Appendix **A**

Central Bedfordshire Health and Social Care Review

Review of Community Bed Provision in Central Bedfordshire: Recommendations for Improvement

January 2013

Executive Summary

The national agenda promotes choice and local control in the delivery of services for adults and older people. There is also an emphasis on providing a whole system approach that is designed around the customer. This will drive greater levels of collaborative health and social care commissioning and a focus on customer outcomes and high quality services.

People are living longer and there will be a significant rise in people over the age of 85 and those suffering with dementia and complex needs. This will increase demand for high cost services at a time when resources are scarce. Investment in early intervention and prevention will be important to help people retain their independence for longer. Similarly, services that focus on reablement and rehabilitation will be important to enable people to return to independent living at home after a period of ill health.

Local Authorities will need to plan to meet the needs of the whole population, not only those people that meet eligibility funding requirements. They will need to have a role in stimulating private and voluntary sectors in service provisions for older people. Quality, value for money and choice and transparency will be at the heart of service improvements that are outcome focused and have local and political support.

Partnership Offer

The emerging Health and Social Care partnership provides an opportunity for innovation and a better offer for people. Social Care, working in partnership with the Clinical Commissioning Group, have established principles of significantly improving and increasing the Health offer within the are of Cental Bedfordshire. Examples of this emerging approach can be found in the following three draft proposals:

1. Keeping the 29 beds in Biggleswade Hospital open and have some capacity to provide short stay medical unit provision at the site learning from two similar services in Dunstable and Houghton Regis as a basis
2. Joint Health and Social Care development of urgent care pathways to provide alternatives to acute hospital care
3. Having a joint approach to future community bed developments.

This review has also identified a number of key service improvements, some of which offer opportunities for closer collaboration with Health:

1. Following a successful Step up, Step Down reablement service pilot in the South of Central Bedfordshire a similar service is recommended for the North. It will focus on supporting customers discharged from hospital where there is a need for intensive reablement in a safe environment to facilitate a return to living independently at home. Given

the positive evaluation of the pilot in Houghton Regis and Dunstable, we believe there is merit in continuation of the model, but it will require re-directing investment from acute hospital based care toward the community alternative.

2. Establishing a Framework Agreement for engaging with providers of care homes including a quality system for informing general residential and nursing care home fee levels from 2013/14.
3. To improve the quality and level of dementia provision, establish a quality accreditation scheme for care homes and introduce an incentive scheme for all dementia related residential care home placements from 2013.
4. A programme to provide a range of supported living / Extra Care housing across Central Bedfordshire will be taken forward to provide more choice for older people with care needs.
5. Implementation of an integrated Urgent Care Pathway to streamline proactive and reactive support arrangements so as to avoid inappropriate admission to hospital and residential care and support timely discharge. This means more partnership working between health and social care professionals with service users and carers. Achieving this will require providers of care to come together to solve issues relating to the patient pathway. We recommend the development of provider partnerships in 2013 to implement pathway integration.
6. Provision of a number of 'Assessment Beds' in a care home environment that allow people to consider, with professional support, advice and a full health and care needs assessment, how they can best satisfy their future care needs.
7. Single commissioning arrangements for all residential and nursing care home services, based on quality and, where appropriate, assessed customer need. This would provide a transparent framework for local providers and customers and reduce the overheads of contract management.

Central Bedfordshire
Health and Social Care Review

1. Introduction

1.1 This paper describes the services available to adults and older people in Central Bedfordshire and proposes a number of changes necessary to meet future needs. Its represents a joint review between the Bedfordshire Clinical Commissioning Group and Central Bedfordshire Council. A similar joint review has been conducted by the Bedfordshire Clinical Commissioning Group and Bedford Borough Council.

1.2 The paper describes the need for change, setting out the key drivers that are influencing, and will continue to influence, the provision of services; and developments that are planned or in implementation. It also proposes a number of joint Health and Social Care initiatives that aim to improve outcomes for adults and older people.

1.3 The primary focus of this review has been on services for older people since they are by far the most significant consumers of health and social care services. People in other client groups are important but to have the greatest impact swiftly an initial focus on older people's services is necessary. Many of the services described in this paper will be appropriate to other client groups. Non-mainstream services that are designed to support specific needs for customers, for example acquired brain injury, but not mentioned in this paper are also available and subject to similar developments and improvement.

