East Lothian
Integration Joint Board

21 DECEMBER 2017

AGENDA ITEM 6

OPTIONS FOR FUTURE PROVISION OF WARD 2, BELHAVEN HOSPITAL

East Lothian
Integration Joint Board

REPORT TO: East Lothian Integration Joint Board

MEETING DATE: 21 December 2017

BY: Chief Officer

SUBJECT: Options for Future Provision of Ward 2 Belhaven Hospital

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1 PURPOSE

1.1 For the East Lothian Integration Joint Board to consider the options for the future provision of the 12 beds currently provided within Ward 2 of Belhaven Hospital in order to address current unacceptable risks to patients and staff arising from the layout and environment of the ward.

2 RECOMMENDATIONS

The IJB is asked to:

2.1 Discuss the options for future provision of Ward 2 (described in more detail in 3.4).

2.2 Agree to support the delivery of the recommended option, number 3, (described in more detail in section 3.5).

2.3 Note the engagement with representatives of the Dunbar area and the Belhaven Forum.

3 BACKGROUND

3.1 Ward 2 in Belhaven Hospital is a 12 bedded unit providing a range of services for primarily elderly patients. The ward includes GP access beds.

3.2 Recent Inspections of Ward 2 Facilities

3.2.1 For some time there have been concerns that limitations within the layout of Ward 2 prevent it from meeting modern environmental and infection control standards and regulations for a healthcare facility. The building's limitations have also been assessed as heightening risk to staff, as good manual handling practice cannot be maintained.

3.2.2 Regular inspections carried out to assess infection control approaches and the quality of the building's fabric and facilities have continued to identify a number of failings. An unannounced audit on the 7th May 2017 by NHS Lothian Infection Control concluded that the ward needed *"...major upgrading, the fabric is extremely poor and not designed for the purpose now used*...[and is]...*not assisting dementia friendly care"*

3.2.3 An official report on a Mental Welfare commission visit of 18th September 2017 is still awaited. The team did however highlight informally many of the issues already found in other inspections. They felt that the area in Ward 2 needed to be more user friendly and homely in nature to provide a better environment for patients. They noted that the ward lacked shower facilities which would be more appropriate for the current patients. They had particular concerns about privacy and dignity, with the beds being so close to each other. They did not feel that the environment was conducive for patients with dementia.

3.2.4 The problems within Ward 2 arise from the age of the building, its space limitations and the physical environment (summarised in appendix 1). These problems cannot be easily overcome. To correct the numerous deficits, to meet infection control standards and healthcare environment guidance, to support safe moving and handling of patients and to deliver best care to patients would require fundamental remodelling of the facility, considerable expense and lengthy disruption to service delivery.

3.2.5 The May 2017 inspection team highlighted and recognised that the care being delivered within the ward was good despite the restricted space and layout within the building, the lack of storage and other problems affecting the ward.

3.2.6 A follow up infection control inspection carried out on the 26th July 2017 compared the Ward 2 facility with what is expected for care of the elderly patients in relation to current NHS and healthcare standards. The report clearly demonstrates that the ward delivers very good nursing care in difficult environmental conditions, but recognised that the quality of the care being delivered was being compromised because of environmental limitations.

3.2.7 A second Patient Quality Indicator audit was carried out by the NHS Lothian infection control team/quality department on the 20th of September 2017. The team focussed their audit on seven areas that had been noted as themes from Older People in Acute Hospital and Health Acquired Infection inspections. In addition to the previously stated issues they noted that the ward floor was uneven and the flooring was rippled. With the addition of poor lighting throughout the ward this increased the risk of falls for patient with cognitive impairment. The use of free-standing heaters to compensate for poor ward heating also posed a falls risk. The poor heating itself was also considered as a risk for patients who because of cognitive impairment might not appreciate or respond to reduced ambient temperatures.

3.2.8 A full and comprehensive list of all work required to bring ward 2 in line with standards and legislation has been compiled and up-dated following each PQI or infection control audit. Any work that can be completed without decanting the ward has been carried out, however, the current outstanding work cannot be scheduled without decanting the whole ward for a period of at least 8 weeks. A full and comprehensive list including costs of outstanding work to achieve these standards and legislation is contained within appendix 4.

3.2.9 In reviewing assessments of Ward 2's physical environment and in developing its recommended option the HSCP management team recognise that the Ward 2 team deliver good care despite the poor environment they are working in.

3.3 Assessment of Bed Occupancy and Ward Activity

3.3.1 To assess bed occupancy and reason for admission over the period January 2014 to October 2017 a manual count was taken of the figures in the hand written ward admission book. The ward admission book was used for data gathering as it was judged that this better reflected the wider usage of the ward than the patient administration system which does not necessarily record all activity, such as day cases for blood transfusion.

3.3.2 Ward 2 does utilise TRAK (Lothian's electronic patient data system) for admissions and discharges. The data (appendix 2) demonstrates that bed occupancy has ranged from 75% to 89% from 2014 to October 2017.

3.3.3 Population growth in Dunbar to date in the over 65s is average for East Lothian. The future growth in this age group is expected to remain in line with the county average.

3.4 Options for Ward 2

3.4.1 The following options were discussed at the Belhaven engagement Forum on 28th November:

- Option 1 - Continue to provide the existing Ward 2 service within the existing premises.

This option is considered untenable as the current poor state of the premises and its layout does not comply with modern standards for infection control, space utilisation, patient dignity, nursing practice and healthcare provision. Essential works have however been carried out on an ongoing basis.

- Option 2 - Provide the Ward 2 service within a replacement 'modular' facility.

Use of modular ward facilities as an adjunct to the existing ward is not considered to be an appropriate solution due to the long term rental, fitting out and commissioning costs (appendix 3) and decommissioning costs at the end of the life/end of rental of the units. There are inherent

limitations of modular premises when compared to other more traditional building provision.

- Option 3 - Move the Ward 2 service to Ward 3.

Ward 3 is judged to be suitable to accommodate the patients and associated clinical activity within the current ward 2.

Once Ward 2 is no longer used for clinical purposes it would be suitable for conversion to community staff offices, providing a Community Hub for the expanding Elsie team embedded into the heart of the community. This team would work alongside local community services and general practice. Initial estimates suggest the cost of conversion will be in the region of £60,000. More detailed costs are being prepared.

- Option 4 - Carry out upgrade work to bring Ward 2's facilities up to modern standards.

It is considered that the necessary remedial works and remodelling of the premises needed to sort its many problems cannot be effectively carried out within the limitations of the space. In addition, any work is likely to have a limited impact on improving the utility of the ward facilities. This option would require closure of ward 2 for a minimum of 8 weeks to enable work to be completed. The costs of this option are estimated as £553,000 (appendix 4).

3.4.2 The preferred option presented to the forum was option 3.

3.4.3 The HSCP management team made a commitment that whatever option of the 4 was recommended, the range of services in Belhaven Hospital would continue to support GP access to beds (through referral to the Clinical Lead for Frailty at Roodlands Hospital) nursing home beds and NHS long term care.

3.4.4 Ongoing monitoring will ensure that the services delivered through Belhaven Hospital continue to meet all necessary standards of care for the patients it serves.

3.5 **Development of the Preferred Option**

3.5.1 At the meeting with the Belhaven Forum on 28th November there was detailed discussion on the options. The HSCP responded to the content of the discussion by proposing a new option to the forum. However, there was significant negative reaction from the forum to the new option and this has now been removed and the preferred option is still option 3.

3.5.2 In considering the options, the management team has also taken into account the information contained in the report *'Analysis of Belhaven Ward 2 beds and drivers for change'* (appendix 6):

- Option 3 maintains all three functions currently provided at Belhaven; nursing home, NHS long term care and GP beds.

- It also allows some capacity to continue for patients who are waiting for a package of care or care home/residential home placement. This would be delivered in the more suitable facilities in ward 3.

- The relocation of the step-down facility at Liberton Hospital to the new care home due to open in Haddington will increase capacity by 6 beds compared to provision in Crookston Care Home.

- It maintains access to the GP beds for palliative and end of life care, for patients who need increased nursing input and those needing transfusions. This could be delivered in the more suitable facilities in ward 3.

- Accommodating Ward 2 in Ward 3 will ensure Dunbar and area patients continue to receive care closer to their home in a fit for purpose environment which meets all relevant standards.

- It is recognised that option 3 means a reduced nursing home capacity in Belhaven, however, the HSCP is continuing to reduce delayed discharges which frees up capacity and additional capacity is becoming available in East Lothian. In addition a new Hospital to Home team will be established in December 2017 to serve the Dunbar area, increasing capacity for care at home.

- Option 3 allows the opportunity for the vacated Ward 2 to be used as a local community base for home care and hospital at home.

- The process for delivery of option 3 is described in appendix 5.

4 ENGAGEMENT

4.1 A Belhaven Working Group meeting was held on 10th October 2017.

4.2 As part of engagement, press releases and statements have been issued to the local media.

4.3 Meetings of the Belhaven Forum, attended by representatives of the HSCP Management Team, have been held since November 2016. There have been 6 meetings held during 2017, most recently on 28th November 2017. To inform discussion at the forum, members received information briefings. At its November meeting, the briefing covered described 4 options (appendix 7).

4.4 On the 7th December, members of the Belhaven Forum were provided with an updated briefing on the options which included a description of the new option.

4.5 **Feedback from Belhaven Forum, Community Councils and Dunbar GP Practices**

4.5.1 The feedback received from Belhaven Forum members, Community Council representatives and the three GP Practices in Dunbar (Cromwell Harbour, Lauderdale and Whitesands) is reproduced in full in appendix 8.

5 POLICY IMPLICATIONS

5.1 the proposals in this paper are consistent with the IJB's strategic direction to provide more care at home or in a homely setting and to address the issues raised by care facilities that are not fit for purpose.

6 INTEGRATED IMPACT ASSESSMENT

6.1 The subject of this report has been through the Integrated Impact Assessment (IIA) process to consider each of the options (appendix 10). A further IIA will be required for the option approved by the IJB.

7 RESOURCE IMPLICATIONS

7.1 Financial – Many of the options have financial implications attached. These are outlined in the relevant sections/appendices of this paper. Final and definitive estimates will be developed for the option supported by the IJB and an associated business case developed.

7.2 Personnel – The implications for personnel will be fully assessed in partnership with staff side for the option supported by the IJB.

8 BACKGROUND PAPERS

Appendix 1 - Summary of current issues with the fabric and fittings in Ward 2

Appendix 2 - Bed utilisation in 2014-15, 2016-17 and 2017-18 (to end October 2017)

Appendix 3 - Costs of delivering Option 2 - Provide the Ward 2 service within a replacement 'modular' facility

Appendix 4 - Costs of upgrading and remodelling of Ward 2 in accordance with Scottish Health Facilities Note 30 (2002) (SHFN 30)

Appendix 5 - Outline Plan for Implementation

Appendix 6 - Report on Belhaven Ward 2 – Bed Utilisation and Ward Activity

Appendix 7 - 28th November 2017 Briefing to Belhaven Forum on Options for Ward 2

Appendix 8 - Feedback from Belhaven Forum Members, Local Community Council Representatives and Dunbar GP Practices (note this includes comment about the new option)

Appendix 9 - Notes of Belhaven Forum 28th November 2017

Appendix 10 - Integrated Impact Assessment on Ward 2 Options

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DATE	14 December 2017

Appendix 1

Summary of current issues with the fabric and fittings in Ward 2

- Space between beds inadequate not allowing for appropriate and safe manual handling or the space deemed necessary for appropriate infection control principles. The ward would need to be remodelled and expensively up-graded to achieve appropriate bed spacing.
- All windows within the ward required to be removed and replaced with double glazed units, current windows are not fit for purpose, the putty where the glass is held in place is very damaged and dirty
- Treatment room units need replaced however, there is a lack of space for clinical storage, and the room has open shelving, which is not in keeping with current standards. The floor in this area had rust patches on it where the oxygen cylinders have had to be stored
- The current kitchen units and kitchen layout does not meet appropriate standards and need to be replaced, the walls within the kitchen area are noticeably damaged, due to the lack of space the door handle hits the wall on opening
- The current heating system needs up grading. Inadequate heating has led to the use of freestanding heaters in sitting room. This is not considered safe for elderly patients suffering from dementia
- Not all bathrooms have enough space to accommodate hoists, this creates manual handling risks for nursing staff
- The domestic service room is in a state of disrepair and needs to be fully up-graded and remodelled to comply with standards
- As the sluice is not compliant with standards it needs complete up grading
- As none of the wash hand basins and taps throughout the ward have mixer taps they are not compliant with standards. In addition, the current hand hygiene sinks are not compliant with SHTM 64 Sanitary Assemblies standard
- Corridors were cluttered with equipment due to the lack of storage
- The presence of carpets in some areas of the ward, make lifting and handling of patients difficult. There is staining to the carpet along the corridor and throughout the ward. For these reasons, the flooring throughout the ward needs to be removed and replaced
- Neither the male or female bedded areas have nearby hand hygiene sinks. There should be one per two beds (NBN 00-03) for clinical staff to use
- There are no toilets within 12m walking distance of most patient areas facilities (HN 00-03)
- Staff move patients on stand aids etc along a carpeted corridor to the toilets or to the toilet or bathroom
- The bed space areas do not meet recent spatial sizes and are overcrowded with chairs, lockers and belongings. Bed spaces for some years have been advocated to be 3.6 m by 3.7m (SHFN 30 Part A Manual)
- Exposed pipes in various areas need to be boxed in and covered

- The flooring is vinyl in the care area but it is not coved to the wall, instead there is wooden skirting that is damaged throughout the areas – flooring should be slip rated and be coved to the wall, must be impermeable and easily cleaned (SHTM 61)
- Both areas have an inbuilt bank of wardrobes that are chipped in places and various corners of walls are broken and damaged, and need to be removed and replaced
- Lighting in care areas, especially the single room accommodation is not compliant with current guidance as lights should be selected and installed to eliminate or minimise ledges/gaps/dust traps and, as far as is practicable, be accessible and easily cleanable. (SHTM 06-01)
- Although there are 12 beds within the ward, only 11 can be used because one bed is inaccessible for patients and staff. The team also illustrated that patient chairs were obstructing hand washing facilities. Because of the lack of space around the area, the hand washing facilities within the bays are not compliant or adequate
- Estates have also indicated that the ward needed both re-wired and re-plumbed.

