Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Summary Report – Trust Board Meeting (Part 1)	**Date: 28th August 2013**
Report Title: Establishing effective inpatient bed management	
Agenda Item: BD/13/142	**Enclosures: n/a**
Sponsor; Hazel Watson	**Presenter: Hazel Watson**
Report Author: Emma Adams	
Report discussed previously at:	*n/a*

Purpose of the Report and Action required		
The report informs the Board of action being taken to establish effective inpatient bed management across the Trust.	Approval	
	Discussion	
	Information	X

Executive Summary of Key Issues

Inpatient beds are a scarce and expensive resource. All areas of the Trust are reporting significant challenges in managing demand for beds. The report outlines the actions being taken to establish a sustainable bed management system which can be shared and understood across the Trust both internally and externally with other partners in the urgent care system.

Establishing Effective Bed Management

Which Strategic Objective does this paper address	
Consolidate	Y
Integrate	
Expand	

Recommendations to other committees
n/a

Recommendation/Decision
The Board is recommended to **note** the report

Establishing Effective Bed Management

1. Introduction

1.1. Inpatient beds are a scare and expensive resource. The Senior Management Team identified that all delivery units are facing significant challenges in managing the demand for inpatient beds. The consequences of ineffective bed management are increased levels of clinical, reputational and financial risk. Optimizing the bed management system means admitting the right patients, to the right beds, at the right time and for the right duration. The system is complex and multi-factorial, and relies on procedural, structural and behavioural responses from many teams and professionals.

1.2. A small project group, consisting of representatives from the Academy, the Medical Directorate, inpatient, intensive, and recovery services, was established to:

- Consider how to implement a "live" bed management system to control inpatient capacity across the Trust
- Analyse the acute care pathway and make proposals to support sustainable management of inpatient beds in the future.

1.3. In addition, the Associate Medical Director undertook to engage with the Trust's Medical Advisory Group as to how doctors could work to optimise the management of inpatient beds.

2. Background

2.1. The Trust's inpatient beds are organised into Adult Acute Inpatient, Older People's functional and organic beds, Psychiatric Intensive Care Units, Rehabilitation units, Medium and low secure units and specialised beds such as Mother & Baby. Following a redesign programme which commenced in 2010, a number of inpatient beds were closed, in particular, across Adult Acute inpatient and Older People's beds. Alongside these closures, the redesign programme reconfigured community services, with increased investment, to provide an enhanced crisis service, now termed Intensive service. The intention was to provide greater home treatment leading to reduced admissions and a reduction in lengths of stay.

2.2. Recently, delivery units have reported considerable pressures on inpatient beds, particularly for Adult Acute inpatients, and have reported regular occasions where no beds have been available locally. This situation has resulted in high numbers of patients being placed in units outside of their immediate locality and an overall increase in Out of Area placements (reported to Finance & Planning Committee in July 2013).

2.3. There are many reported problems with the current management of beds, the key ones being:

- Inpatient beds are geographically situated across several localities, but not systematically aligned to the new operational management and commissioning systems
- There are inconsistent processes for bed management across localities and within teams and wards resulting in poor control over admissions and

discharges
- Occupancy rates are extremely high, often resulting in local areas "running out" of beds and requiring placements in other units or out of area.
- TMAG reported many problems with unfocused admissions, delays in commencing treatment, suboptimal communication around discharges and poor post-discharge support resulting in re-admissions. With respect to out-of-hours, they reported a culture which did not involve senior consultants on-call in decision-making around admissions, especially from S136 suites

2.4 Initial analysis of Trust data has highlighted:
- Very low levels of admissions and discharges during the weekend
- Variable admission and discharge rates across weekdays, e.g. Wiltshire having peak admissions on Fridays and Bristol having peak discharges on Mondays
- Significant levels of transfers across all units
- Variable lengths of stay across and within service types
- Variable care cluster allocation, with significant numbers not clustered or clustered into low need categories
- Rising levels of Delayed Transfers of Care resulting in an average of 24 beds lost between August 2012 and July 2013
- High lengths of stay for delayed patients, particularly in older people's beds, with average weeks delayed for the majority of patients being 5-8 weeks
- A small number of patients having repeat admissions (c.14%) with one patient having had 8 admissions in a 12 month period
- Increasing levels of Out of Area placements (as reported to Finance & Planning Committee in July 2013)

