overview and Scrutiny Committee

14th November 2017

1 Introduction

This paper describes the case for change for the interim reconfiguration of inpatient Respiratory, Cardiology and Elderly Medicine Services. This change is a stand-alone change, and is important for reducing the risk of causing harm to patients now. The benefits of this change will be delivered to patients as soon as the change is made, the proposal does not pre-empt the full reconfiguration.

Kirklees Overview and Scrutiny Committee have requested the following points be addressed in the paper regarding this proposal:

- An explanation of the planned changes including clarity/emphasis on how the changes will result in patients receiving better care; to include quantifying the numbers of people who will be impacted by the changes; and an overview of the relevant performance indicators and what the Trust expects to achieve.
- A focus on the work that is being done to reduce the numbers of patients being admitted to hospital by providing increased support in the community.
- Highlighting the difference in the length of stays between the two sites for respiratory patients.
- More detail on the work that has been carried out on patient engagement to include where events were held and numbers (if known).

The service leadership, both clinical and managerial, are keen to progress the changes before winter begins, to reduce risks to patients over the intensive winter period. Through the document we describe clearly the recommendations of the Invited Service Reviews of the Royal Colleges which describe how making the changes will mitigate quality and safety risks that we are currently managing. We received these reports in 2016, and have spent time engaging with staff and patients, developing an implementation plan to address the recommendations. We have already taken actions in response to many of the recommendations, this reorganisation is one of the final steps we need to take, it is important we do it now to reduce the potential of harm to our patients.

In March 2016 the CQC inspected Calderdale and Huddersfield NHS Foundation Trust. Overall the trust was given a rating of Requires Improvement. Medical Care was one of the core services inspected. Overall Medical Care was rated as good. The CQC rated Medical Care as good in the domains of Effective, Caring, Responsive and Well-led. The CQC rated Medical care as requires improvement in the domain of Safe. These service changes are planned to reduce the risk of harm to patients.

We provide some patient stories to illustrate the potential risks to patients with the current service model, and the benefits the new model will provide. These are attached at appendix A. Both the CQC and Royal Colleges have identified that safety does require improvement, through these changes we can reduce risk of harm.

We have undertaken experience based design workshops and focus groups with patients, looking at ways in which we can improve our inpatient services. Their feedback has been used along with the information in the Report of Findings from the CCG’s public consultation on the overall reconfiguration of clinical services in 5 years’ time to ensure we address the two main public concerns about potential service change. These concerns are:

<p>Travel time to the appropriate acute site in an emergency</p>	<p>Concern about time to access the hospital site in an emergency has been a theme coming through all engagement and consultation with the public. We recognise this is something the public are concerned about. We reiterate the significant benefit of arriving at the right site, with increased consultant input, and that this is a model already used in many of our specialties and in regional services.</p>
<p>Travel and transport - Opportunity to visit patients when the services are on one specific site.</p>	<p>The CCGs have a travel and transport group working on improving links between the two hospitals. Visits from family and friends are a critical part of recovery, and we are really keen to work with families to make this as easy as possible. The shuttle bus is available for relatives who want to transfer between the two sites. More shuttles have been put on at peak times to improve the opportunity to travel. Relatives are also able to book taxis from the main reception (payable by them). Age UK volunteers will be supporting patients with companionship. One of the key benefits of the reconfiguration is that the patient’s stay in hospital will be shorter.</p>

Scrutiny are asked to note that whilst we are making internal changes to specific specialties, the overall bed numbers remain consistent on both sites and patient access to acute services remains through an ED on both sites. Scrutiny are further asked to note the contents of the report and the proposed start date of the service reorganisation: end of November 2017. Scrutiny are asked to provide any comments on the report for the Trust’s review.

Not making this change now will mean we continue to carry the risks identified by the invited service review and CQC. These include:

- Inequality to access acute frailty service, respiratory hot service and cardiology diagnostics and interventions depending on which site patients are admitted to
- Potential harm to patients through;
 - Avoidable admissions
 - Increased length of stay
 - Delay in investigations
 - Need to outlie into non-specialist beds
 - Open extra capacity
 - CQC review of NIV (non-invasive ventilation) provision
- Resulting in HCAI (health care acquired infection), harm falls, PU (pressure ulcer), delirium, deconditioning, increased dependency

Of course we continue to work to minimise these risks in the current service configuration.