Appendix 2

Bed utilisation in 2014-15, 2016-17 and 2017-18 (to end October 2017)

Activity in 2014-15 (ward capacity is based on 11 beds, equivalent to 4,015 bed nights)

Belhaven Ward 2				
2014-15 (24 months Jan 14 to Dec 15)		11 beds on ward	8030 bed days (24 months)	
Reason for Admission	**No. Patient Episodes**	**Sum of days in ward**	**Beds per anuum this activty equalled**	
Assessment	15	178	0.2	
Blood Transfusion	47	47	0.1	
Falls at home	4	88	0.1	
Infection-wound management	7	108	0.1	
No recorded reason	5	128	0.2	
Other	8	251	0.3	
Pain control	11	98	0.1	
Palliative	17	404	0.6	
Post op care	5	102	0.1	
Reduced mobility	3	158	0.2	
Respite	14	303	0.4	**2.6**
Continuing Care	2	612	0.8	
POC	35	1386	1.9	
Nursing home	30	2341	3.2	**5.9**
Grand Total		**6204**	**8.5**	

- A 75% ward bed occupancy rate was achieved in 2014/15.
- 5 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.
- 3 beds on average were utilised via local primary care services.
- 1 bed was used for NHS Continuing Care.

Activity in 2015-16 (ward capacity is based on 11 beds, equivalent to 4,015 bed nights)

2016 (12 months -Jan-Dec)		11 beds on ward	4015 bed days	
Reason for Admission	**No. Patient Episodes**	**Sum of days in ward**	**Beds per anuum this activty equalled**	
Assessment	17	199	0.5	
Blood Transfusion	35	35	0.1	
Continuing Care	1	8	0.0	
Falls at home	3	36	0.1	
Infection-wound management	10	116	0.3	
No recorded reason	5	357	1.0	
Other	4	113	0.3	
Pain control	1	27	0.1	
Palliative	14	181	0.5	
Respite	1	12	0.0	
Post op care	1	43	0.1	**3.1**
Nursing home	12	718	2.0	
POC	46	1741	4.8	**6.7**
Grand Total		**3586**	**9.8**	

- An 89% ward bed occupancy rate was achieved in 2015-16
- 7 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.
- 3 beds on average were utilised via local primary care services.

Activity for the 1st 10 months of 2017 (ward capacity is based on 11 beds, equivalent to 4,015 bed nights)

2017 (10 months -Jan-Oct)		11 beds on ward	3344 bed days	
Reason for Admission	**No. Patient Episodes**	**Sum of Days in ward**	**Beds per anuum this activty equalled**	
Assessment	10	178	0.6	
Blood Transfusion	5	5	0.0	
Continuing Care	4	443	1.5	
Falls at Home	5	174	0.6	
Infection-wound management	3	67	0.2	
No recorded reason	2	14	0.0	
Other	2	27	0.1	
Pain Control	5	138	0.5	
(blank)	3	64	0.2	
Palliative	17	270	0.9	**4.5**
Nursing Home	11	473	1.6	
POC	28	1039	3.4	**5.0**
Grand Total		**2892**	**9.5**	

- An 87% ward bed occupancy rate was achieved in 2017 up to October.
- 5 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.
- 5 beds on average were utilised via local primary care services.

Appendix 3

Costs of delivering Option 2 - Provide the Ward 2 service within a replacement 'modular' facility

Indicative costs for a 12 bedded ward modular unit for 3 years				
	Cost per week £	**Cost for 3 years £**	**One off costs £**	
12 bed unit	1175	183,300.00		
hire of ramps & steps	303.07	47,278.92		
hire of fire & intruder alarm systems	71.05	11,083.80		
hire of climate control system	296.04	46,182.24		
transport of modules to site			5,950	
installation			23,413.76	
grounds works (estimate pending survey)			30,361.5	
Subtotal		287,844.96	59,725.26	
Total				**347,570.22**

These costs **exclude**:

- any specialist rooms requirements (e.g. assisted bathrooms)
- IT, electrics
- fixtures & fittings e.g. lights
- specialist flooring
- decommissioning and removal of units.

Appendix 4

Costs of upgrading and remodelling of Ward 2 in accordance with Scottish Health Facilities Note 30 (2002) (SHFN 30)

Schedule of works	Estimated Costs £
Remove all carpets and current flooring, repair uneven flooring, and supply new vinyl floor coverings throughout the ward	20,000
Remodel ward to create single rooms with en-suite facilities, hand washing in the room and appropriate wet room provision	300,000
Review and replace heating system to remove the need for portable heaters within the sitting room.	5,500
Upgrade relatives toilet and staff toilet facilities (installing clinical type wash hand basins) to provide compliant hand washing facilities	2,000
Upgrade bathrooms to comply with DDA & HEI and to allow for safe and effective moving and handling	40,000
Replace current blinds with washable blinds to meet standards and to properly fit newly installed windows	5,000
Replace/upgrade as necessary the kitchen/sluice /treatment room/DSR, including a segregated linen area.	45,000
Replace all windows throughout the ward and install automated doors at the ward entrance	30,000
Supply and fit fly screens to windows	3,000
Allowance for professional fees and plans	10,000
Review current wiring and plumbing taking action as necessary	10,000
Create a nurses' station (and provide 'touchdown' stations) to improve observation of patients and to improve working conditions	5,000
Upgrade the IT system (to include a new server) to improve patient record keeping	10,000
Total	**553,000**

Appendix 5

Outline Plan for Implementation

Agree at onset an agreed delivery date e.g. 1st April 2018

Establish a Project Team in January 2018 comprising:

- Group Service Manager — Lorraine Cowan
- Service Manager — Carolyn Wyllie
- Assistant Service Manager — Matt Kennedy
- Senior Charge Nurse Wd 2 — Angela McLean
- GP Representative — to be confirmed
- Advocacy — Carers of East Lothian
- Strategy/Project Manager Support — to be confirmed

Planned actions:

- Fortnightly meetings to start the first week of February 2018
- Stop admission to Wards 1 & 3 in February 2018
- Review current client group
- Allocate clients to individual Social Workers
- Individually review and assess each client (include input of relatives, carers, staff and GP in each assessment)
- Review alternative choices if those have been identified with family
- Confirm choices
- If client wants to move then establish vacancies available
- Arrange visits to and assessment of Care Home of choice
- Social Workers to negotiate transfer to new Care Home if necessary

To facilitate transfers all completed paperwork will need to be completed for the:

- Assessment
- Support Plan
- Discharge letter
- Discharge meeting
- Review of arrangements

As 71% of the current patients in ward 3 originate from Dunbar (as do 54% of the patients in ward 1) relatives may be receptive to a planned and co-ordinated move closer to home.

The timeframe is flexible to enable individual residents to be supported.

Appendix 6

Report on Belhaven Ward 2 – Bed Utilisation and Ward Activity

East Lothian
Health & Social Care Partnership

Analysis of Belhaven Ward 2 beds and drivers for change

Draft: 3rd DRAFT
Issued: 06.12.17

DOCUMENT CONTROL SHEET

Title	Analysis of Belhaven Ward 2 beds and drivers for change
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Document Author:

Version	Name	Contact Details
1.0	Lorraine Cowan /Gordon Gray	0131 536 8356- 01620 827728

Revision History:

Version	Date Issued	Summary of changes	Changed made by
1.2	06.12.17	Updated costings	Gordon Gray
1.1	23.11.17	Up-dated version	Lorraine Cowan
1.0	06.04.17	Addition of RIE A&E admission activity	Gordon Gray

Approvals:

Version	Date Approved	Name	Signature	Designation

Distribution:

Version	Date Issued	Name	Designation

Link Documents / Location:

Documents Title	Location
Ward 2 admittance book	K Drive/ East Lothian SMT/Gordon Gray
IRS1403 - Emergency Admissions to RIE from residents of Dunbar and surrounding areas, 2016	K Drive/ East Lothian SMT/Gordon Gray

Contents

1 Summary

1.1 Ward Usage

The bed usage records cover the period January 2014 to June 2016, as detailed in the Ward Admittance Books. Occasionally (18 of the 282 patients) where no length of stay has been recorded, Trak was accessed and the relevant information added. The various reasons for admittance have been grouped into headings for ease of information display.

Grouping
Assessment
Blood Transfusion
Continuing Care
Falls at home
Infection-wound Management
No recorded reason
Nursing home
Other
Pain control
Palliative
Packages Of Care
Post op care
Reduced mobility
Respite

1.2 Overview

The information indicates the greatest use of beds is for ‘Patients awaiting a Package of Care’ (POC) to return home, or waiting transfer to their choice of Nursing or Residential Home when it becomes available. In 2014 a large % of bed days were used for NHS Long Term Care — what is now referred to as Health Board Continuing Complex Care (HBCCC). However, this was usage was by only 2 patients and does not continue into 2015, 2016 or to October 2017 (most recent data available).

2 Breakdown of Bed usage

2.1 Activity across 2014-15

Belhaven Ward 2				
2014-15 (24 months Jan 14 to Dec 15)		11 beds on ward	8030 bed days (24 months)	
Reason for Admission	**No. Patient Episodes**	**Sum of days in ward**	**Beds per anuum this activty equalled**	
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Blood Transfusion	47	47	0.1	
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Continuing Care	2	612	0.8	
POC	35	1386	1.9	
Nursing home	30	2341	3.2	**5.9**
Grand Total		**6204**	**8.5**	

Ward capacity based on 11 beds, would be 4015 bed nights. The above indicates a 75% bed occupancy for the ward across 2014/15.

5 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.

3 beds on average were utilised via local primary care services.

1 bed was used for NHS Continuing Care.

2.2 Activity across 2016

2016 (12 months -Jan-Dec)		11 beds on ward	4015 bed days	
Reason for Admission	**No. Patient Episodes**	**Sum of days in ward**	**Beds per anuum this activty equalled**	
Assessment	17	199	0.5	
Blood Transfusion	35	35	0.1	
Continuing Care	1	8	0.0	
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Nursing home	12	718	2.0	
POC	46	1741	4.8	**6.7**
Grand Total		**3586**	**9.8**	

Ward capacity based on 11 beds, would be 4015 bed nights. The above indicates an 89% bed occupancy for the ward across 2016

7 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.

3 beds on average were utilised via local primary care services.

2.3 Activity for the 1st 10 months of 2017

2017 (10 months -Jan-Oct)		11 beds on ward	3344 bed days	
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Nursing Home	11	473	1.6	
POC	28	1039	3.4	**5.0**
Grand Total		**2892**	**9.5**	

Ward capacity based on 11 beds, would be 3344 bed nights (10 months Jan-Oct). The above indicates an 87% bed occupancy for the ward to date in 2017.

5 beds on average were used for patients waiting on their care home of choice becoming available or waiting to return home when the appropriated care package became available.