3. Establishing a bed management system

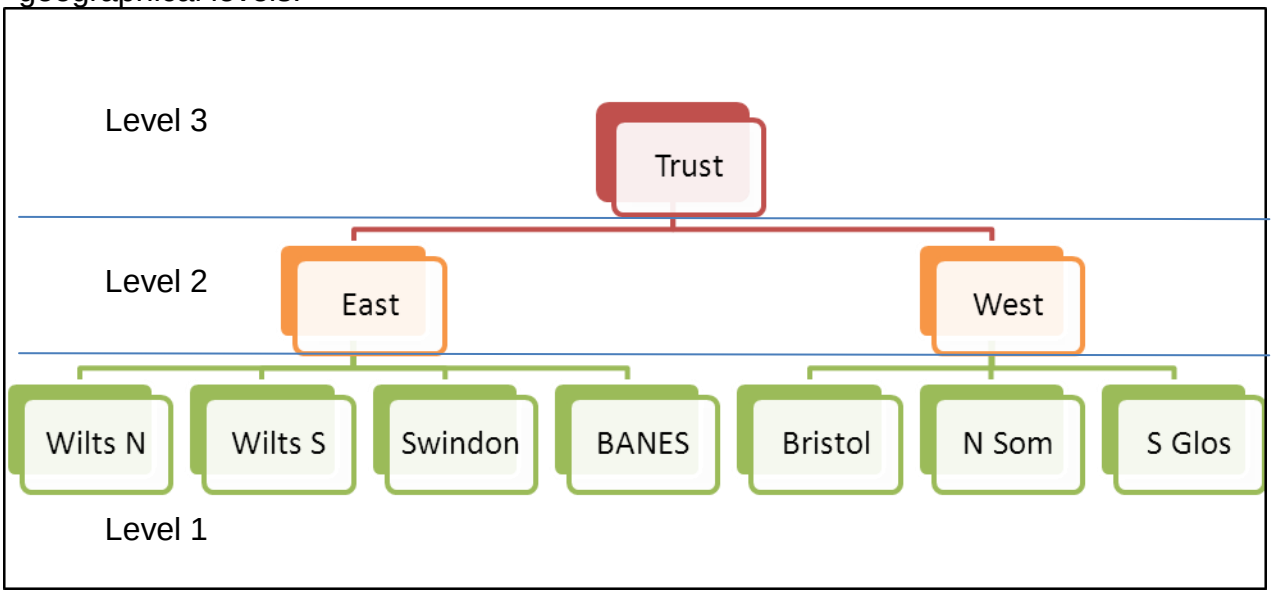
3.1. All acute hospitals have operated bed management systems for many years. Within that system, "live" data is captured on bed occupancy, likely demand and factors affecting future capacity. The project team has reviewed the system used by the Royal United Hospital in Bath as a basis for developing a similar system for the Trust. In addition, there is a bed manager already in post within Bristol who has provided expert input into the proposals given below. These proposals relate to the management of all age functional beds (Adult Acute, PICU, Rehab and Older People functional beds) with the intention of developing a flexible local system which covers the whole functional and ageless pathway. Further work will be required to establish a system for Older People's organic beds and secure beds if considered necessary.

3.2. The aim of the bed management system would be to ensure that all patients receive timely treatment in the most appropriate clinical setting. Subject to consultation with our staff and service users, this aim could be supported with the following principles:
- That care within a community setting at home or close to home should be the default setting
- That admission to hospital will be for a defined therapeutic purpose and an expected date of discharge should be set at the nearest available opportunity
-

3.3. .The objectives of the system would be to:
- Identify bed management principles within the organisation
- Provide clear and agreed operational standards

- Provide a clear escalation process with identified triggers for all involved
- Provide a framework for working within our partners to manage our capacity
- Improve the patient and carer experience by aiming to provide treatment as close to their geographical home as possible
- Improve the care pathway by ensuring that admissions are appropriate and well-managed and that discharges are timely and well-supported
- Improve support to high intensity users of our services

3.4. The bed management system will be based on Trust organisation at three geographical levels:



3.5 The principle aim is that most patients are placed as close to home and their care co-ordinator as possible. For example, the Wiltshire North bed management group will first place patients within the Wiltshire North (Green Lane) inpatient unit. If that unit is full, they will then place within the East level 2 area. If that area is full, they will place within the Trust level 3 area. If the Trust is full, then an out of area placement will be required.

3.6 Bed capacity for Acute, PICU, Rehab and functional older people inpatients would be expressed like this:

Level 1						
Wilts N	Wilts S	Swindon	BANES	Bristol	N Som	S Glos
20 Adult	21Adult	18 Adult	20 Adult	52 Adult	20 Adult	13 Adult
7.1 PICU		3.3 PICU	1.6 PICU	13.4PICU	2 PICU	1.6 PICU
10 OP	10 OP	12 OP	3 OP	11 OP	15 OP	13 OP
		10 Rehab	5 Rehab	20 Rehab		10 Rehab
Level 2						
East				West		
82 Adult				85 Adult		
12 PICU				17 PICU		
32 OP				39 OP		
15 Rehab				30 Rehab		
Level 3						

167 Adult
29 PICU
71 OP Functional
45 Rehab

3.7 A bed management office will be established at Level 2 (with East and West bed managers) which will monitor "live" capacity via RiO and manual collection through direct contact with wards and Intensive teams. The bed state will summarise yesterday's activity of admissions and discharges via the RiO bed report produced at 9pm, admissions made after 9pm and before 9am and will describe today's capacity. The latter will show, by level, vacant beds, outliers by level, delayed transfers of care, and other factors affecting capacity such as ward closures, restrictions on admission etc. A full Standard Operating Procedure will be produced for this office.