2 Background

2.1 The proposal

- The current dual site model of hospital services provided by CHFT does not, and cannot, meet national guidance.
- This paper describes the case for change for the interim reconfiguration of inpatient Respiratory, Cardiology and Elderly Medicine Services. The Hospital Reconfiguration is at Full Business Case stage. If it progresses as planned all three inpatient services would be consolidated at CRH in 2022.
- In 2016 the Trust's care of older people and respiratory medicine services were reviewed by the Royal College of Physicians (RCP). The RCP recommended that action should be taken to enable cardiology and respiratory services to be co-located on the same hospital site and for the care of older people to be located on a single hospital site. The RCP queried whether the Trust could afford to wait five years for these services as proposed in the wider reconfiguration of hospital services particularly given immediate concerns over the fragility of the services and workforce
- In the interests of protecting and improving quality, safety and patient outcomes the Trust has therefore been working to develop proposals for the interim reconfiguration of cardiology, respiratory and elderly care services across the two hospital sites. Since early 2017 there have been a number of discussions and meetings with CCGs and YAS to discuss development of these plans.
- The interim proposal is to consolidate all inpatient Respiratory and Cardiology Services at CRH and Elderly Medicine at HRI.
- The proposal does not affect outpatient and diagnostic services; they will continue to be provided on both hospital sites.

2.2 The current service

- The trust currently provides inpatient Respiratory, Cardiology and Elderly Medicine services on both hospital sites, Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI).
- The Trust faces considerable workforce challenges which undermine the resilience of clinical services and includes intense fragile clinical rotas, and recruitment and retention challenges resulting in a heavy reliance on locum and agency staff. Compared to the total WTE establishment for these three specialties 7 out of 25 posts i.e. 28% of posts are vacant and require agency / locum staffing. These challenges arise specifically due to the current dual-site service model.
- Details of consultant workforce and beds numbers is:

Speciality	Workforce (WTE) Consultants	Calderdale Royal Hospital	Huddersfield Royal Infirmary
Elderly Medicine	establishment: 8 actual in post: 4 agency / locums: 4	47 beds	47 beds
Cardiology	establishment: 10 actual in post: 10	24 beds 13 Coronary Care beds 2 Angioplasty / Pacing labs	12 beds on shared ward
Respiratory	establishment: 7 actual in post: 4 agency / locums: 1 vacancy: 1	16 beds 5 day Consultant 'hot clinic'	12 beds on shared ward

- Activity:
 - In 2015/16 there were 4,880 medical admissions with acute respiratory conditions.
 - In 2015/16 there were 3,232 medical admissions with acute cardiology conditions.
 - In 2015/16 there were 6,982 acute medical admissions for patients aged 75 years or older (excluding patients with a primary cardiac or respiratory condition).

2.3 The drivers for change

- Recommendations from the Royal College of Physicians (RCP) Invited Service Review (ISR) for Elderly Care Services report date June 2016 and Respiratory Medicine report date 26th August 2016.
- There was a strong recommendation that improvements could be made through centralising the services into a single site models. *“Overall, the review team were firmly of the opinion that the respiratory team would benefit from having inpatient services located on one site as they considered this would*

improve cover arrangements of patients (particularly at weekends), would facilitate a sharing of skill sets and a move to 7-day service” (Respiratory ISR)
“The review team did consider the Trust should give serious consideration as to whether the CoE services are able to move to one site sooner than presently planned [in 2022]” (Care of the Elderly ISR)