2. Need for Change

2.1 Central Bedfordshire has an ageing population with increasing levels of disability and frailty. The number of people aged 85 and over is expected to increase significantly by 2031 and the numbers of people with dementia will more than double by 2020. As people live longer, demand for health and social care services is expected to increase.

2.2 The current economic climate is placing increasing pressure on councils and clinical commissioning groups to improve quality and outcomes for service users while improving efficiency and use its resources effectively. The increasing demand for services will result in rising costs that will need to be addressed by refocusing services toward those with the greatest need and improving levels of independence through earlier intervention and preventative services. Customer expectations are also rising, stimulating more immediate and flexible services. The ability to provide seamless Health and Social Care services that are tailored to meet individual customer needs will be increasingly important.

2.3 There is a need to increase the provision of community based services which will promote people's quality of life, physical and mental wellbeing and

their independence in their own homes. In order to meet this demand, the Council and its partners need to understand its local position in being able to meet existing care and support needs and ensure there is a robust market to supply the range of services now and into the coming years.

2.4 There also needs to be a particular emphasis on joint commissioning and care arrangements between health and social care to deliver better and more integrated care and support, which moves from traditional forms of care in residential and nursing home settings, to targeted support within the community.

2.5 In 2011/12 services for people over 65 accounted for 50% of the total social care budget. Demand for older people's services is increasing due to the general rise in population but also because people are living longer, many with increasingly complex care needs.

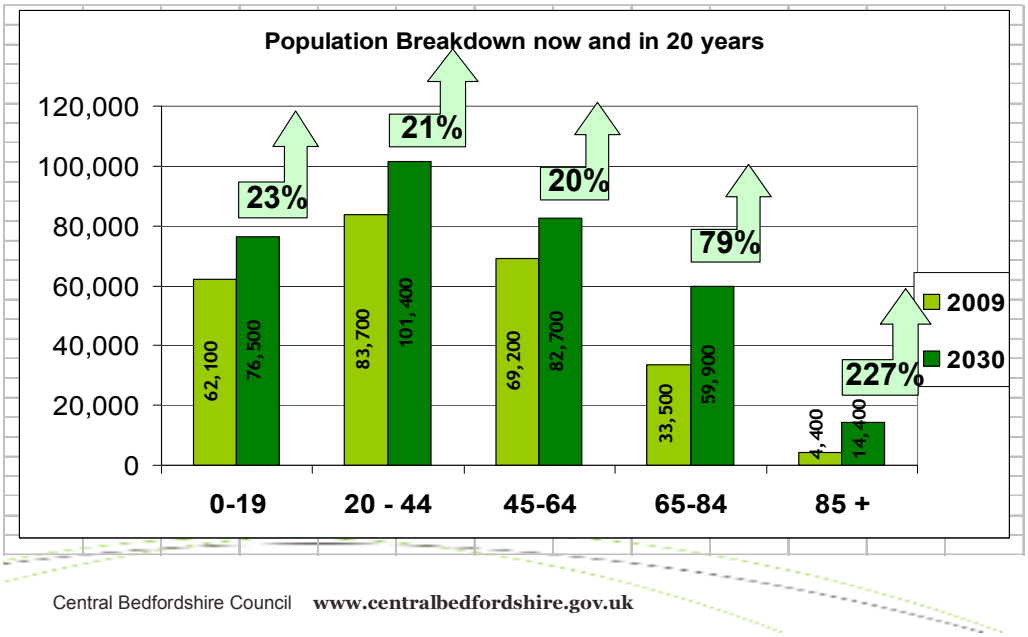
2.6 The forecast population for people over 65 set out in the JSNA is shown below and indicates the relative breakdown between the North of Central Bedfordshire and the South. The North accounts for approximately 55% of the total population of older people.

	2012	**2016**	**2021**
Central Bedfordshire	41828	48900	55500
North Central Bedfordshire	23398	26965	30605
West Mid Beds	11280	11978	13595
Ivel Valley	12118	14987	17010
South Central Bedfordshire	18430	21935	24895
Chiltern Vale	11711	13196	14977
Leighton Buzzard	6719	8738	9918

Based on JSNA predictions, Adjusted for Areas

2.7 The forecast increase in population for people over the age of 85 is particularly significant and is illustrated below. It is recognised that the need for care home services is related to age and that it becomes increasingly common for those over the age of 85. It is also known that admissions to residential care can often result from unplanned health episodes, for example falls, where people need higher levels of care for a short period after leaving hospital. In many cases such short term admissions result in more permanent care home placement.