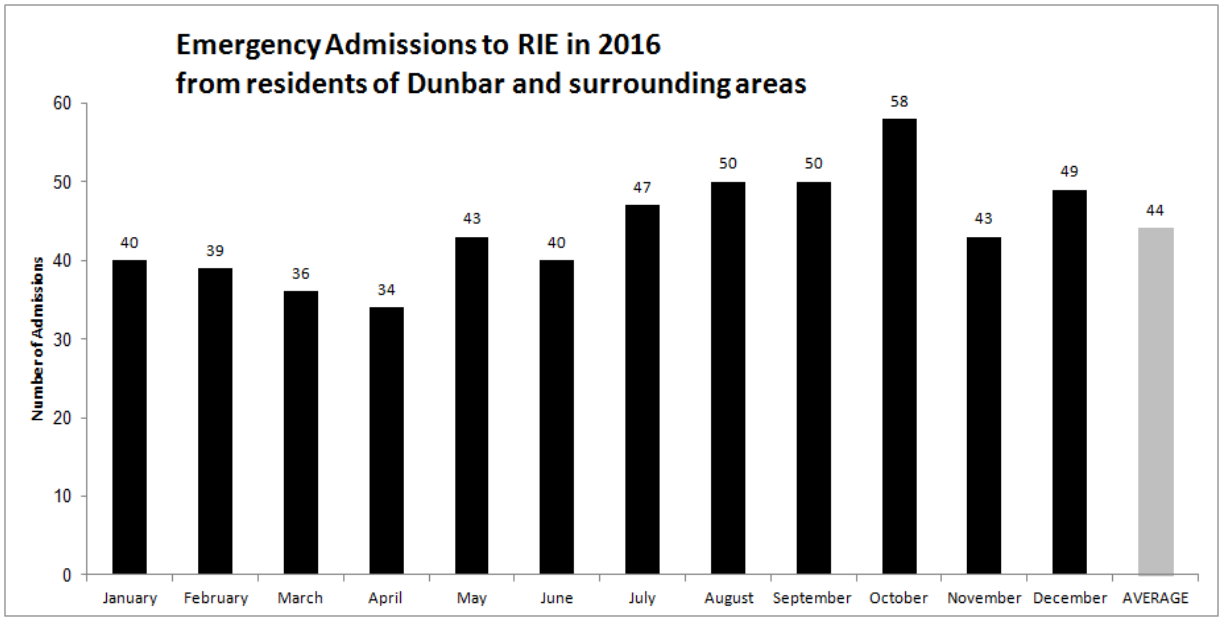
5 beds on average were utilised via local primary care services.

2.4 A&E Admittance across 2016 at the Royal Infirmary of Edinburgh

To ensure that there are not patients being admitted to acute sites that could otherwise be supported within ward 2 at Belhaven, admissions to the Royal Infirmary and Western were examined. Across the 2016 calendar year, there were 529 admittance from the Dunbar and surrounding area into the Royal Infirmary of Edinburgh via the unscheduled, unplanned route.

This averages out at 44 per month. The range being 34 (April) to 58 (October).

The graphics below table below shows the numbers across each month and the sex and age range.



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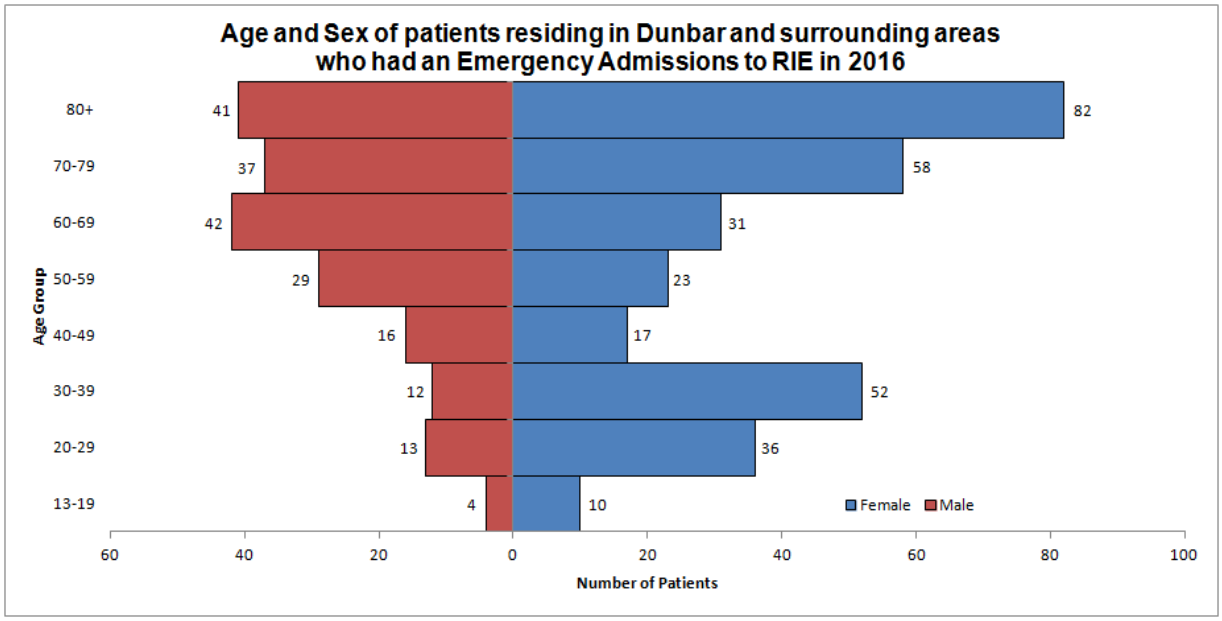

The information captured in relation to the usage of Ward 2 demonstrates that over the course of the last three years the usage of the area has increased, this being with patients waiting on either packages of care or nursing home places. The information demonstrated that if both nursing home places and packages of care were available at point of assessment the number of beds needed to support the local community would be less than the current 12 beds (only 11 being used due to constraints within the environment). Initial indications suggest that the beds needed to support the patient group excluding those delayed would be three to four however, patient admitted on a

day care basis which is 1% of the activity could have their transfusion arranged at home by hospital at home. The three beds would support palliative, end of life care and those needed nursing care or assessment and evaluation.

3 Drivers for Change to review activity within Belhaven Hospital

3.1 Developments with East Lothian

Within East Lothian there have been a number of drivers to deliver a new model of care that is sustainable for the future and delivers care close to home. For this reason there has been considerable investment in a number of new initiatives that formulated the Elsie project (East Lothian Service for the Integrated Care of the Elderly) which have collectively brought about a change in the way we have delivered care to the residents of the county, allowing those requiring care to receive this at home or in a homely environment which may be a care home or residential home. The opening of a step down unit has also influenced the way in which patients waiting on packages of care, nursing home places and residential home places are supported. However, it must be recognised that the Edington hospital in North Berwick also plays a vital pivotal role in supporting patient flow by ensuring that patients waiting on packages of care/nursing home return to their local community.

However, the development and expansion of the following teams has significantly shifted the balance of care from secondary care back into the community which has been received positively by both patients and their families, who prefer to return home as soon as medical fit to do so.

These teams being:

- Hospital to home
- Hospital at home
- Care home team
- Discharge to assess
- Discharge to assess plus.

All the above teams have expanded and developed over the last two years to provide service to patients who would otherwise be admitted to an acute hospital

The Hospital to Home team provides packages of care in the community. The service is led by the Senior Charge Nurse, has 18 fulltime band 3 carers and two registered nursing staff. Previously, these packages would alternatively be provided by social care and private care agencies. A reablement model is used which leads to a reduction in the need for care through time and where appropriate the package of care is ended. By using this approach it maximises, maintains and can improve a person's independence by empowering them to return to the activities of daily living and maintaining their independence. To date the hospital to home team have stopped 50 care packages, reduced 28 care packages and have supported 7 palliative patients who were cared for at home and died at home. The service has scored 97% satisfaction rates by patients and their families, 429 patients over the last 2 years have received the services of the team.

Hospital at home service led by a Lead clinician seeks to support the twin goals of avoiding unnecessary Hospital admissions, and where an admission is necessary, to support the patient's prompt Discharge from hospital back to their own home in the community. The service brings together the multidisciplinary team (MDT) and integrates this around the needs of the patient, setting goals and implementing a care plan to reach these goals through continuous review and monitoring that takes place at the daily huddle where all members of the team lead meet to discuss progress. The service provides an urgent assessment that is responsive and able to provide monitoring and intervention for patient with an acute episode of illness that would otherwise require to an acute hospital admission, working with all members of the multidisciplinary team to get the patient seen in the right place at the right time by the right person who reviews the patient on a regular basis. The service works with teams who already exist within the community, such as the district nurses and general practitioners to achieve the best outcome for the patient within their own home setting.

Although the service originally had difficulty maintaining medical staff input they have successfully recruited a half time lead clinician , a GP who provides two sessions per week and a full time Staff Grade doctor, to support the service which has provided care for over 800 patients to date.

The care home team provide support and guidance to the 17 care homes in East Lothian. They identify training needs and provide education, facilitate access to specialist services when required. They work closely with East Lothian Council when concerns are raised or investigated.
The aim of the service is to help maintain quality care, improve standards of care, aide staff to access the skills & knowledge needed to care for their residents, prevent unnecessary hospital admissions, facilitate hospital discharge for complex cases and to improve links and access to secondary care services. They work in conjunction with other teams to ensure that residents within the care home setting are supported to remain within their home.

Discharge to assess provides early discharge from hospital, to facilitate getting patient home from hospital when it is safe to do so, working with the patient to identify ongoing support and continue their rehabilitation in their home. The level of support depends on patient needs and ongoing continuous assessment carried out the allied health professionals to ensure that the patients reach their optimum.

All of the above services work together to support patients to avoid admission to hospital and to support early discharge from hospital.

The supporting funding for the above-mentioned new and different ways of delivering care to reduce both hospital bed days, delayed discharges by shifting the balance of care back into the community has been made available through the following funding streams.

- Integrated Care Fund.
- Delayed Discharge Funding.
- Elsie Funding.

All of the available funding streams have been released to achieve moving towards providing care for patient at the right time, in the right place and in the right way to ensure that patients receive holistic patient care within the community setting that optimises available resources, ensuring the delivery of effective and efficient services that are fit for purpose.

A full overview and full description of each service, benefits, cost effectiveness and progress is contained within appendix one.

The second driver for change in looking at a new way of working and evaluation of the services being provided at Belhaven is the deterioration of both the environment and the building of ward two at Belhaven for some considerable number of years it has been identified that ward two does not meet infection control standards or regulations. Concern has been raised from the estates department and infection control for some considerable time.

Patient Quality Audits have been carried out every 18 months, although concern has been raised for some years, a recent unannounced audit carried out on the 7th of May demonstrated that the deteriorating condition of the ward continues, the view of the inspection team was that the ward was not fit for purpose and did not provide an environment that supported in any way dementia care. The inspection team also identified that the ward was in need of not only major up-grading, but would be required to be remodelled. This would ensure that the care delivered was holistic in nature and in an environment that meets patient's needs, legislation and standards.

The inspection team stated in their report that the ward 2 was an "old building in need of a major upgrading, the fabric is extremely poor and not designed for the purpose now used, not assisting dementia friendly care".

The inspection team highlighted and recognised that the care being delivered within the ward was good despite the restrictions, layout of the building, lack of storage and carpets in some areas of the ward, it was reassuring to the team for it to be recognised that they were delivering good care despite the poor environment.

A follow up infection control inspection carried out on the 26th July compared the present facility with what is expected for care of the elderly patients in relation to current NHS and health care standards. The report findings are included in the highlighted issues below, however, the report clearly demonstrates that the ward again delivers very good nursing care in difficult environmental conditions that staff have adapted well to, the quality of the care being delivered was being compromised because of environmental limitations, and restrictions.

A second Patient Quality Indicator audit was carried out by the NHS Lothian infection control team/ quality department on the 20TH of September 2017. The approach the team took during these audit was to focus efforts on seven areas that had been noted as themes from OPAH and HAI inspections. The themes being :

- ward environment
- the standard of patient equipment cleaning
- PPE and Uniform/Dress Code Policy
- PVC management.
- patient documentation
- OPAH/dementia friendly environment
- patient feedback

The areas of concern noted are also included in the highlighted areas below, this report stated that in general, the environment was not dementia friendly. They also noted that the flooring was not optimal for patients with cognitive impairment and the lighting was not good throughout the ward for patient with cognitive impairment, leading to increased risk of falls.

They noted that the ward floor was uneven and the flooring was rippled, leading to a falls risk. There are multiple slip trip and fall hazards presented due to various environmental issues.