4. Escalation

4.1 Essential to this system will be an Escalation policy which provides a framework for controlled action in relation to bed capacity. This escalation policy will be similar to that used by acute general hospitals in order to align the language of our bed management with that of the wider urgent care system.

4.2 Escalation trigger points will be developed with operational staff and are likely to include, as an example:

Green
Capacity is available within level 1 & no outliers within level 2 or above
Leave is not restricted
DTOC at <1%
Positive bed state predicted for 4pm
All wards are open

Amber
Outliers at level 2
Capacity is available within level 2 & no outliers within level 3 or out of area
1 ward closure
DTOCS at >1% but <2%
Restrictions in place for leave
Access to transport delayed

Red
Capacity is available within level 3 & no out of area placements
DTOCs at >2%
>1 ward closure
No PICU step-down
No Leave beds

Black
No Capacity is available within level 3

4.3 Each escalation state will trigger a set of actions, to be agreed with operational staff, and likely to include as an example:

Green Usual best practice activities within Level 1 for admission gate-keeping and

timely discharge.

Amber	On-call managers for the local delivery units within level 2 will agree an action plan as indicated by the escalation guidelines, considering interventions by Intensive, Inpatient, Recovery teams and medical staff
Red	Operations Director and Director of Nursing to agree action plan at level 3 considering interventions: • To reduce the number of emergency admissions by reinforcing decision managers in Intensive teams and Acute Liaison • To increase the number of discharges by secondary review of all inpatient wards by ward clinicians • To expand the bed base by use of escalation areas either internal or external to the Trust • Compromise on inpatient admission type – e.g. older people into acute wards • To consider re-direction of community resources towards ward and intensive teams and postponement or cancellation of all non-urgent activities • Trust to inform commissioners • Trust to inform local authorities
Black	Consider initiating major incident procedures

4.4 These escalation triggers will be discussed with commissioners in order to seek agreement over the responsibilities for partner agencies to take action alongside our internal escalation process.

4.5 In addition to these actions, the project group will develop with operational staff a set of pre-emptive actions for the trigger points such as outliers placed out of hours, staffing pressures relating to sickness or holiday periods, or activity levels for emergency assessments higher than predicted variance.

4.6 The new bed management system will be developed over the next few weeks and will be implemented, following the Operations directorate consultation, after the recruitment of the second bed manager in September 2013.

5 Developing a sustainable care pathway

5.1 As previously stated, the bed management or urgent care system is complex and multi-factorial, and making it “flow” so that patients move in a timely way along the pathway relies on responses from many teams and professionals. Although the green status refers to usual best practice activities to manage beds, these, in effect, are not clearly defined or understood across all teams and wards that contribute to the acute or urgent care pathway.

5.2 The initial analysis of bed usage described in 2.4 has also highlighted that further work is required to understand local behaviours and historical patterns of usage.

5.3 It is proposed, therefore, that an urgent care project is established to meet the objectives outlined in 3.3. The project would work in collaboration with local delivery units

around the following work-streams:

Hitting the green target	Developing local agreements relating the procedural, structural and behavioural activities required to maintain a green status
Sharing best practice	Identifying cross-Trust standards which reflect best practice in management of admissions and planning for discharges
Alternatives to admission	Reviewing support to prevent admissions to hospital and considering how alternatives to hospital could be better developed, including identifying solutions for high intensity users of services
Doctors at the forefront	Establishing a medical work-stream, led by the Associate Director Dr Dan Meron, to develop medical leadership and decision-making across the urgent care system

5.4 The project will be led by the Academy, with significant input from Operations, and will report regularly into the Senior Management Team. In other organisations where this system has been implemented, there has been a concerted time-limited period to "return to green" in order to establish a good footing on which to operate the system. It is proposed that this initiative is replicated in the Trust in early October.

6 Recommendations

6.1 The Board is recommended to note the contents of the report.

7 Report authors

7.1 Emma Adams, Head of Academy

Project group:
Dr Dan Meron, Associate Director of Medicine
Lou Curtis, Lead Nurse, Safety & Compliance
Phil Cooper, Interim Head of Professions & Practice, S&SS
Kevin Connor, Service Director
Jules Brown, Bed manager – Bristol
Toby Rickard, Head of Information Management & Performance Information