Central Bedfordshire population now and in 20 years time



2.8 The number of older people expected to experience dementia is predicted to rise significantly over future years. The table below shows that the most significant rise will affect people over the age of 85. New ways of working will be essential if we are to provide effective support to this group of older people and help as many as possible to remain independent rather than taking up more traditional institutional forms of care.

People aged 65 and over predicted to have dementia, by age and gender, projected to 2030

	2012	2015	2020	2025	2030	Increase
People aged 65-69 predicted to have dementia	176	192	180	203	242	38%
People aged 70-74 predicted to have dementia	274	315	399	374	427	56%
People aged 75-79 predicted to have dementia	468	508	602	771	738	58%
People aged 80-84 predicted to have dementia	670	741	869	1,036	1,332	99%
People aged 85-89 predicted to have dementia	644	700	856	1,050	1,289	100%
People aged 90 and over predicted to have dementia	508	567	714	949	1,273	151%
Total population aged 65 and over predicted to have dementia	2,740	3,022	3,620	4,382	5,300	93%

Figures may not sum due to rounding. Crown copyright 2010
Rates for men and women with dementia are as follows:

Age range	% males	% females
65-69	1.5	1
70-74	3.1	2.4
75-79	5.1	6.5
80-85	10.2	13.3
85-89	16.7	22.2
90+	27.9	30.7

The most recent relevant source of UK data is Dementia UK: A report into the prevalence and cost of dementia prepared by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and the Institute of Psychiatry at King's College London, for the Alzheimer's Society, 2007.

The prevalence rates have been applied to ONS population projections of the 65 and over population to give estimated numbers of people predicted to have dementia to 2030.

To calculate the prevalence rates for the 90+ population, rates from the research for the 90-94 and 95+ age groups have been applied to the England population 2006 to calculate the numbers in each age group, the sum of these groups is then expressed as a percentage of the total 90+ population to establish the predicted prevalence of the 90+ population as a whole.

2.9 It is also expected that there will be significant growth in a number of other conditions that will affect older people's ability to live without support. The table below sets out the predicted levels of prevalence for Central Bedfordshire provided by POPPI. Falls account for the second highest level of prevalence for older people and many of those that result in a hospital admission result in people taking up a place in residential care.

Forecast Disease Prevalance 2012-2030 (POPPI)

	2012	2015	2020	2025	2030	Increase to 2020	Increase to 2030
Dementia	2,740	3,022	3,620	4,382	5,300	32%	93%
Diabeties	5,314	5,894	6,649	7,495	8,660	25%	63%
Longstanding health condition caused by a stroke	976	1,084	1,237	1,425	1,642	27%	68%
Longstanding health condition caused by bronchitis and emphysema	718	797	901	1,021	1,180	25%	64%
Longstanding health condition caused by a heart attack	2,073	2,295	2,602	2,970	3,429	26%	65%
Fall	11,065	12,257	14,103	16,169	18,939	27%	71%
Admitted to hospital as a result of falls	845	928	1,103	1,337	1,519	31%	80%
Limiting long-term illness	18,121	20,032	23,005	26,763	30,742	27%	70%

2.10 Admissions to residential care are predicted to rise significantly over the next 10-15 years. The table below suggests that the demand for

residential care, with and without nursing, is expected to rise by 34% by 2020 and almost 100% by 2030.

Forecast of people living in a care home (POPPI)

	2012	2015	2020	2025	2030	Increase to 2020	Increase to 2030
Total population aged 65 and over living in a care home with or without nursing	1,026	1,128	1,374	1,703	2,042	34%	99%

2.11 If the current models of care services are continued we can expect to see the numbers of people supported by the local authority in a residential care home without nursing setting to increase by 48% by 2020. Without changes to the models of care and efforts to improve the ability of older people to remain independent this level of increase will become unsustainable.

2.12 It will be important to provide for alternative housing opportunities, for example extra care and other older peoples' housing styles. Improved home care models, arrangements that prevent people attending hospital unnecessarily and support for people when leaving hospital will be equally important.