The team noted that in line with previous review, the sitting room was cold and required additional heating from free standing heaters. For patients with cognitive impairment they may not appreciate or respond to ambient temperature and could be a risk, these free standing heaters would also pose a falls risk.

In the male toilet, there were wall mounted coat hooks for patient to put their clothes on, which could pose risk of head injury on rising from the toilet if the patient had poor balance, but due to limited space within the toilet there was little or no space for patients to place their clothing.

Several areas of concern have been highlighted across all three recent audits:

- ❖ Space between beds inadequate not allowing for appropriate and safe manual handling or the space deemed necessary for appropriate infection control principles. The ward would need to be remodelled and expensively up-graded to achieve appropriate bed spacing.
- ❖ All windows within the ward required to be removed and replaced with double glazed units, current windows are not fit for purpose, the putty where the glass is held in place is very damaged and dirty.
- ❖ Treatment Rooms units need replaced however, there is a lack of space for clinical storage, and the room has open shelving, which is not in keeping with current standards. The floor in this area had rust patches on it where the oxygen cylinders have had to be stored.
- ❖ The current Kitchen units and kitchen layout does not meet standards and need to be replaced, the walls within the kitchen area are noticeably damaged , due to the lack of space the door handle hits the wall on opening .
- ❖ Inadequate heating, freestanding heaters in sitting room which is not conducive for elderly patients suffering from dementia. Current heating system needs up grading.
- ❖ Not all bathrooms have enough space to accommodate hoists.

- Domestic service room (DSR) not compliant and is in a state of disrepair needs to be fully up-graded and remodelled to meet standards. Storing unnecessary items due to lack of storage.
- Sluice needs complete up grading, non-compliant with standards.
- All wash hand basins and taps throughout the ward not compliant – no mixer taps. The current hand hygiene sinks are not compliant with SHTM 64 Sanitary Assemblies standard.
- Corridors were cluttered with equipment due to the lack of storage
- Carpets in some areas of the ward, making it difficult for lifting and handling, the flooring throughout the ward needs to be removed and replaced. There is stained carpeting along the corridor and throughout the ward.
- Both the male and female bedded areas are the same and have the same issues in relation to not having hand hygiene sink in or near the area – there should be one per two beds (NBN 00-03) for clinical staff to use for hand hygiene
- There are no toilets with in 12 m walking distance of most patient areas – multi bedded room should be supplied with en-suite facilities (HN 00-03)
- Staff move patients on stand aids etc along a carpeted corridor to the toilets or to the toilet or bathroom
- The bed space areas do not meet recent spatial sizes and are overcrowded with chairs, lockers and belongings. Bed spaces for some years have been advocated to be 3.6 m by 3.7m (SHFN 30 Part A Manual).
- Exposed pipes in areas that need to be boxed in and covered.
- The flooring is vinyl in the care area but it is not coved to the wall, instead there is wooden skirting that is damaged throughout the areas – flooring should be slip rated and be coved to the wall, must be impermeable and easily cleaned (SHTM 61)
- Both areas have an inbuilt bank of wardrobes that are chipped in places and various corners of walls are broken and damaged, and need to be removed and replaced.
- Lighting in care areas, especially the single room accommodation is not compliant with today's guidance as lights should be selected and installed to eliminate or minimise ledges/gaps/dust traps and, as far as is practicable, be accessible and easily cleanable. . (SHTM 06-01)
- Although there are 12 beds within the ward, only 11 can be used because one bed is inaccessible for patients and staff, the team also illustrated that patient chairs were obstructing hand washing facilities because of the lack of space around the area, the hand washing facilities within the bays are not compliant or adequate.
- Estates have also indicated that the ward needed both re wired and replumbed.

A review meeting took place following the audit , the estates department confirmed that the ward would also need rewired and the current plumbing would need to be evaluated and may need replaced, this along with the above mentioned areas of non-compliance the whole ward would need remodelled and fully up-graded to meet current regulations and standards. In previous years cost were identified and put forward to improve the ward facilities these in no way complied to the HEI standards, this amounted to £238,000 unfortunately, funding to date has not been available to address the shortfalls identified at time in 2015. These costs were estimated two years

ago to smarten the ward up. Single rooms with en suite facilities and hand washing facilities in each room are necessary. Plans were produced a few years ago and costs obtained to carry out the remodelling and up-grading work. Unfortunately no funding was secured or made available. It was recognised that the measures proposed would have in no way comply with the HEI required standards. The ward had open plan dormitories and has no single accommodation or en-suite facilities. Full remodelling and up-grading needed which will result in 8 beds within the area.

It can be concluded that extensive work is needed to modernise the area and bring it up to an acceptable standard to comply with current HEI regulations and standards, a full breakdown of these are being compiled at present, however estimated costs are contained within appendix two. It is recognised to do this extensive work the ward would be out of commission for some considerable time and other facilities would need to be identified to support and manage the current activity.

3.2 Future Objectives

The objective would be to in conjunction with the Dunbar General Practitioners to develop an action plan that details what the future steps would be to move towards a model of care on site that was not dependant on the beds within ward two at Belhaven, due to the continued concern that remains around both the building and the Ward environment not being fit for purpose or compliant with standards or regulations. Given the continued lack of available funding stream to support the previous identified work which would still not have ensured that the area was fully compliant, future funding streams will be very difficult to secure in the very near future to achieve completely remodelling and up-grading the area. It is now therefore necessary to look at alternatives given that the ward has been deemed not fit for purpose, this represents a governance issue that is of high concern, there is therefore a great need to explore and secure alternative ways of delivering care to the Dunbar population that reduces any potential major risks.

3.3 Constraints

The major constraint in providing care for patient in ward two is the continued deterioration of the building and the accessibility to funds to up-grade and modernise the current facilities to meet the needs of patients and standards and regulations.

As outlined above although action plans and costs have been previously identified and funding sought, no funding has been secured, the building continues to deteriorate, due to the age and presentation of many patients, providing nursing care in an area that is not fit for purpose or dementia friendly remains a challenge, this limits the types of patient who are admitted to the ward for example patients who need a full hoist cannot be supported in this environment, there is therefore a need for the partnership to look at alternative ways of providing this care that meets the needs of the community but is compliant and risk adverse.

3.4 Assumptions

The data and information illustrates that if the model of care was to move towards one that supports patients more fully within the community by the expansion and usage of the Elsie services to reduce the delayed discharges, avoid admissions and supports early discharge from secondary care the number of beds needed

within the unit at Belhaven could be reduced to three. Although the area would not be able to support patient care it could be used to bring services such as hospital at home for example so that they can be embedded into the local community within a hub model.(needs expanded)

4 Conclusions

The current bed usage of ward two is primarily driven by patients who are waiting on a package of care or care home/residential home placement, this coupled with the continued deterioration of both the building and environment, warrants a different approach to the way in which ward two beds are used and configured.

There is a need to look at providing the bed base required to continue to palliative and end of life care, support patients who needed increased nursing, and those needing transfusions, this could be achieved within another ward on site. Thus ensuring that patients continue to receive care closer to their home, but would ensure that the care required remained within the local community and fit for purpose, cost effective but more essentially meets government legislation and standards.

Increasing the services provided within Elsie , providing three beds for palliative care and those who need nursing care within ward 3 (Hollytrees) in Belhaven negating the need to use ward 2 which is no longer fit for purpose. This would reduce the nursing home beds within Hollytrees however, this could be supported with the provision of further nursing home beds within the county.

Using the ward not for the delivery of care for patients but introducing a hub facility would ensure that the local community would have the advancing services being provided by the expanding Elsie team embedded into the heart of the community who would work in conjunction and alongside the local General practices. Estates have been asked to costs turning ward 2 into a community hub, the costings for which have still to be provided.

5 Recommendations

The information contained in this report suggests that the care being delivered to patients within Ward 2 at Belhaven is very good despite the constraints and difficulties staff face in relation to the environment and building. For some considerable time concerns have emerged in relation to the ward being fit for purpose.

The recommendation is that the growing successful community delivered initiatives and developments within East Lothian should be used to support patients within the community. In addition, development of Ward 3 at Belhaven will support bed provision for people with palliative and end of life care needs, those who need transfusions and those who have increased nursing care needs thus supporting the local community and allowing Ward 2 to close, with the premises adapted to provide office space for the growing community teams.

Appendix One

Elsie Services

HOSPITAL TO HOME TEAM

Hospital at home was originally set up to support patient's discharge into the community who would otherwise have spent a large volume of time waiting on their care package in an acute hospital bed, this is neither cost effective nor beneficial for the patients or families.

This has been a successful venture, which has seen the team expand from one run in 2014 to five runs including a double up run at this current time.

The Team now consists of:

- 1 Band 7 Senior Charge Nurse
- 1 Band 6 Co-ordinator
- 1 Band 5 Staff Nurse
- 18 WTE Band 3's

The above staffing covers the whole of East Lothian. Five teams including one of which is a double up team, ensuring that the care packages are provided until local providers are in a position to support patients.

Advantages of this service.

A flexible service is offered, patients agree to their visits will be at variable times, staff work with the patient to ensure that they support their care needs but also to ensure that patient do not become very fixed. It is a proactive service - If a patient's needs alter once home then the service can increase their care until things improve and they return to their normal.

A reablement model is used which leads to a reduction in the need for care through time, at times stopping the care of package altogether. By using this approach it maximises, maintains and can improve on a person's independence by empowering them to return to the activities of daily living and maintaining their independence.
The service has received excellent feedback from patients, relatives and other professionals. Most recent patient satisfaction audit scored 96.7%
The Care staff are trained to SVQ 3 level and working towards completing relevant community competencies. Planning is underway to increase the competencies of staff to be able to complete simple dressings, take clinical observations, bladder scans etc.
If the staff have concerns about any patients they commence weekly weights; food diaries and are referred to Dietician if required with support from the co-ordinator.
Carers are managed by Registered Nurses so they can provide support, advice, and continuous guidance. This can and has prevented readmissions because problems are being dealt with early. Carers also are able to discuss concerns with the registered nurses on an ongoing basis.

The registered nurses complete an initial visit with the patient and set person centred goals. They carry out weekly reviews of the care plans; these reviews are very comprehensive and include a review of the next of kin/carers. The staff can then refer or sign post patient or relatives to appropriate help. If necessary which is not included in the service provided by agencies?

The staff also has access to ELMS for ordering equipment, complete continence assessments and order from cc online.

Carers able to work across disciplines and services such as

- Nursing
- Physiotherapy
- Occupational Therapy
- Emergency Care Service

This is an excellent example of integrated teamwork and improved communication between OT/Physiotherapy and Health/Social.

Providing this service lessens institutionalisation, reduces the risk of contracting a hospital acquired infection, delirium and confusion by discharging when fit for discharge and allows patients to return to their own home setting with support.

Successfully managing palliative patients at home with their wish to die in their own home
Hospital to Home is a cost effective service when comparing the number of bed days that those patients would have remained in hospital, the service has successfully supported over 150 patients in the last two years.

To date the hospital at home team have stopped 50 care packages, reduced 28 care packages and have supported 7 palliative patients who were cared for at home and died at home.

In essence the Hospital to home team provide a very good highly efficient service to residents within East Lothian which without its conception would have otherwise had a lengthy stay in an acute hospital environment, with the successful implementation of this nursing approach to Care in the Community many positive benefits have been established these being:

1. Due to reviewing patients, no less than weekly, which prevented re-admission and influenced a change to some of care packages, either reducing or increasing or stopping some altogether. However, essentially meeting the needs of the patients within their own home in line with the patient's abilities.
2. Patient care is managed efficiently and effectively through integrated teamwork and enhanced improved communication between both Health and Social care.
3. Maintain and deliver high standards of quality holistic care by implementing a flexible person centred approach, based on patient needs.
4. Applying the enablement model to maximise, and maintain, the patients' independence thus empowering the patients.

5. Support patient flow from acute Secondary Care beds by facilitating a swift and timely discharge.
6. Cost effective by reducing acute bed days, enabling beds to be closed at Roodlands.
7. Lessens institutionalisation, the risk of contracting Hospital Acquired Infection, delirium and confusion thus maintaining patients well being and health.

HOSPITAL AT HOME SERVICE

East Lothian Hospital@Home service seeks to support the twin goals of avoiding unnecessary Hospital admissions, and where an admission is necessary, to support the patient's prompt Discharge from hospital back to their own home in the community.

The Hospital@Home service brings together the multidisciplinary team (MDT) and integrates this around the needs of the patient, setting goals and implementing a care plan to reach these goals through continuous review and monitoring that takes place each day at the huddle.