- Cardiology and respiratory specialist services should be co-located *“The review team concluded that in an ideal situation the cardiology and respiratory services should be co-located on the same site so that the pathway for the breathless patient would be clearer, and patients with mixed cardio-respiratory disease could access both specialist services on one site” (Respiratory ISR)*
- Failure to recruit or retain consultant respiratory and elderly medicine physicians due to high volume of work and lack of a specialty rota. *“The Trust needs to take steps to understand the reasons why they are struggling to recruit to substantive consultant positions. The review team considered that if the Trust had a document, which clearly outlined the vision for the future delivery of the elderly service, then they could use this as part of their recruitment materials to attract new staff” (Care of the Elderly ISR)*
- The need to open additional capacity for winter pressures results in large number of overspill beds being opened which are predominantly for older people. *“We understand delays in transfer of care affect flow of patients during the winter, but these temporary wards raised concerns about the delivery of safe care due a major reliance on locum and agency staff” (Care of the Elderly ISR).* The centralisation of services will create additional capacity to cope with winter pressures (bed optimisation)
- The current configuration of dual services on two acute sites and the challenge to fund and recruit senior clinical staff limits the ability to offer continuity of care for patients or provide consultant led 7 days services.
- Specialist services are increasingly inequitable and due to the challenges of recruitment and retention of staff can only be delivered on one acute site; for example the respiratory admission avoidance hot service is only available at CRH and the acute frailty assessment and management service is only available at HRI.
- The Cardiology service has inequitable access to diagnostic and therapeutic procedures (cardiology interventional laboratories based at CRH) leading to increased length of stay for patients at HRI and an inability to deliver the PCI (Percutaneous coronary intervention) target within 72 hours.
- Work prior to this project through patient’s focus groups (respiratory) and site visits (Leeds Teaching Hospitals Trust) and other initial scoping has indicated there is a case to explore in greater detail the actual benefits of amalgamation of resource onto single site provision for all three Specialties.
- Current pathway issues which lead to confusion for wider clinical teams within the hospital and delays in diagnostic and therapeutic tests for patients. For example in appendix A we provide case studies for 4 patients who have been

treated in our hospitals. There are 2 Frailty patients in these case studies. Both studies describe confusion for the wider clinical team in the best way to support these patients. The reorganisation of services will consolidate the frailty service, and ensure patients get the care they need from the right team in a timely way.

- The need to create a foundation for 7 day Specialist review to avoid clinical variation.
- The Trust continues to be a regional outlier where neighbouring trusts have developed services to have standalone specialist elderly medicine, respiratory and cardiology models of care.

The case for urgent change:

- Patients are not admitted to specialty bed base
- Patients do not receive appropriate/timely specialty review
- Unable to provide consistent 7 day senior review of patients
- Unable to provide Respiratory or Elderly medicine specialty rota
- Unable to substantively recruit to meet the rotas of the two sites, difficult to recruit Consultant workforce
- Challenges to staff retention and need to increase Consultant numbers
- Expert peer review (RCP, Royal College of Physicians) has told us the current service model is fragile and needs to change quickly
- ECIST (Emergency Care Intensive support Team) feedback has raised concern regarding lack of Comprehensive Geriatric assessment & LOS impacts
- CQC (Care Quality Commission) identified the medicine service as good. Under the safety domain it identified the service requires improvement.
- Old fashioned Model, outlier regionally and nationally - most hospitals have consolidated services
- Significant variation in service between sites
- Longer length of stay has negative clinical and organisational impact
- PCI & Day case rate is inefficient and risks adverse clinical impact
- There are adverse outcome risks for patients that need to be admitted to additional flexible inpatient bed capacity
- Impact on nursing workforce capacity from additional demand for services (across all specialties)
- Changes are essential to strengthen the resilience of the hospital and the wider system services for Winter 2017/18

3 Patient engagement:

To ensure any interim service model met the needs of patients, the project teams actively engaged patients for information

- In February 2014 the service leads organised an Experience Based Design for cardiology and respiratory patients at Calderdale Royal Hospital to listen,

understand and learn from what our patients had experienced through their admission, inpatient stay and discharge. This was repeated in May 2017 at Huddersfield Royal Infirmary.

- A Patients focus group for frailty was held at Huddersfield Royal Infirmary on the 10th August 2017. In addition, the physiotherapy lead did interviews with 5 patients, separate to the focus group. This information was used to supplement/triangulate the feedback from the focus group session.
- Each of these sessions was attended by between 10-12 patients and relatives, allowing for in depth views to be obtained and included.
- Learning from the public engagement and Report of Findings from the Right Care, Right Time, Right Place consultation on overall service reconfiguration have been considered where they apply to these services for example travel and transport.