2.13 There are number of teams and services designed to treat and care for people outside of hospital. They have shown they are able to respond effectively when something goes wrong but they are not working well to proactively prevent problems arising. This results in people being inappropriately admitted to hospital, where they loose their ability to live independently. They then leave hospital with a higher level of dependence on other services.

2.14 Acute hospitals are experiencing increased pressure on their services[1]. Over the last decade there has been a 37% rise in emergency admissions. People over the age of 65 account for 65% of all hospital admissions and an increasing number are frail or have a diagnosis of dementia. Many older people admitted to hospital have multiple, complex needs and hospital buildings, services and staff are not well equipped for such needs. People therefore find they are moved through a number of different wards which has been shown to add to the overall length of stay in hospital. The gaps in provision are exacerbated during the out of hours period where not all services are available or able to respond. Information sharing and joint management arrangements are not tools used systematically by providers to support people in their journey, providing commissioners with an opportunity to improve partnership working and communication.

[1] Report by the Royal College of Physicians, 2012

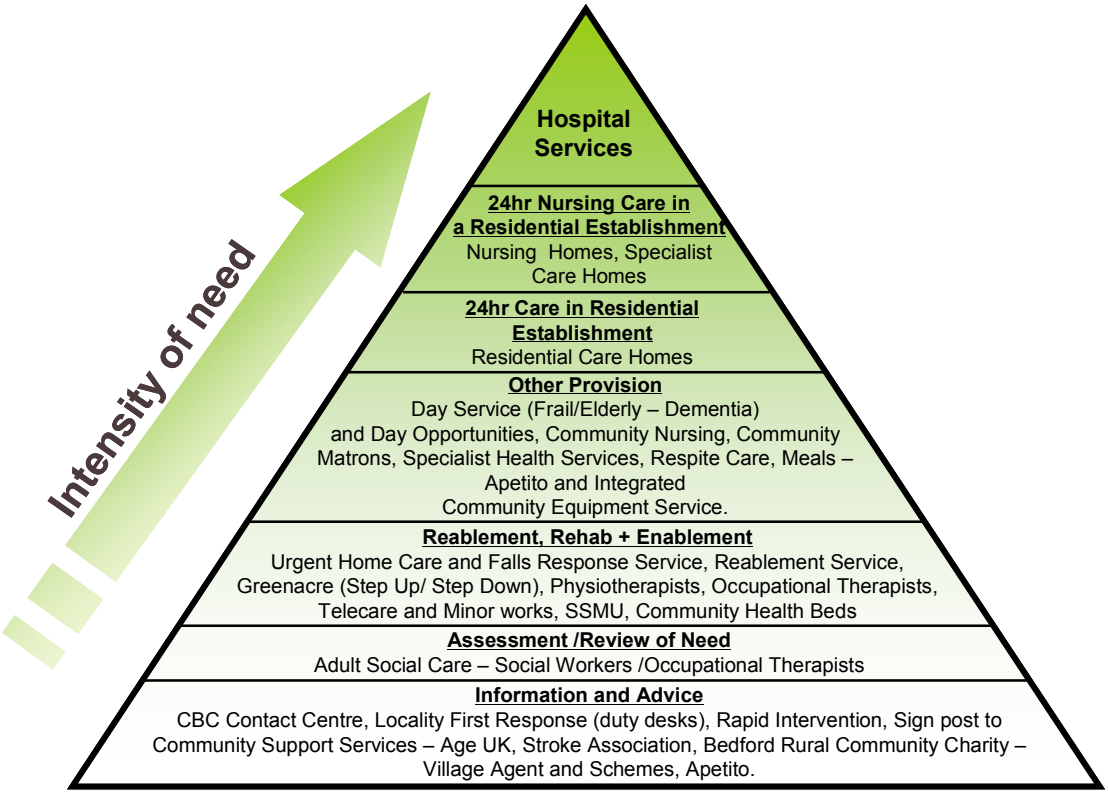
2.15 The Royal College of Physicians recommend that services be redesigned to deliver patient-centred care. It is known that hospital admission for older people can result in a loss of independence and sometimes hospital infections. Services that reduce inappropriate hospital admission will therefore be key to improving outcomes for older people and reducing dependence on health and social care services. Similarly, services that enable timely discharge from hospital and enable a return to independent living will be equally important.