The team consists of the following professionals:

- 0.50 Lead Clinician
- Two sessions from a General Practitioner
- One full time staff grade
- 3.00 Advanced Nurse Practitioners
- 3.00 Nurse Practitioners
- 2.00 Staff Nurses
- 3.00 Clinical Support workers
- 0.50 Occupational Therapist
- 0.50 Physiotherapists.
- 0.50 Clinical Pharmacist
- 1.00 Nurse Specialist Mental Health

A Social Worker from the current social work team attends the daily huddles every day at 08.15.
The above team from the Hospital@Home team either meet at the hub each day or teleconference in to participate in the discussions regarding the patients within the virtual ward. They discuss and review the care plan for each patient who is currently being supported at home by the Hospital@Home team; they will agree the next step in the patient's journey, by collectively discussing and deciding which member or members of the team are best placed to support the patient's journey and implement the care plan. The team are also joined and supported by the delayed discharge co-ordinator who can also help to facilitate a bed as necessary and the Home care advisor who will interface with the team if a patient from any care home is admitted or needs support in their care home environment.

There are two categories of patients in accessing the Hospital@Home service:

- Admission avoidance

- Early discharge from hospital.

For admission avoidance, the Hospital@Home service accepts referrals from the following health care professionals and areas:

- GP's across East Lothian.
- District nursing teams in consultation with the team and the patients GP.
- Community Hospitals.
- Acute Hospitals consultants and medical staff.
- Nurse Specialists. Specialist Palliative Care Teams.
- Accident and Emergency.
- ECAT – Royal Infirmary of Edinburgh
- Team 65 – Western General Hospital.
- Psychiatrist.
- Care Homes across East Lothian, via General Practitioners.

The Hospital@Home service then provides an urgent assessment that is responsive and able to provide intensive monitoring and intervention for the patient with an acute episode of illness that would otherwise require an acute hospital admission. This Nurse led multidisciplinary team will provide care within (12) hours of referral as required, working with other members of the multidisciplinary team to get the patient seen in the right place at the right time and by the right person and whose care is reviewed on a regular basis.

For early discharge, Hospital@Home accepts referral from acute care medical physicians, ward senior charge nurse, therapists, Frail Elderly Teams and other acute care consultants. The aim is to allow a timely advanced discharge for patients in secondary care who have had acute intervention or treatment and who require ongoing treatment, monitoring, nursing care and therapy support, and who would otherwise remain in hospital without this active and necessary intervention. This elevates pressure on acute hospital beds and allows patients to return to the activities of daily living supported, and reduces the number of failed discharges due to lack of early intervention because the patients is not being monitored or supported with some areas of ongoing care.

To date the team have supported over 774 patients since February 2014, the average length of stay depends on the patients presenting condition this can be from 1 Day to up to 50 days. The team will support the patients in the community to remain in their own home and environment.
Patient satisfaction is excellent, patients and relatives have expressed that they feel that the service is patient centred allowing patient to be supported within their own environment through their acute episode or exacerbation of a chronic condition. Relative feedback however, demonstrates that some relatives feel that they do not benefit from an opportunity of a rest whilst their relative is in hospital therefore increasing carers stress.

Benefits of the service

- Patients remain in their own home, surrounded by their family and carers.

- Patients are not admitted and therefore do not lose their package of care and have a further delay of having to be reallocated a package further down the line when available, if a complex package of care patients can wait some considerable months.
- Reduced bed days allowing the service to close 13 beds.
- Allows the service to ensure that the patient receives the right treatment in the right place at the right time.
- Patient benefits from a multiprofessional approach to care.
- Strengthened links with social care and mental health.

Over the last 6 months the service has managed patient activity and has reduced bed occupancy by 694 bed days which equates to a saving of £247,900, however, the benefits for patients particularly frail elderly patients is much improved because they do not become institutionalised, diminishing the risk of contracting Hospital Acquired Infection, delirium and confusion thus maintaining and improving patients well being and health by maintaining their independence within the community.

EAST LOTHIAN CARE HOME TEAM

East Lothian Care Home Team continues to develop from its creation in May 2014 with a single member of staff it now comprises the following team

- 1 WTE Band 7 Care Home Team Manager
- 2 WTE Band 6 Care Home Liaison Nurses
- 2 WTE Band 6 Nurse Practitioners
- 1 WTE Band 5 Staff Nurses

The team now has three strands of operation but all work cohesively and collaboratively. This model works well and all staff in the team are able to cross-cover, these strands are:

1. The provision of education.
2. Nurse Practitioner service
3. Support to nursing and residential homes.

The aims of the Care Home Team (CHT) are consistent with previously and are to:

- Promote and enhance quality standards of care and clinical practice through education and clinical support.
- Prevent admission and facilitate earlier discharge
- Improve communication between primary care, secondary care, community and specialist services
- Enhance partnership and integrated working
- Improve uptake of and access to educational resources/opportunities

Education:

45 formal education sessions delivered locally on various topics including pressure ulcer prevention, Nurse Verification of Expected Death, Anticipatory care, catheterisation.
233 staff have attended these formal training sessions – various levels of staff including carers and registered nursing staff.
Facilitated flu vaccination training programme for RNs in 13 care homes – organised programme and ensured that staff achieved competencies.
Multiple additional informal educational input within care homes as required and requested e.g. bowel care, skin care.

Individual referrals:

253 individual patients seen since January 2015
73 patients seen since September 2016
153 contacts with patients since September 2016
The CHT are now recording all individual contacts on TRAK.

Benefits

With the most recent expansion of the CHT, this provides the opportunity to offer regular visiting to each care home along with responding to requests for intervention, which aims to pro-actively support staff within care homes. It will also allow the team to develop a more structured educational programme to run alongside the more informal sessions, which will continue. The team have recently conducted a survey of all the homes to find out what training will be required in the coming year and also what training would be most useful but may not currently be being offered – this will form the basis of the structured educational programme but will also inform educational developments that will need to be put in place or facilitated. Links with the education team continue to be strengthened to ensure that the governance around the delivery of specific educational sessions is robust. This approach means that staff within the care homes is able to access education at local level which enhances their skill level and enables them to be more able to care for more complex patients e.g. VAC dressings. It has also enabled staff to need less support from community nursing services e.g. care of supra pubic catheters, compression bandaging.
The team continues to enhance its working with council colleagues and in particular with council care home managers e.g. assessment of suitability of potential residents along with its role in issues of adult support and protection and as part of Large Scale Investigations.

Nurse Practitioner Strand of the Service

The Nurse Practitioner led service in Eskbridge is now embedded within the practice, is the lead contact for five care homes in Musselburgh, and provides holistic assessment, diagnosis and treatment for approximately **135** patients registered with Eskbridge MP. This team is now able to offer a more comprehensive service with regard to anticipatory and preventive care whilst continuing with its routine visiting. The service continues to be the first point of contact between 8am-6pm for any acute periods of illness within this care home population. A recent questionnaire elicited positive results with some areas of improvement highlighted that were already being actioned or will be passed to other members of the CHT to action e.g. education requirements. One of the NPs has now completed her independent prescribing course and the second NP is nearing completion of the course.

Face to face encounters

1003 encounters between December 2015 – August 2016
1118 encounters between August 2016 – February 2017

Benefits

The benefits of the NP service are that the service is holistic and very responsive in its approach to prevent hospital admission and facilitate discharge whenever possible. The NPs are very accessible, will respond within a short timeframe when a patient is acutely unwell, and are committed to providing a high quality of care at all times. The numbers of patients in care homes covered by this service is rising and this is because

of the care home managers choosing to register new patients with Eskbridge to ensure that they can be covered by the NP service.

Nursing Home Strand

The CHT has most recently started to work more closely in partnership with one independent provider in employing a Band 5 Staff Nurse who works as part of the CHT but is based within a nursing home. This partnership arrangement also includes EL Council. The role of this Band 5 is to provide direct patient care to the residents in the home but also to provide leadership, clinical teaching and role modelling to staff within the home. Her role, although in its infancy, has been welcomed and initial feedback is positive.

Benefits

This involvement is partly enabling this particular nursing home to remain open and functioning to ensure that patients from EL. can access the 23 beds within the home. The continuity of this member of staff enhances the care provided for patients whilst also improving the skills and clinical practice of the staff in the home. Working in close partnership with this independent care home provides challenges but also offers a chance to learn and develop this relationship.

Step-Down Facility

This is another example of an initiative that has been introduced through delayed discharge funding which has significantly improved the patients journey , increased patients satisfaction and maintained patients independence .

Crookston step-down beds provide an in-patient facility for people predominantly over the age of 65. The purpose of the unit is to provide care for patients who are medically fit to be discharged from an acute hospital setting but are awaiting a package of care, nursing home placement or are encountering a delay, which would otherwise cause them to remain within the acute hospital setting.

Crookston Care Home is a purpose built facility, housed within a 60 building bedded purpose build unit that houses 40 residential patients, the top floor of the building has until recently been dedicated to providing 20 step down beds for the purpose of reducing delayed discharges and also continuing and maintaining the patients rehabilitation whilst they wait on a care package or care home placement.

The unit admits patients who are:

- For people who are medically ready to be discharged from hospital
- For people who are awaiting completion of social care arrangements

Crookston step down admission criteria:

- Aged 65 and over
- No longer requires medical intervention, within a hospital setting – but may have ongoing AHP needs
- Has been assessed by the MDT, is unable to go straight home but there is a clear plan in place.
- Needs can be met within Step down bed setting
- Have been assessed by Medicine of the Elderly services as being medically fit.

Crookston step down exclusion criteria:

- Respite care
- Palliative care
- Are confirmed as having met inpatient complex care criteria
- Require some specialist forms of care
- Are medically unfit
- Recent diagnosis of an unresolved delirium
- Are awaiting guardianship
- Under 65

Guidelines for referring to Step Down:

- A geriatrician will deem appropriate the referral to Step Down.
- Before referring, the option must be discussed and agreed with the patient.
- People must know that they could be moved to Crookston once they no longer need a hospital bed.
- People must know that admission to Crookston is not regarded as an interim placement to await a nursing home or residential placement.

The unit has adopted a multi-disciplinary approach to patient care and assessment and the nursing team are well supported by a range of clinical staff including occupational therapists, physiotherapists, psychologists, pharmacists and social workers. A dedicated social worker was secured through delayed discharge funding to support the patients within the unit; this has proved very successful in maintaining excellent communication links with patient and their families.

Weekly multidisciplinary meetings take place to continue the discharge planning process for each individual, ensuring that the patients needs are met and that they continue to be fit for discharge, the unit has a dedicated part-time physiotherapist and part-time occupational therapist who strive hard to ensure that patient continue their rehabilitation to maintain or improve their independence.

All patients are treated as an individual and be given every opportunity to maintain their independence as much as possible. The unit has adopted a holistic approach to care in that they address psychological, social and spiritual as well as physical needs. We will aim to promote a safe environment based on trust and support, which will allow

patients to both maintain and develop different skills and personalities to the benefit of all.

Patient and relative feedback has been excellent, the staff have build good relationships based on mutual trust and respect, through good communication with patients, carers, relatives and visitors and all members of the multidisciplinary team.

Nursing structure and ward staffing

The Senior Charge Nurse has continuing 24-hour responsibility for management of the facility and maintaining agreed standards of care, the following staff supports the delivery of holistic patient care:

- 1 WTE Senior Charge Nurse.
- 1 WTE Deputy Charge Nurse.
- 10 WTE Staff Nurses.
- 10 WTE Care Assistants.
- 1 WTE Ward Clerkess.

To date the unit has supported 381 patients who would otherwise have been delayed sitting in an acute hospital bed at a cost of £350 per night. They now have the opportunity to be within the environment at the Crookston step down facility, which provides them with greater dignity and privacy.

Patient satisfaction and feedback has been excellent, the unit have successfully managed to reduce the package of care for some 30 patients and have managed to support patients to return to the activities of daily living independently without a package of care, which they had originally been assessed as needing.

All of the above initiatives have had a positive impact on reducing delayed discharges, bed occupancy and bed acuity by shifting the balance of care back to providing a wide range of facilities within patient homes, thus ensuring that patients remain within the community.

Appendix Two

Current estimated costs of fully modernising and remodelling Ward 2.