Overall there was positive feedback about both the current services and the proposed consolidated services. The key points raised in the sessions are listed below, together with our response:

Patient feedback	Our response
Patients were left concerned and confused about being on the Coronary Care Unit at HRI having been admitted with a respiratory condition (HRI Ward 11 is a mixed cardiology/respiratory ward).	We recognise this concern. The reorganisation of services will mean patients are on the right ward for their needs and will eliminate this issue.
Patients saw clear benefits in seeing a specialist and being in a specialist bed	We note this point. The reorganisation of clinical services is designed to maximize this benefit.
Good affirmation and agreement from patients about how the frailty service at HRI is currently running	We welcome this feedback. Through reorganising services we look to expand this benefit at CRH through the provision of rapid access geriatrician out-patient appointments and a nurse led frailty team at CRH (pilot) to support admissions avoidance
Concerns around the additional time taken to travel across sites and clinical impact in an emergency	Concern about time to access the hospital site in an emergency has been a theme coming through all engagement and consultation with the public. We recognise this is something the public are concerned about. We reiterate the significant benefit of arriving at the right site, with increased consultant input, and that this is a model already used in many of our specialties and in regional services.
Additional travelling time for family and friends to visit	The CCGs have a travel and transport group working on improving links between the two hospitals. Visits from family and friends are a critical part of recovery, and we are really keen to

Patient feedback	Our response
	work with families to make this as easy as possible. The shuttle bus is available for relatives who want to transfer between the two sites. More shuttles have been put on at peak times to improve the opportunity to travel. Relatives are also able to book taxis from the main reception (payable by them). Age UK volunteers will be supporting patients with companionship. One of the key benefits of the reconfiguration is that the patient's stay in hospital will be shorter.

The project Workstreams were asked to consider concerns through development of the models.

4 Community Services

Scrutiny requested a focus on the work that is being done to reduce the numbers of patients being admitted to hospital by providing increased support in the community. This work includes:

- A focus in community services on case finding through primary care access to the GP Dashboard developed by THIS. As well as providing a view (updated every 24 hours) of patients discharged or admitted to hospital, it also provides a tool for risk stratifying patients on the basis of their current utilisation of planned and unplanned hospital care. – identifying those who are frail and who at risk of unplanned admission, and then co-ordinating care through community matrons, general practice, social care or the third sector; depending upon the needs of the person. This builds on the current national evidence base related to the use of electronic frailty indices. The intention of the work is to avoid the need to admit patients to hospital for unplanned and episodic care, or into permanent residential care.
- New models of care to reduce admissions from care homes. These models; provide MDT (multi-disciplinary team) approaches, access to technology, and education and support to staff.
- A range of services to support those who people who arrive at the hospital and who need interventions to prevent an admission. These services include; frailty and ambulatory care services on both sites – accelerating diagnostic and clinical assessment to reduce the need for admission. Hospital Avoidance Teams and Seamless Home from Hospital Services (provided by the third sector) provide practical support and transport to enable the patient to go home rather than being admitted.
- Reduction in the length of time elderly patients are in hospital – thereby reducing the harm related to deconditioning. We are implementing 8 national high impact changes to strengthen our discharge planning – particularly links with social care. This has been a key feature of the investments made under IBCF (Integration and Better Care Fund) this year.