2.16 The Kings Fund's report in 2012[2] concluded that the key to reducing the use of emergency beds lies in changing the ways of working across the care system rather than implementing piecemeal initiatives and that whole system approaches are necessary to deliver a shift from hospital to community-based care. This paper suggests a number of initiatives that utilise locally available resources and teams differently to provide this joined up, whole system approach to support effective community-based care.

3. Current Provision

3.1 We have a range of services that can meet the needs of older people in their own homes. The illustration below sets out the range of social services available to people living in Central Bedfordshire.

Current Customer Pathway and Provision



Information and Advice

[2] Imison c, Thompson J, Older people and Emergency Bed Use, The Kings Fund, August 2012

3.2 For older people our Customer Contact Centre is the first point of contact giving customers a wide range of information and advice as well as taking any necessary details for a referral to a particular service.

3.3 Our First Response (Duty Desks) are locality based in Ampthill, Dunstable, Biggleswade and Leighton Buzzard. The social workers are able to provide a wide range of information and advice. When a customer has been identified as needing urgent support and meeting our eligibility criteria the duty desk will arrange the necessary support.

3.4 There are a range of social care services provided on an urgent basis, including:

- Universal Services from the 3rd Sector
- Increases in currently provided care support
- Reablement
- Meals provided by Appetito
- Respite Care
- Step Up / Step Down, currently a pilot service

3.5 These social care support services together account for a cost of £241,000, expected to rise to £355,000 by 2025 assuming that the services grow with the joining of more volunteers across a wider geographical spread.

3.6 Customers/patients are also able to access a range of urgent services funded by Health. They include:

- Urgent GP/practice appointments and home visits
- Rapid Intervention, provided by Health and catering for medical and social care needs;
- Short Stay Medical Unit, provided by Health and currently only available in South Central Bedfordshire;
- Admission to a community bed (at Biggleswade Hospital, Taymar Nursing home or The Knolls)
- Hospital, where the need is acute.

3.7 The Rapid Intervention service provides quick access to nurses and therapists allowing time for other mainstream services to mobilise. It is a service commissioned and jointly funded by Health and Social Care and provided by South Essex Partnership Trust (SEPT). It aims to prevent inappropriate admission to hospital and costs approximately £650,000 per year.

3.8 The Short Stay Medical Unit is a pilot initiative with an annual budget of £1.8m providing 16 beds in Houghton Regis. It is funded by Health and provided by SEPT. It is supported by a multi-disciplinary team led by a consultant geriatrician and provides short term medical support. This service has demonstrated positive outcomes and satisfaction among patients and has shown it can prevent inappropriate hospital admissions and facilitate timely

discharge. However, it has not relieved pressure on hospital services because we have added to overall capacity rather than replace hospital care with community alternatives.

Assessment and Review of Need

3.9 Where support is not identified as urgent the customer's case will be allocated to a locality based social worker and a visit will be arranged to complete the assessment and advise on the most appropriate suite of services. The services available following a needs assessment are shown below and include those provided by Primary Health, Community Health and Universal Services:

- Universal Services from the 3rd Sector including Age UK and Carers in Bedfordshire;
- Increases in currently provided care support;
- Reablement;
- Home Care
- Direct Payments
- Adaptations
- Assistive Technology
- Community Equipment
- Rehabilitation and Enablement
- Rapid Intervention
- Community Beds
- Day Care for the very frail or those with dementia
- Day Opportunities
- Meals provided by Appetito
- Respite Care – carer's breaks
- Residential Care
- Nursing Care
- End of Life Care

3.10 The social care services aimed at assessing the needs of older people and managing the delivery of all their care covers all Central Bedfordshire. In 2011/12 over 12,500 people (North - 7,064, South - 5,707) benefited from these services at a cost of £4.121m. By 2025 it is expected that these services will provide for 18,500 people and cost £6m.

Reablement, Rehabilitation and Enablement

3.11 Reablement is a social care service aimed at improving older people's functional skills and abilities to maximise their full potential to live independently. It provides tailored support for up to six weeks following an individual assessment and is free of charge at the point of delivery. The service is provided in people's own homes and in many cases results in reduction in the long term care package required. The service is complemented by Health's Rehabilitation and Enablement (Intermediate Care) service which provides Physiotherapy and Occupational Therapy. The delivery of these services are aligned with a single point of entry.