Schedule of works	Estimated Costs £
Remove all carpets and current flooring, repair uneven flooring, and supply new vinyl floor coverings throughout the ward	20,000
Remodel ward to create single rooms with en-suite facilities, hand washing in the room and appropriate wet room provision	300,000
Review and replace heating system to remove the need for portable heaters within the sitting room.	5,500
Upgrade relatives toilet and staff toilet facilities (installing clinical type wash hand basins) to provide compliant hand washing facilities	2,000
Upgrade bathrooms to comply with DDA & HEI and to allow for safe and effective moving and handling	40,000
Replace current blinds with washable blinds to meet standards and to properly fit newly installed windows	5,000
Replace/upgrade as necessary the kitchen/sluice /treatment room/DSR, including a segregated linen area.	45,000
Replace all windows throughout the ward and install automated doors at the ward entrance	30,000
Supply and fit fly screens to windows	3,000
Allowance for professional fees and plans	10,000
Review current wiring and plumbing taking action as necessary	10,000
Create a nurses' station (and provide 'touchdown' stations) to improve observation of patients and to improve working conditions	5,000
Upgrade the IT system (to include a new server) to improve patient record keeping	10,000
Total	**553,000**

Appendix Three

Standards considered during second review by infection control.

Scottish Executive Health Department: Provision of Single Room Accommodation and Bed Spacing CEL 27 2010.

Health Building Note 00-02 – Sanitary spaces. Department of Health.

Health Building Note 00-03 – Clinical, clinical support and specialist spaces. Department of Health.

Health Building Note 00-09 – Infection control in the built environment. Department of Health. *SHFN 30 Part A: Manual Version 4.0: October 2014 Page 67 of 69 Health Facilities Scotland, a Division of National Services Scotland*

Health Building Note 00-10 Part A. Flooring. Department of Health.

Health Building Note 00-10 Part B. Walls and ceilings. Department of Health.

Health Building Note 00-10 Part C. Sanitary assemblies. Department of Health.

Scottish Health Planning Note 04: In-patient accommodation: options for choice, Health Facilities Scotland.

Scottish Health Planning Note 04-01: Inpatient accommodation: Option for choice, Supplement 1: Isolation Facilities in Acute settings, Health Facilities Scotland 2008.

Scottish Health Technical Memorandum 55: Windows.

Scottish Health Technical Memorandum 64: Sanitary assemblies.

Appendix 7

28th November 2017 Briefing to Belhaven Forum on Options for Ward 2

Briefing – Future Provision of Ward 2, Belhaven Hospital

East Lothian Health and Social Care Partnership is exploring the options for the future provision of the 12 beds within Ward 2 of Belhaven Hospital.

Background

For some time there have been concerns that limitations within the layout of Ward 2 prevent it from meeting modern environmental and infection control standards and regulations for a healthcare facility.

Regular inspections carried out to assess infection control approaches and the quality of the building's fabric and facilities have continued to identify a number of failings. An unannounced audit on the 7th May 2017 concluded that the ward needed *"...major upgrading, the fabric is extremely poor and not designed for the purpose now used...*[and is]*...not assisting dementia friendly care".*

The problems within Ward 2 arise from the age of the building, its space limitations and the physical environment. These problems cannot be easily overcome. To correct the numerous deficits, to meet infection control standards and healthcare environment guidance, to support safe moving and handling of patients and to deliver best care to patients would require fundamental remodelling of the facility.

Options for Ward 2

Work is underway to assess bed usage and reason for admission over the period January 2014 to October 2017 to support a robust description of activity within the ward. So far, the data from Jan 14 to Dec 16 has been analysed. The outcomes of this work, the reports on the ward's physical environment and options for future development of services to the patient group served by Ward 2 will be presented in a report to East Lothian Integration Joint Board (IJB) at its meeting on 21 December 2017. This report will explore 4 options for the future of Ward 2:

Option 1 - Continue to provide the existing service within the existing premises.
Option 2 - Provide the service within a replacement 'modular' facility.
Option 3 - Close the ward and provide the service through Ward 3.
Option 4 - Carry out upgrade work to bring the facility up to modern standards.

Each of these options is considered in brief below.

Option 1 - Continue to provide the existing service within the existing premises.

This option is considered untenable as the current poor state of the premises and its layout does not comply with modern standards for infection control, space utilisation, patient dignity, nursing practice and healthcare provision.

Option 2 - Provide the service within a replacement 'modular' facility adjoining Ward 2.

Use of modular ward facilities as an adjunct to the existing ward is not considered to be an appropriate solution due to the long term rental, fitting out and commissioning costs (and decommissioning costs at the end of the life/end of rental of the units) the inherent limitations of modular premises when compared to other more traditional options and the requirement to continue using Ward 2.

Option 3 - Close Ward 2, provide the service through Ward 3 and change the use of Ward 2.

This option is considered to be most feasible as Ward 3 is suitable to accommodate the patients and associated clinical activity within the current ward 2. Also, once Ward 2 is no longer used for clinical purposes it would be suitable for conversion (at manageable cost) to community staff offices, providing a base for the growing numbers of staff providing health and social care services to the local area.

Option 4 - Carry out upgrade work to bring the facility up to modern standards.

It is considered that the necessary remedial works and remodelling of the premises needed to sort its many problems cannot be effectively carried out within the limitations of the space. In addition, any work is likely to have a limited impact on improving the utility of the ward facilities.

Preferred Option

Option 3, to close Ward 2, to provide the service through Ward 3 (which has single room provision) and to change the use of Ward 2 from patient accommodation to community staff provision is the preferred option. This would allow current ward 2 services to be reprovided within more suitable premises, allowing ward 3 to provide a more comprehensive selection of services while meeting current and projected bed demand across the two wards. This option would also free up the current Ward 2 premises to accommodate the growing range of community service staff and the expansion of ELSIE to provide support to frail elderly people across East Lothian.

Delivery of this option will not affect the range of services in Belhaven Hospital which will continue to support GP beds, nursing home beds and NHS long term care.

Appendix 8

Feedback from Belhaven Forum Members, Local Community Council Representatives and Dunbar GP Practices

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I am writing in reply to the email of Thu 7th Dec regarding the options for the future of ward 2 at Belhaven Hospital. I would like to categorically state that I would like to see option 3 (three) taken to the IJB on 21st Dec .

I feel very strongly that option 5 should not even be considered without a full meeting of the Belhaven Forum and would like to make it clear that I would not support a presentation of this option by Stephen Bunyan if this is what is taken forward.

I feel the patients,residents and population of Dunbar and district are being very unfairly treated by option 5 as it has never been mentioned before either to the Belhaven Forum or to the meeting that the CHP had with the dunbar community council.They have at all times stated that all present services would stay at Belhaven.

Irene Laidlaw
Belhaven Hospital League of Friends

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COMMENTS FROM WEST BARNS COMMUNITY COUNCIL REPS TO THE BELHAVEN FORUM :- JIMMY THORBURN AND ROBERT ELLIOTT

1) The timescale between receipt of the briefing paper and the timescale given to make comments is too short. Only one Community Councillor has a computer and it has been out of action. There has been no opportunity to discuss the updated information and the new option 5 with other Community Councillors. It is felt that any discussion and decision on the options should not come to the IJB meeting on 21st December.

2) We are not happy to lose 12 beds in Ward 2 with the knock on effect on Residents in Ward 3 and Ward 1. This would be the case with Options 3 and 5.

3) We are not happy to lose the GP beds as in Option 5.

4) We feel more work needs to be done on the costings before dismissing Options 2 and 4.

5) We are concerned as to the length of time between any closure of beds in Ward 2 and the building of any new facility at the Belhaven site. The population of Dunbar and West Barns is growing and there is an increasing number of older people in particular who may need to be cared for in the years before a new hospital/care home is built. Haddington and Edinburgh are too far away for people to be cared for and visited by family, particularly if their family do not drive or have access to a car.

9/12/17

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FUTURE PROVISION OF WARD 2, BELHAVEN HOSPITAL

COMMENTS BY JACQUIE BELL, MEMBER OF BELHAVEN FORUM AND WARD 2 WORKING GROUP

1) The timescale between receipt of the briefing paper on Thursday 7th December and the need to submit views by 11th December is too short.

a) It has not been possible to feed back to the full memberships of Dunbar Community Council and Dunbar and East Linton Area Partnership.

b) The Forum has not had opportunity to discuss Option 5 at all. It has appeared as an extra and has been noted as the Health and Social Care Partnership Preferred Option. This Option did not come from the Working Group which has only had one meeting.

I believe that a paper should not be taken to the IJB on 21st December. The Forum had asked for more information to be given on all the options. It needs more discussion time.

I also believe that a decision on Ward 2 should not be rushed given the uncertain time it will take to provide a new NHS/Social Care facility at the Belhaven site. Reprovision was being discussed as part of the Older People's Strategy nearly a decade ago before it was dropped after the Council elections in 2012.

REGARDING THE OPTIONS

OPTION 1 – It is recognised that this is not possible due to the poor physical fabric of the building which impinges on patient care.

OPTION 2 – I had suggested this at the Working Group. I am concerned that it has been quickly dismissed without full clarification of the costs for the information of the Forum. Temporary facilities were being considered for Roodlands before the cheaper option of using Wards 9 & 10 at Liberton came up. Use of a temporary facility could mean that not all 12 Ward 2 beds would be lost. This is particularly important given the uncertainty regarding how long it will take to provide a new and permanent facility. Dunbar and East Linton Ward has a rapidly growing population. There is also an increasing number of older people who will need NHS and social care facilities in the area. Although there are costs of fitting out it is possible to re-use such a facility elsewhere.

OPTION 3 – Moving services given in Ward 2 to Ward 3 impacts on the provision of care home type beds in Ward 3 with a knock on effect on Ward 1. The need for people to move from Wards 3 and 1 could cause distress to patients and families who had been told these resources were a home for the rest of their lives.There could potentially be a bed shortage. At present some people have been waiting, many months for care packages in Ward 2. Delayed discharges have affected the capacity for GP use of beds. Fortunately, the financial crisis of Four Seasons which owns Lammermuir House, seems to have been averted in the short term. With the increasing number of older people the demand for care home beds is likely to rise. Not all can be cared at home with packages of care and the recruitment and retention of care at home staff is difficult across the country, particularly in rural areas. I have concerns about this option. It is noted that NHS Lothian planned to have Liberton Hospital fully closed by 2017 but although the acute and rehab beds have closed it is still being used to board delays from Edinburgh and East Lothian. Edinburgh IJB look as though they will still not have closed it by Summer 2018.

OPTION 4 . This has not been fully costed. Unfortunately this has been needed for a long time and the money has not been forthcoming. Integration of Health and Social Care has led to efficiency savings across NHS Lothian. ELC is also under financial pressure. However, refurbishment should not be totally dismissed. It would mean the loss of fewer beds. Refurbishment may cover the time before a new facility can be built. Other hospitals have been upgraded to benefit inspection standards and then been designated for closure e.g. Liberton.

OPTION 5 This is worse than Option 3. There is the same knock on effect on beds in Wards 3 and 1 as Option 3. There is also the loss of the GP beds. These are needed for people who need 24 hour supervision when they are unwell e.g. those with delirium who may be confused and wander. They are also important for palliative/end of life care. If there is not the option of GP beds people will need to go to the Royal or Western in Edinburgh. Those beds have become more difficult to access due to the cuts in acute and rehab beds in Edinburgh at hospitals like Liberton and the Astley Ainslie. Step Down beds are currently too far away in Wards 9 and 10 at Liberton which have limited access by public transport. Crookston House at Tranent has no direct public transport from Dunbar and East Linton. Haddington with the proposed new care home for step down also has limited public transport. This is particularly concerning for families whose members may wait a very long time for packages of care/care homes. At present some family members spend most of each day with their relatives which would nlot be possible if they were further away.

COMMUNITY SERVICES HUB.
An option to use Ward 2 for this is possible. However, the costs of setting it up are vague in the paperwork presented. An idea to create a hub at Liberton was costly in terms of IT rewiring and other structural changes. There was the alternative suggestion of using the Admin block for this purpose which has not been explored further. This needs to be considered.
There is also the question of staffing of such a hub and recruitment/retention of a further hospital at home/hospital to home team. The team would help some people but not all those who currently use Ward 2.

COMMUNITY ENGAGEMENT
The options paper does not detail how the decision of the IJB will be shared with the wider community. Acceptance of Option 5 by the IJB as the preference of the Health and Social Care Partnership which is not agreed by the membership of the Belhaven Forum could potentially lead to problems in engaging with the community in the longer term. This issue has been mentioned at Forum meetings.

CONCLUSION
There is insufficient information for the IJB to make a decision on December 21st and the paper on the future of Ward 2 should be deferred until the Forum has had a further opportunity to meet. The various organisations which are represented at the Forum also need opportunity to discuss the briefing paper.