5 Proposed service change

5.1 Service model:

- A model of care consolidating the three clinical services onto single site provision was developed using clinically led processes and programme management methodology.
- All stakeholders were informed and had opportunity to input into the model and recommend options
- The views of patients were sought and shaped the model
- Out-patients services are NOT affected by the proposal. The changes are to acute in-patients services only.
- Elderly services: The proposal increases the bed base by 10 beds consolidated onto the HRI site with enhanced support for front end frailty review by specialist nurses and Consultants. This will be 6 frailty beds on AMU and additional frailty ambulatory services. Rapid access geriatrician out-patient appointments and a nurse led frailty team at CRH (pilot) will support admissions avoidance. There will be daily Geriatrician presence at CRH to review patients in other specialty beds who require expert advice and review. A Geriatrician will be available by phone 9-5pm Monday to Friday for support to YAS/GP's on queries re ED/AMU attendance.
- Cardiology and respiratory services will be co-located at CRH. The Royal College of Physicians recommended these services be co-located.
- The Cardiology bed base will change. By consolidating the specialty onto one site we will reduce the length of time Kirklees residents are in hospital (as they will no longer need to be transferred between sites to receive diagnosis or treatment in the catheter labs). This means we will be able to reduce the number of Cardiology beds from the current 51 beds across the two sites to 37 beds consolidated at CRH and then reduced further to 29 beds. This is in line with capacity planning for the service. The phased approach is to ensure patients safety and to test the assumed reduction in in-patients stay with increased day case procedures. HRI wards and departments will be supported by daily in-reach by Cardiologists and Specialist Nurses. A Consultant of the week model will ensure continuity of care and consistency of review.
- The Respiratory bed base is to be consolidated and increased in line with the recommendations of the ISR team. The proposal for Phase 1 increases the bed base from 28 to 32 beds consolidated at CRH which includes 4 monitored beds. Phase 2 will see a further increase to 48 beds. The phasing is to ensure patients safety and appropriate number of Consultants in post. A Consultant of the week model will ensure continuity of care and consistency of review.

- To note: the bed changes do not impact on the total bed numbers and is a bed neutral position. Beds are however, being appropriated into the correct specialty bed base from General Medical wards and Short Stay wards.
- Clinical input from YAS (Yorkshire Ambulance Service), ED (Emergency Department) and AMU (Acute Medicine Unit) have allowed development of admissions criteria to ensure patients present and are treated on the most appropriate sites. YAS will expect to transfer between 2-4 patients across site per day.
- Numbers of patients attending each ED site is not expected to be significantly impacted. The type of patients will of course change with more frail elderly patients attending HRI. This will be supported by more ambulatory services and 6 AMU frailty beds. CRH will be supported by an in-reach nurse led frailty team (pilot)
- Self-presenters will experience no change and will present to the nearest hospital site. Patients will be treated on site and transferred across site if clinically indicated
- Collaboration with Local Authority to ensure safe and timely discharge of patients on the 'opposite' hospital site to avoid increases in DTOC (delayed transfers of care) cases and subsequent bed blocks have been agreed. New models of working started to take effect in September 2017.
- A collaborative approach with Locala has developed pathways where community in-reach teams support patients regardless of postcode origin.

Supporting services in the Trust were engaged and support the proposal.

5.2 Impact on patients

Based on analysis of 2016 figures high level modelling indicates the following impacts (*Figures are high level upside downside based on current YAS/CHFT analysis)

Greater Huddersfield Patients:

- Between 2180-2840* patients per annum who attended HRI by ambulance would go to CRH
- 1160-1510 patients who were in-patients at HRI would be admitted to CRH
- 1-2 patients per day would be transferred to CRH

Calderdale Patients:

- 1880-2260 patients who attended CRH by ambulance would go to HRI
- 840-1010 patients who were in-patients at CRH would be admitted to HRI
- 1-2 patients per day would be transferred to HRI

5.3 Benefits and Risks

Key benefits identified through the workshops, workstream meetings and clinical analysis of the proposed service:

- The proposed service model either fully meets the aims of the project and/or provides a platform for further service improvements and efficiency gains in the future such as 7 day provision of services. (Whilst of course inpatients are in hospital for 7 days a week the staff available on site changes on Saturdays and Sundays and out of hours). This reconfiguration would allow us to have more staff groups working across the whole 7 days.
- Patients will have quicker access to Specialist review improving time for diagnosis and treatment. Improving outcomes and patients experience.
- Whilst we are unable to forecast specific improvements in mortality data, we can point to evidence from previous service changes where mortality has improved following reconfiguration. Here a review of mortality data demonstrates that mortality has improved in all specialties that have moved to single site provision. The table below illustrates the improvement in mortality rates for three specialties following reorganisation to single site provision. These are Stroke (acute cerebrovascular disease), Hip fracture (fractured neck of femur) and acute GI bleed (gastrointestinal haemorrhage).