3.12 In 2011/12 the reablement services achieved a 40% reduction in care package provision. During 2011/12 the reablement service provided support to 1626 clients (North: 778, South: 848) and incurred costs of almost £2.07m. Investment in reablement services has been increased over successive years, with a 9% year on year increase in 2010/11 and 2011/12. As a result of its success the service was expanded further in 2012/13 with a 21% increase in investment. It is estimated that by 2025 the services will support nearly 2,400 older people at a cost of £3.04m, assuming the demand will rise in proportion to the population of older people.

3.13 The Step Up, Step Down Reablement service is aimed at providing intensive reablement services in a care home environment either after a spell in hospital (Step Down) or as an alternative to a hospital admission (Step Up). The aim of the service is to help older people regain both confidence and capability to help them return home to live independently rather than needing to use more institutional forms of care. At present only 8 beds are provided in one facility in the South of Central Bedfordshire as a pilot service. To date this service has supported over 75 customers of which almost 70% are able to return home. This pilot service costs £214,000 pa.

3.14 Rehabilitation and Enablement services consist of physiotherapists and occupational therapists, commissioned and jointly funded by Health and Social Care and provided by South Essex Partnership Trust (SEPT). They work together to improve physical function in people, the team includes neuro-rehabilitation, specialists who support people recoving from brain injury such as a stroke. The service is delivered at a cost of approximately £2m across Central Bedfordshire.

3.15 The Telecare and Minor Works service provides technology that supports emergency call facilities together with minor adaptations to premises. It includes installation and maintenance of equipment together with the provision of the emergency call support system. In the period January to December 2012 a total of 528 customers benefited from the Telecare and Minor Works service (North: 290, South: 238) at a total cost of £210,000. By 2025 it is expected that 776 customers will be supported by this service at a cost of £309,000. It has been assumed that 60% of customers will, in future, be charged a nominal £4 per week for the service.

<u>Other Social Care Provision</u>

3.17 Both standard and specialist dementia Day services are provided across a number of centres across Central Bedfordshire for older people. These services provide a range of activities for older people to engage in, helping to keep people active and reduce levels of isolation. These services also include an element of reablement activity with the aim of re-establishing or maintaining older people’s independence.

3.18 In 2011/12 Day services supported nearly 506 older people (North: 280, South: 226) at an average of two attendances per week and an annual cost of £1.5m. It is estimated that by 2025 over 744 older people will benefit from Day services at a cost of £2.2m.

3.19 The Integrated Community Equipment service provides, installs and maintains a range of equipment for older people that enables them to continue with their daily lives. As a joint service with health, it includes medical and other specialised equipment, adaptations to homes, and aids that help with normal activities.

3.20 In 2011/12 there were 1099 recipients of equipment services (North: 604, South: 495) at a cost of £264,000. It is estimated that by 2025, the number of recipients will increase to over 1600 at a cost of £388,000.

3.21 Home Care is provided to people in their own homes and aims to cater for a range of care needs as determined by regular needs assessments. In 2011/12 this service supported 1327 customers at a total cost of £7.117m. By 2025 over 2,500 people are expected to be supported in their own homes, including those that are able to take up opportunities in newly developed extra care housing. It is expected that the cost of this service by 2025 will be £13.681m.

Residential Care

3.22 Residential Care is provided for older people with more complex needs, including dementia. In 2011/12 Central Bedfordshire Council supported 559 customers in a residential care home setting (North: 390, South: 250) at a total cost of £15.67m. This figure includes people placed both within the county and out of county.

3.23 It is expected that by 2025 the demand for Local Authority funded residential care will be approximately 600 places as a result of the combined effect of reablement, preventative activities and the availability of extra care housing across Central Bedfordshire. This level of residential care provision is expected to cost £16.04m by 2025.

Residential Nursing Care

3.24 This is provided for older people with a range of medical needs where the availability of nursing support is considered essential 24 hours a day. The Local Authority funded 156 customers (North: 85, South:70) in 2011/12 at a cost of £3.92m. It is estimated that the demand arising from the forecast population of older people will increase this level of provision to over 300 by 2025 at a cost of £7.589m.

Hospital Interface in social care

3.25 There is not a hospital based in Central Bedfordshire, although Adult Social Care are responsible for assessing the needs of Central Bedfordshire

residents who are in hospital and meet our Fair Access to Care eligibility criteria - Critical, Substantial and Moderate. The main aim is to prevent admission to acute base wards from A&E and Acute Assessment Unit (AAU) and enable customers to return home with appropriate support as early as possible.