Jacqueline Bell

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Ward 2 - Summary of options 1 to 4 plus additional option - 5

Thank you for giving us the opportunity to comment on the summary of options 1-4 and the new option 5 for Belhaven Hospital. We have all known that Ward 2 was not up to scratch for a number of years now and we are keen to help find the right way to reach a better arrangement for the benefit of those in Dunbar and the surrounding villages of Innerwick Oldhamstocks Spott and Stenton which we (East Lammermuir Community Council) represent.

Our comments are made on the basis of the information provided. However, as with any project there are a number of considerations and it would have been useful if we had at least an estimated budget figure for each option to assist in the decision making process. At this stage our preferred option would be 3 or 5.

Overall, concern still remains about the following statement "This would allow current ward 2 services to be reprovided within more suitable premises, allowing ward 3 to provide a more comprehensive selection of services *while meeting current and projected bed demand across the two wards*." We don't see evidence of that projected demand set out in detail, It will be bucking the national trends if the demand is decreasing. Let's assume that it is being held at a level - in which case we need to know where the 12 people who have been using Ward 2 and the 12 people who have been using Ward 3 are going to be directed from now on.

We are told "The 2 respite beds will contribute to increasing the number of short breaks as outlined in the Carers' Strategy document, *and* In addition, 2 of ward 3 nursing home beds will revert to Hospital-Based Complex Clinical Care (HBCCC)." Are we to presume that these are respite beds for frail elderly people? The ward (3) will likely continue its communal space and activities like eating meals together. It would be interesting to know what current thinking is - including that of the scrutiny bodies, particularly Healthcare Improvement Scotland - about mixed use wards like this. Can it be a conducive environment for all "types" of patient, living together?

Needless to say, the notion that we are going to be directed to 6 new care home beds in Haddington instead of Dunbar is entirely unacceptable for Oldhamstocks residents, and clearly represents a significant reduction in quality of service for us.

The one element of truly local alternative provision that we can see mention of is "Action to address, in a timely manner, any increased pressure to local discharge by recruitment of a 6th Hospital to Home team (to be established in December 2017). This will serve the Dunbar area and will increase of collaborative allocation working with local independent providers." This is good news but should be linked to a commitment to working with local communities to develop alternative forms of care at home support, not dependent on contracts with large providers from Tranent or Musselburgh who cannot afford to send staff down to the East of the borough.
Our key point would be this, tying together the initial concerns about projected demand, and this later point about alternative provision (or the lack of it at present);

We support the intention to move services and support so that more people can stay at home for longer at the end of their lives in East Lammermuir and the Dunbar area as a whole. We ask for a cast iron guarantee that local resources will not be taken away to Haddington (or elsewhere). We cite the relative changes in population of the two towns as evidence that moving scarce resources away from Dunbar will not provide an arrangement fit for the future. With such a guarantee in place, we will be keen to work with the HSCP to see this proposal brought into reality. (We don't think

the proposed membership of the working group reflects a desire to work with the local community to get this done right!)

Finally, if the IJB adopts the proposals as written next week, we will need an effective communication plan about the changes proposed for February 2018, in which we believe we the local community councils could be helpful.

Regards

Janice Hanvidge
East Lammermuir Community Council

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Response by Dunbar and East Linton GPs on the Future Provision of Ward 2 Belhaven Hospital

Option 4 preferred -Upgrade of ward 2

As local GPs we have been looking after our own patients on ward 2 Belhaven for many decades.

We see this as a logical extension of our continuity of care towards our patients in the community and ward 2 provides a valuable asset when managing patients with a variety of conditions.

In particular this includes caring for terminally ill patients and those needing mostly nursing care during a period of illness before returning home. We also use admissions to stabilise medication changes or assess a patient's ability to function at home and at times to provide blood transfusions.

The value of the facility is enhanced by a caring and skilled nursing team who are trained to provide nursing care for the type of patients we admit and their clinical judgement plays an integral part of the patient's and their family's journey.

Over the last few years increased pressures on beds (and less of them) at the New Royal Infirmary of Edinburgh has impacted on Belhaven. As local GPs we have assisted our secondary care colleagues by looking after patients on ward 2 awaiting transfer home or to another facility but this in turn has reduced our ability to admit our own patients to ward 2 when in need. This has been challenging when dealing with patient's from outside the Dunbar area with complex needs for whom we have little or no background knowledge. However we have agreed to this because we know the system in general is under pressure.

We certainly realise that the structure of the ward requires upgrading and enhancement to bring it into line with 21st century hospital standards and that some infrastructure changes are required. Until now this has made no difference to the high standard of care provided to patients. We also recognize that this refurbishment may mean a reduction in the number of inpatient beds.

Given the high value we place on ward 2 we would ask the Integrated joint board to carry out upgrade work to bring the current facility up to modern standards and retain the skilled nursing team that already exists. Other areas of Scotland place a high value on their community hospitals and we are surprised that East Lothian Health and Social Care Partnership does not appear to feel the same.

As local GPs with a large stake in delivering the patient care via the facility of ward 2 we have concerns at the way the engagement and decision making process regarding the future provision have been managed.

We feel the process was flawed in not enabling the working group to report back to the forum.

We also feel the lack of anything more than 'back of an envelope' costings of the proposed options was unhelpful and did not allow the Belhaven forum group to make an informed decision.

We are also unhappy with the undue reliance on the services of the Hospital at home team in the future to support patients at home for whom the possibility of admission to ward 2 will no longer be available. This service cannot provide full time 24 hour nursing care in the way that admission can.

We see from option five that there is now a road map to relocate existing residents from their homes on wards 1 & 3. We would plead with the IJB that these residents and their families are dealt with compassionately in deciding their future homes because these are our patients too.

We look forward to the Integrated Joint Board giving due consideration to our professional concerns as outlined above and working with us to provide the best possible care for our patients and our community.

Dr Neil Black , Dr David Cassells , Dr Simon Bagley, Dr Debbie Strachan, Dr Del Lavelle, Dr Patricia McPhail, Dr Ian Thompson, Dr Miranda DeBurgh , Dr Catriona Campbell, Dr Liz McIntosh, Dr Helen Barker, Dr John Hardman

Appendix 9

Notes of Belhaven Forum 28th November 2017

BELHAVEN MEETING NOTES – 28 NOVEMBER 2017

Attendance:

Irene Laidlaw
Patricia Rooney
Thomas Miller
David Small
Angela McLean
Stephen Bunyan (Chair – Options for Ward 2 Discussion)
Peter Murray (Chair – Welcome/Long Term Strategy)
Jo Smail
Margaret Drew
Alison Macdonald
Robert Elliott
Jim Thorburn
Jacqui Bell
Jill Wilson
Neil Black (joined after start of meeting)
Norman Hampshire (joined after start of meeting)
Paul McLennan (joined after start of meeting)
Jane Ogden-Smith (notes)

Apologies:

Lorraine Cowan

Notes of previous meeting

The meeting agreed that the notes of the previous meeting were accurate except that Stephen Bunyan had been marked as giving his apologies when he had in fact been present.

Introduction

Peter Murray, in his role as Chairperson, welcomed Forum members and set out the agenda for the evening. He explained that he would chair the first section of the meeting but that he would cede the chair to Stephen Bunyan for the section of the meeting relating to Ward 2 to Stephen Bunyan. This was to ensure complete impartiality in the ensuing discussions and allow Stephen to represent the Forum's views to the IJB meeting on 21st December.

Long-term strategy

David Small explained that he was not presenting the long-term strategy/vision at this forum meeting because the Musselburgh and North Berwick area engagement forums had not yet met and it would not be right to rush to bring something to the Integration Joint Board (IJB) in December before those forums had a chance to be engaged in the process too. He added that more work also needed to be done on the financial aspects of the strategy. He said that extra care housing still has a role to play and the Partnership was looking at what other councils in Scotland are doing (e.g., Moray, which had invested extensively in it, and other authorities who were looking at other models). We were keen to learn from their experience. David and Alison would also be looking at the privately-funded extra care proposals coming forward in Musselburgh, although these were being developed independently of the strategy.

Options for Ward 2

Peter Murray asked Stephen Bunyan to chair this part of the meeting, as previously agreed at the outset of the meeting, so that Stephen could collate a response that reflected the overall feelings of

the group and represent the Belhaven Forum's views on Ward 2 to the IJB on 21 December, as agreed by the Forum at the outset of the meeting. Alison Macdonald then presented an options paper for Ward 2. She explained that she had produced the paper as part of her role as Chief Nurse and Professional Adviser to the IJB. She said that East Lothian Health and Social Care Partnership is exploring the options for the future provision of the 12 beds within Ward 2 of Belhaven Hospital. This paper would be going to the IJB on 21 December. She said that the paper was still in development and open to further discussion and that there was one further working group planned with an option for a further meeting if necessary.

Background

For some time there have been concerns that limitations within the layout of Ward 2 prevent it from meeting modern environmental and infection control standards and regulations for a healthcare facility.

Regular inspections carried out to assess infection control approaches and the quality of the building's fabric and facilities have continued to identify a number of failings. An unannounced audit on the 7th May 2017 concluded that the ward needed *"...major upgrading, the fabric is extremely poor and not designed for the purpose now used...* [and is]*...not assisting dementia friendly care"*.

The problems within Ward 2 arise from the age of the building, its space limitations and the physical environment. These problems cannot be easily overcome. To correct the numerous deficits, to meet infection control standards and healthcare environment guidance, to support safe moving and handling of patients and to deliver best care to patients would require fundamental remodelling of the facility.

The Forum had agreed to the establishment of a Working Group to look at the options for ward 2 in more detail. The working group had met on 10th October 2017. It had not been possible to arrange a meeting in mid-November. The next meeting was scheduled for 30th November 2017.

Options for Ward 2

Work is underway to assess bed usage and reason for admission over the period January 2014 to October 2017 to support a robust description of activity within the ward. So far, the data from January 2014 to December 2016 has been analysed. The outcomes of this work, the reports on the ward's physical environment and options for future development of services to the patient group served by Ward 2 will be presented in a report to East Lothian Integration Joint Board (IJB) at its meeting on 21 December 2017. This report will explore 4 options for the future of Ward 2:

- Option 1 - Continue to provide the existing service within the existing premises
- Option 2 - Provide the service within replacement 'modular' facilities
- Option 3 - Move the services provided in the ward to Ward 3
- Option 4 - Carry out upgrade work to bring the facility up to modern standards.

Each of these options is considered in brief below.

Option 1 - Continue to provide the existing service within the existing premises.

This option is considered untenable as the current poor state of the premises and its layout does not comply with modern standards for infection control, space utilisation, patient dignity, nursing practice and healthcare provision.

Option 2 - Provide the service within a replacement 'modular' facility adjoining Ward 2.

Use of modular ward facilities as an adjunct to the existing ward is not considered to be an appropriate solution due to the long term rental, fitting out and commissioning costs (and decommissioning costs at the end of the life/end of rental of the units) the inherent limitations of modular premises when compared to other more traditional options and the need to vacate ward whilst work was underway.

Option 3 - Move the services provided in the ward to Ward 3 and change the use of Ward 2

Ward 3 is suitable to accommodate the patients and associated clinical activity within the current ward 2. Also, once Ward 2 is no longer used for inpatient purposes it would be suitable for conversion (at modest cost) to community staff offices, providing a base for the growing numbers of staff providing health and social care services to the local area.

Option 4 - Carry out upgrade work to bring the facility up to modern standards.

It is considered that the necessary remedial works and remodelling of the premises needed to sort its many problems cannot be effectively carried out within the limitations of the space. In addition, any work is likely to have a limited impact on improving the utility of the ward facilities. In addition the ward would have to fully close to allow the work to proceed.

Preferred Option

Option 3, Move the services provided in the ward to Ward 3 (which has single room provision) and change the use of Ward 2 from inpatient accommodation to community staff provision is the preferred option. This would allow current ward 2 services to be reprovided within more suitable premises, allowing ward 3 to provide a more comprehensive selection of services while meeting current and projected bed demand across the two wards. This option would also free up the current Ward 2 premises to accommodate the growing range of community service staff and the expansion of ELSIE to provide support to frail elderly people across East Lothian.

Delivery of this option will not affect the range of services in Belhaven Hospital which will continue to support GP beds, nursing home beds and NHS long term care.