Mortality Rate						
	2012/13	2013/14	2014/15	2015/16	2016/17	Var 2016/17 v 2012/13
						%
Acute cerebrovascular disease	19.7%	19.2%	16.8%	21.1%	15.4%	-4.3%
Fracture of neck of femur (hip)	8.2%	5.5%	8.1%	6.7%	4.1%	-4.1%
Gastrointestinal haemorrhage	3.7%	2.7%	3.1%	2.4%	2.6%	-1.1%
Total	10.5%	9.1%	9.3%	10.1%	7.4%	-3.2%

- Supports winter resilience by creating capacity in current bed base.
- Admission avoidance from frailty teams at CRH & frailty ambulatory chairs at HRI. The frailty model at HRI implemented in February 2017 is already demonstrating an average of 165 avoided admissions per month. The extension of this service at CRH, with rapid access geriatrician appointments and an in-reach frailty team at CRH to support admissions avoidance would enable us to extend this reduction in admissions further.
- Reduced LoS (length of stay). The table below describes the current length of stay and discharges before midday on each site. The difference in length of stay is driven by the difference in service provision on each site. For example Huddersfield Cardiology patients have to wait for a transfer to Calderdale if diagnostic intervention is required. Calderdale in-patients have access to 7 day access to senior respiratory opinion commissioned through the 'hot clinic'. Consolidation of the specialties will allow these clinical variations to be removed, ensuring all patients can benefit from the shorter length of stay. The improvements in reducing LoS are expected to deliver additional 1,577 bed days for cardiology and 1,789 bed days for respiratory patients. For elderly care the improvements will support winter resilience and avoiding opening additional beds.

- Meets the 72 hour PCI diagnostic target (95%). Negates the need for 220 cardiology patients per annum to transfer across site for diagnostics/treatment.
- Consultant of the week model for Cardiology/ Respiratory to reduce length of stay and outcomes. Platform for 7 day working
- Increased move from in-patients to day case rate
- Reduces inequality in access to diagnostics

The table below described key performance indicators for the current services. This includes PCI in 72 hours (Percutaneous coronary intervention, also known as coronary angioplasty), day case rate, spend on agency staff and also the difference in los (length of stay) and % of discharges before midday.

	PCI in 72 hours (standard 60%)	Day case rate (12.2 % national average)	Agency Spend YTD	Activity increase 15/16-16/17	SITE	LoS (2016 or 16/17)	% of discharges before midday (w/c 25/09)
Elderly Care			£585k	3%	HRI	15.4	9%
					CRH	13.1	25%
Cardiology	53%	8.1%	£455k	5%	HRI	9.1	9%
					CRH	5.3	3%
Respiratory			£67k	3%	HRI	11.0	9%
					CRH	7.7	18%

Alongside reducing the number waiting over 72 hours for PCI the number of Respiratory patients waiting for specially beds (outlying) will fall; number of elderly patients waiting for specially beds (outlying) will fall.

Key risks:

Key Risks	Mitigation
The high number of current vacancies: Consultant workforce, Nursing Workforce, therapists and Social Services, engagement workers	Creating more attractive clinical roles may increase recruitment success. Consolidation of nursing workforce will increase role opportunities. Working in larger teams will reduce the risk of agency staff and locum staff working unsupported by substantive staff. Leavers from the Trust have confirmed one reason for leaving was that the service had not been consolidated.
The benefits from the reconfiguration can only be achieved with excellent triage and easy cross site transfers and safe bed occupancy rates on both sites	YAS agreed site decision criteria will be audited and tested for compliance. Patients flow team continuously monitor activity levels across sites and make clinically informed judgement calls about safe capacity

Key Risks	Mitigation
Patients may have less access to Specialist staff (medical/ nursing/ therapists). This is because each specialty is single site, for example geriatric patients at HRI may have reduced access to respiratory or cardiology opinion.	Patients assessed as requiring a specialist bed will be transferred across site. Acute physicians at CRH and HRI will be supported by in-reach geriatricians, respiratory and cardiology medical teams on both sites. Specialist nursing teams to work on both sites
The skill mix of nursing and therapy staff will not be adequate to support the increased speciality bed numbers without further training.	A phased approach to the increase in respiratory specialist bed numbers to ensure safe staffing levels. Training requirements are being addressed to minimise this risk.
Patients on the non-specialist site receive poorer or delayed services as a result of service being on the 'other' site	Both hospitals have full acute service support through ED/AMU/ICU (intensive care unit) to ensure patients safety. Patients will be transferred across site when clinically appropriate
Relatives and carers will have longer to travel. Patients may not have carers/ relatives/visitors to support them during in-pts stays	Relatives and carers of in-pts can use the cross-site shuttle bus. This information will be shared on admission and on the wards. Information on quieter times to use the shuttle bus to be published & held on the wards. Taxi bookings are available at the security desks (payable by user)