3.26 To enable customers to be discharged from base wards in a planned and structured way, so that they can return home with appropriate support where it is safe for them to do so, we have a dedicated team. Our customers may also be transferred to other community bed units.

3.27 The following arrangements are in place in the hospitals:

- **Bedford Hospital** - the Social Work Team is a shared service with Bedford Borough
- **North Herts (Lister Hospital) and Addenbrookes Hospital** - a dedicated social worker is based in the locality office in Biggleswade
- **Stoke Mandeville and Milton Keynes Hospital** - a dedicated social worker is based in the locality office in Leighton Buzzard
- **Luton and Dunstable Hospital** - there is a dedicated Social Work Team based in the Disability Resource Centre in Dunstable.

Primary Health Care

3.28 GPs and Community Health services are an essential part of every care pathway as they oversee people's health needs and our social care teams work very closely with these services. GPs are in the unique position in healthcare of having access to the complete patient history and are the part of the health system that patients have greatest contact with.

3.29 In addition to GPs and out of hours GP services a number of community based services are commissioned from South Essex Partnership Trust (SEPT) including:

- Community Nursing (or District Nursing) comprising a team of nurses who work mainly with older people in their own homes to support recovery from illness.
- Community Matrons, who provide specialist nursing services to people with multiple long term conditions, assessing needs, agreeing care plans and coordinating care provision.

3.29 In the Dunstable area some GPs have piloted the use of Practice Matrons who are attached to each practice. They oversee a caseload of patients most of whom have multiple with long term health conditions and have had frequent admissions to hospital. This has been augmented by dedicated social workers (Caseload Manager) who coordinate access to social care services for these customers.

3.30 There are currently 4.5 FTE social workers (Case Managers) covering the localities of Chiltern Vale, Leighton Buzzard , West Mid Beds and Ivel Valley at an annual cost of £170,000. This team works together with patients

who have at least 1 long term health condition and have had frequent admissions to hospital, and/or frequent contact with GP's and social care. The aim of this service is to avoid unnecessary admission to hospital or residential care.

Community Health Beds

3.31 Bedfordshire Clinical Commissioning Group commissions 57 beds across Central Bedfordshire, of which 16 are in the Short Stay Medical Unit in Houghton Regis. There are 12 provided in nursing homes in Leighton Buzzard and Silsoe and customers are supported by peripatetic rehabilitation and enablement teams. The remaining 29 beds are in Biggleswade Hospital.

3.32 The 12 nursing care home beds are specifically contracted to support rehabilitation and enablement and cost a total of £0.5m per year. Whilst the aim is for these beds to support both admission avoidance and supported hospital discharge they mainly provide for support after a hospital stay and help improve levels of mobility and confidence to allow people to return home.

3.33 The 29 beds at Biggleswade Hospital cost £1.3m per year and are commissioned and funded by BCCG and delivered by SEPT. The current service design is not meeting the customer outcomes expected and the levels of occupancy are low despite demand estimates for community beds in the area suggesting that there is sufficient customer demand.

Other Community Health Services

3.34 There are a number of specialist services commissioned by health that operate to support community needs. These include continence, speech and language therapy and tissue viability.

3.35 There are also 48 beds directly commissioned by Health to provide long term care to people with challenging behaviour and acute dementia. They are located in Flitwick and Biggleswade and cost £1.5m per year. In addition a significant number of beds are spot purchased in local nursing care homes for people with diagnosed dementia or other specialised conditions and attracting continual healthcare funding.

4. Future Model for Central Bedfordshire

4.1 It is clear that the current model of service provision will be unsustainable in an environment of rising demand, increased complexity and reducing budgets. There is a need for higher levels of integrated working to ensure services are centred around the customer and provide greater choice.

4.2 The Health system responds well to a crisis but does not focus enough on preventing the crisis occurring in the first place. This is reflected in rising hospital admissions and re-admissions and longer stays in hospital. A number of initiatives have been developed to address this however these are often

fragmented and operate without effective coordination and collaboration. This results in services that are often confusing for the customer and difficult to navigate for practitioners.