Discussion

The group then engaged in extensive discussion of the paper and the key points are summarised below:

- Impact of closing Ward 2 – There was concern about the loss of the 12 beds in Ward 2 and the impact of that on patients and families, particularly with pressures around sourcing packages of care. Alison agreed that this was not an easy option but that there would be some capacity in Ward 1 and elsewhere and that there would be a very clear project plan developed with social work colleagues to support patients. The transition would be made carefully and not in a rush.
- Where would patients be going? It was noted that there was already a waiting list for Ward 3. Where would those patients go? Alison said that the waiting list for Ward 3 was low at the moment and often there was no waiting list. She pointed out that capacity in the new care home opening in Haddington would be used for step-down beds (6 more than in Crookston) and we would no longer have to use Liberton. Ward 3 would include 6 beds as step down and this should allow us the flexibility to meet needs.
- Being placed outwith Dunbar/poor public transport links – The group had concerns around the poor public transport links between Haddington and Dunbar making it difficult for families and friends visiting them in Haddington.
- Modular units – Neil Black expressed surprise that option 2 has been ditched so soon as the working group hadn't made a decision yet. The group also wondered whether, if expense was an issue, we could consider having a six-bedded module and whether any module could subsequently be used as a base to support extra care housing. They also discussed whether this could be an add-on unit by Ward 1. Angela McLean said that the Ward 1 location would be problematic because the proximity of GP beds beside long term care beds would breach Care Inspectorate guidance. David and Peter said that there was a more profound problem with finance, however. NHS Lothian Finance and Resources Committee's strategic intent is now that all capital projects have to be long-term. The group wanted more in-depth costings to be done for a modular unit and it was agreed that this could be done, but David said that it would still cost around £0.5 million. NHS Lothian and not the IJB would actually be responsible for the costs of the modules as part of its estates and they would have to develop a capital business case. He thought it very unlikely that NHS Lothian would agree to spend capital on modular buildings for the short term.
- Extra Care Housing/delayed discharge – some of the group felt that current demand still requires Belhaven to have 24 beds – what was the potential of extra care housing. Alison said that if we were able to support people in a different environment, we might not to need to admit them to care home beds. With the right support package, people could be supported at home. Norman Hampshire was worried that this would still mean that we would have fewer beds and EL could go back to the top of the table for delayed discharge. Alison said that delayed discharge was more due to delays with packages of care and David stressed that East Lothian is performing a lot better with delayed discharge compared to previous years.. Norman felt that losing 12 beds would be huge and we would need to have extra care units somewhere in this community – knowing that would ease community concerns. David said that extra care would take 2-3 years to set up and the reports on Ward 2 show that we need to address issues with it now. However, the group felt we still needed to able to show what our plans for extra care were now. Norman went on to say that he knew that NHS is strapped for cash, but in some English authorities, extra care housing units were being sold to people on shared ownership basis with NHS or Council meeting the rest of cost. Similarly, other extra care units were being rented out and subsidised by the NHS

and Council. He felt that we needed to look at this sort of model in East Lothian. We need to have something else to offer in place of 12 beds. David said that NHS Lothian and East Lothian Council were already working on this.

- **What would Ward 2 be used for if is ceased to function as a ward?** – Alison suggested that it would become a community hub for Hospital to Home and Hospital at Home. The services want to work on a more locality based model to bring together integrated teams in each locality. In Dunbar, this would include Community Physios and OTs. There was a high number of people waiting for packages – the hub would bring providers and health and social care staff together and speed this up.
- **Fitness for purpose** – Both the Unison representative and the service manager emphasised that Ward 2 is definitely unfit for purpose for staff and patients. Thomas added that he had concerns about each of the four options but in the best of all worlds he would keep Ward 2 in an improved state as he was not happy to lose another 12 beds, which he felt would have a knock-on impact on acute services. He would like to have the community hub as well but felt it could be based in the Admin Unit. Angela added that we must take into account patients' feelings – there is no internet, no privacy, no dignity, showers – we can't wait any longer to decide on Ward.
- **Doing things differently** – Jo Smail said that there were changes in patterns of care – people wanted to stay in their own homes with support – they didn't necessarily want to go into a nursing home or hospital. She said that we were looking at new schemes and there was a lot in the pipeline about doing things differently. Jacquie and Norman were concerned about availability of care packages. Norman said we needed to make sure that there are resources available and that at the moment it was cheaper to support people together in a inpatient unit
- **Lack of detail** – Paul McLennan emphasised that without knowing what resources were in place for the future, it was impossible to make a decision on the proposals for Ward 2. He said that it was a big concern that it was still not clear what the transition stemming from the closure of Ward 2 would look like and asked if the paper had to go to the IJB on 21 December. He said that if the forum were to represent the preferred option to community meetings they needed clear, resourced plans with timescales otherwise the community wouldn't listen. Peter said that more work would be done on the transition plan.

Decision

David suggested that a more detailed paper be circulated by email to the forum prior to the 21st so they had time to make a more considered response via Stephen to the IJB meeting on the 21st December. Alison undertook to do this, and in so doing, would also consider whether the proposals needed further development. It was agreed that this was the way forward and the scheduled working group on 30th November was agreed by the forum to be cancelled.

Date of next meeting

It was agreed not to hold a meeting in late December 2017. The next meeting of the forum would be in January 2018 – date to be confirmed.

Appendix 10

Integrated Impact Assessment on Ward 2 Options

Section 4 Integrated Impact Assessment

Summary Report Template

Audit Risk level

(Risk level will be added by Equalities Officer)

Each of the numbered sections below must be completed

Interim report	√	Final report		(Tick as appropriate)

1. Title of plan, policy or strategy being assessed

The future provision of Ward 2, Belhaven Hospital.

2. What will change as a result of this proposal?

It is proposed that East Lothian Health and Social Care Partnership remodel the provision of ward 2 at the Belhaven Hospital. The existing facility has been identified as having numerous deficits that prevent it from meeting modern environmental and infection control standards and regulations for a healthcare facility.

The proposal brief considers options around remodelling of the facility to ensure that it meets the infection control standards and healthcare environment guidance, to support safe moving and handling of patients and to deliver best care to patients. It also considers the future development of services to the patient group served by Ward 2 and the wider community.

3. Briefly describe public involvement in this proposal to date and planned

Meetings of the Belhaven Forum, with attendance by representatives from NHS Lothian, elected members, East Lothian Council, H&SCP, staff side representative, and local GP's have been meeting since November 2016. Briefings have been provided to inform discussion on the proposed remodelling of the facilities.

A Belhaven Working Group has been established with representatives from general practice, nursing and clinical Service managers, EL H&SCP and staff representative.

In addition press releases and statements have been issued to the local media.

4. Date of IIA – 5th December 2017

5. Who was present at the IIA? Identify facilitator, Lead Officer, report writer and any partnership representative present and main stakeholder (e.g. NHS, Council)

Name	Job Title	Date of IIA training	Email
Sue Muir	Team Leader - NHSL	2016	Sue.muir@nhslothian.scot.nhs.uk
Emma Dempsey	Senior Health Promotion Specialist NHSL		Emma.dempsey@nhslothian.scot.nhs.uk
Angela McLean	Charge Nurse		Angela.A.McLean@nhslothian.scot.nhs.uk
Margaret Drew			mdrew@eastlothian.gov.uk
Gordon Gray	Assistant Programme Manager H&SCP		Gordon.gray@nhslothian.scot.nhs.uk
Jane Ogden-Smith	Communications Officer H&SCP		Jogden-smith@nhslothian.scot.nhs.uk
Louise Cowan	Emergency Medicine Administrator		Louise.Cowan@nhslothian.scot.nhs.uk
Thomas Miller	Partnership Rep		Thomas.Miller@nhslothian.scot.nhs.uk
Amanda Muir	Medical Secretary		Amanda.Muir@nhslothian.sco.nhs.uk
Marilyn McNeill			Marilyn@rowandrem.plus.com

6. Evidence available at the time of the IIA

Evidence	Available?	Comments: what does the evidence tell you?
Data on populations in need	✓	Across East Lothian the population is growing, becoming more elderly with increasingly complex care needs.
Data on service uptake/access	✓ 3 years activity data for Ward 2. ✘ No activity data for local GP services.	Bed occupancy, range of services provide, demographics of service users.
Data on equality outcomes	Area wide, not specific to Ward 2	
Research/literature evidence	✘	
Public/patient/client experience information	✓ Belhaven Forum minutes.	Service users, carers, GP referrers and representative groups all value the service from Ward 2.
Evidence of inclusive engagement of service users and involvement findings	✓ Belhaven Forum minutes/press releases/information provided to local councillors.	There is a strong local view that any changes should be limited id unavoidable.
Evidence of unmet need	Not an issue, the consideration of options is about making more efficient use of the resources.	
Good practice guidelines	✓ Inspection reports. Infection control reports. Assessments of building fabric and layout.	There are numerous problems with the quality of the existing ward environment in connection with: • infection control • fabric of the building • design and layout of the facility • multiple occupancy rooms • poor toilet facilities

Evidence	Available?	Comments: what does the evidence tell you?
		• restricted space for care; and • difficulties in carrying out manual handing safely.
Environmental data	✓ Only in terms of the fabric and layout of the wards. There is no awareness of any assessment of environmental impact.	The existing Ward 2 (as an old building) is likely to be inefficient in terms of energy efficiency.
Risk from cumulative impacts	✓	Changes to Ward 2 will have impacts of the wider health and social care system and patient journeys. As Ward 2 has a role in 'boarding' patients as they await a place in a care home or a package of care to return home.
Other (please specify)	✓ The financial cost of various options is being explored along with the likely outcomes for patients and staff.	Outcomes awaited.
Additional evidence required		nil

7. In summary, what impacts were identified and which groups will they affect?

Equality, Health and Wellbeing and Human Rights	Affected populations
Positive Increased equity and privacy with the provision of private single occupancy bedrooms with en-suite facilities. Care will be more person – centred and facilities will meet disability regulations. Increase opportunity to personalise living space. More space around patient bed area will enable staff to manoeuvre equipment reducing risk on manual handling and support delivery of safe patient care.	Patients, families, visitors and staff.

Better able to provide quality palliative care with increased dignity, wellbeing and privacy. **Negative** Organisational change which some staff might find disruptive to their lives or wellbeing. In addition there is the possibility of increased travel for staff. Risk for patients of loss of community, to mitigate this there will be a social space provided within the facility where patients can gather if they choose. Short term risk through loss of beds will be mitigated by increased community support.	 Patients, families, visitors and staff.

Environment and Sustainability	**Affected populations**
Positive The facilities will be refurbished working to latest policy around sustainability, better insulated and more energy efficient. **Negative** Increased travel for staff, possibly more noise from the hub and possibly an increase in car usage.	 Budget holder, staff and patients. Staff, patients and families.

Economic	**Affected populations**
Positive Increased care in the community and potential for local businesses, an increase in local spending, good for the local economy. Potential for local employment to increase. **Negative** Increased travel for staff.	 Patients, families, local businesses and local population. Staff

8. Is any part of this policy/ service to be carried out wholly or partly by contractors and how will equality, human rights including children's rights , environmental and sustainability issues be addressed?

Yes. however, by adhering to NHS procurement procedures these issues will be addressed.

9. Consider how you will communicate information about this policy/ service change to children and young people and those affected by hearing loss, speech impairment, low level literacy or numeracy, learning difficulties or English as a second language? Please provide a summary of the communications plan.

Communicate with local forums such as Belhaven Forum, Area Partnerships and Community Councils. Support with communication can be provided as required by NHS Lothian and East Lothian Council. e.g. Brail, easy read etc. Use of local media and press.

10. Is the policy a qualifying Policy, Programme or Strategy as defined by The Environmental Impact Assessment (Scotland) Act 2005? (see Section 4)

No

11. Additional Information and Evidence Required

If further evidence is required, please note how it will be gathered. If appropriate, mark this report as interim and submit updated final report once further evidence has been gathered.

Proposal may change depending on option chosen and therefore a further IIA will be required on final option.

12. Recommendations (these should be drawn from 6 – 11 above)

- Ensure that forums discussed in point 9 are engaged, included and involved in the process.
- Ensure staff are aware of support and how they can access this i.e. through relevant NHS policy at monthly update sessions.
- Ensure proposed changes are communicated with patients, families and staff. Share information regularly on the process of change.

13. Specific to this IIA only, what actions have been, or will be, undertaken and by when? Please complete:

Specific actions (as a result of the IIA which may include financial implications, mitigating actions and risks of cumulative impacts)	Who will take them forward (name and contact details)	Deadline for progressing	Review date
Risk of change of discharges to upstream beds. We need to • Ensure increased packages of care • Ensure care home beds are available • Ensure partnership working with local GPs.	Paul Currie Paul.currie@nhslothian.scot.nhs.uk	January 2018	January 2018

14. How will you monitor how this policy, plan or strategy affects different groups, including people with protected characteristics?

Monitoring of figures for different options selected
Informal feedback from staff, patients, relatives and key partners
Monitoring of complaints

15. Sign off by Head of Service

Name
Date

16. Publication
Send completed IIA for publication on the relevant website for your organisation. See Section 5 for contacts.