(fully analysed in the QIA excel document)

5.4 Implementation

The implementation would be phased over several weeks to ensure patients safety. The proposal is to commence November 2017 over a 2-3 week period subject to full approval

Appendix A

Patient stories

Here are four patient stories, describing how the planned changes will improve patient safety and the inpatient experience. All these incidents have been investigated rigorously through Trust internal processes and the outcome discussed with patients or families in line with the Trust's Duty of Candor obligation.

Respiratory patient

Patient A was a lady in her 60s with chronic chest disease. She was admitted with increasing breathlessness and was being treated for a chest infection. She was admitted to the short stay unit and looked after by the general medical team. On the

Saturday of her admission she was assessed as ready for home and discharged later that day. At home she became more short of breath and needed re-admitting the next day. She was admitted to another ward and because of her breathlessness and the unfamiliar environment of the new ward she suffered a fall and fractured her ankle. This caused her to be bed bound and as a consequence she developed a hospital acquired pneumonia and sadly died.

With the service changes proposed she would have been seen and assessed by the respiratory specialist team on admission and cared for on the respiratory ward. She would have had daily specialist reviews including at the weekend and would have only been discharged when recovered from her respiratory condition.

Cardiology patient

Patient B was a man aged in his 90s who was admitted to HRI with a heart attack. He was transferred to the cardiology ward where his heart rate dropped rapidly. Emergency heart pacing is only available at CRH and he needed emergency equipment to keep his heart rate from dropping further. Staff at HRI were unfamiliar with the specialist equipment and struggled to use it. Medication was given instead to try and keep his heart rate up but he deteriorated and died.

With the proposed service changes planned patient B would have been admitted directly to CRH. Staff would be more familiar with the specialist equipment and he would have had access to emergency pacing. Although Patient B might not have survived he would have had a greater chance with the best treatment options available to the doctors.

Frailty patient

Patient C was a frail elderly gentlemen living in a residential home. He had a complex mental health history and the residential home had raised concerns about an acute change in his behaviour; he was becoming withdrawn and had lost his appetite. He was assessed in the home and it was recommended that he be referred to hospital for an acute medical assessment. In the acute medical unit the doctors had little detail on his condition and the recent concerns from the home and felt that admission was necessary as the only way to investigate and exclude a medical problem. He was admitted to an elderly care ward overnight where, because of the unfamiliar environment and staff, he became more withdrawn and stopped eating and drinking. Because of this he was started on a drip for hydration. His deterioration continued and in spite of good nursing and medical care he developed a hospital acquired pneumonia and died.

On review of his case no medical condition was identified as a cause for his change in behaviour in the residential home; the change in behaviour was due to his mental health condition. With early intervention by the specialist frailty team he would have had a comprehensive assessment and been discharged back to the home that day with a plan of care including increased support from the community team.

Frailty patient

Patient D was a frail elderly woman who was brought to the emergency department having suffered a fall at home. Investigations confirmed a small fracture of a pubic rami (a small bone in the pelvis; these are managed conservatively with pain relief and mobilisation). She was admitted for pain relief and therapy assessment. From ED she was referred to the acute medical unit and then transferred to a non-specialist medical ward before being moved to the short stay unit. Because of her pain and confusion with moving wards patient D became increasingly delirious and could not be discharged home. Sadly she died 2 days later in hospital from a heart attack.

Had she been assessed in ED by the frailty team they would have put a plan in place for analgesia and early mobilisation. She would have needed one night in a specialist frailty bed and have gone home the following day with a plan of care and community support package in place. Although she may still have suffered her heart attack, early intervention from the frailty team would have allowed her to be well, at home and enjoy quality time with her family.