Evidence Base

4.3 A review of the literature relevant to these areas of service was conducted by Public Health and a report to support the work was prepared[3]. This review identified a number of key messages:

- Non-acute bed provision should be seen as a component of care provided outside of a hospital setting and not managed in isolation.
- Rehabilitation provided in community hospitals shows better outcomes than usual hospital care with similar levels of cost effectiveness.
- Admission avoidance schemes appear to deliver similar outcomes to acute hospital care but deliver greater customer satisfaction and at a lower cost.
- Costs and outcomes for rehabilitation provided in people's homes and day hospital settings are similar.
- Rehabilitation in nursing and residential care home settings have similar outcomes to acute care settings.

4.4 A key area for potential improvements relates to the support provided to customers when they experience a change in their condition or care environment. Responding rapidly and in a coordinated way will be important to ensuring that the right health and social care services are mobilised and community services are utilised, rather than hospital admission being the default response.

4.5 The evidence suggests there are benefits to providing non-acute services in community settings and to improving arrangements that might avoid an older person being admitted to hospital unnecessarily.

4.6 The Oak Group MCAPTM bed utilisation model applied at L&D Hospital has been used as a basis for estimating the demand for community beds in Central Bedfordshire. Based on current population figures and non-elective hospital admissions this shows the following demand for community bed services:

Locality	65+ Population (2012)	Short Stay Beds			Medium Stay Beds		
		Estimated Demand	Current Provision	Shortfall	Estimated Demand	Current Provision	Shortfall
Dunstable	11,711	22	16	6	18	8	10
Leighton Buzzard	6,719	12	0	12	10	6	4
West Mid Beds	11,280	16	0	16	12	6	6
Ivel Valley	12,118	25	0	25	20	29	-9
Total	**41,828**	**75**	**16**	**59**	**60**	**49**	**11**

[3] Improving health care outside of acute setting, Helen Knowles, Public Health

4.7 Short stay beds relate to those that focus on meeting medical needs reflecting the arrangements in place within the Short Stay Medical Unit in Houghton Regis. Medium Stay beds relate to those where the length of stay is related to the specific customer reablement and rehabilitation need similar to those provided in the Step up / Step Down unit in Dunstable, the two nursing homes in Silsoe and Leighton Buzzard and Biggleswade Hospital.

4.8 It is clear from the table that there is an imbalance of provision across the area and an overall shortfall in provision for both short and medium stay beds. In Ivel Valley, whilst Biggleswade Hospital provides a substantial number of beds the balance between short and medium stay provision does not reflect demand.

4.9 Work undertaken in a neighbouring County used a benchmarking exercise among PCTs and focussed on bed supply against the older population size. This work concluded that 1 bed community bed was required for every 423 people aged over 75 years. .

4.10 Using this ratio based demand estimation method and the current population figures for the four areas in Central Bedfordshire the following table shows that the existing supply of community beds are sufficient to meet need.

Hertfordshire Model				
Locality	75+ Population Size	Current supply	Estimated bed need	Difference
West Mid Beds	4,389	6	10	(4)
Ivel Valley	5,693	29	13	16
Leighton Buzzard	3,105	6	7	(1)
Dunstable	5,042	16	12	4
Total	18,229	57	42	-15

4.11 The difference between these two models is significant. A recent learning set with Clinical Commissioning Groups suggested that nationally, fewer community beds were required and more care was to be delivered in patients' own homes. Counties such as Lincolnshire do not have any community hospitals or bedded units and instead focus far more on providing the care and therapies required in peoples own homes. Clearly, there is no nationally agreed formula for determining the need for community bedded provision and much depends on the range of other services available.

4.9 This picture leads us to the conclusion that additional beds are not advised at this time and instead, focus needs to be paid on making effective use of the beds currently available including those at Biggleswade Hospital. The pilot in south Central Bedfordshire at the Short Stay Medical Unit has

demonstrated sound outcomes and we see merit in a hybrid model where short and medium stay provision is commissioned at Biggleswade Hospital.

4.10 Future community bed based services will need to be flexible so as to respond to variations in demand and a variety of health and care needs. They will also need to reflect the increasing focus on providing services within people's own homes. Utilising the available nursing and care home provisions to meet some short term health and care needs whilst wrapping rehabilitation and reablement services around the individual customer will provide both flexibility and efficiencies.

Principles

4.10 A number of specific principles should underpin the development of services to meet future needs. These are:

- Maximising opportunities to prevent ill health and increasing the emphasis on early intervention,
- People should be supported to remain independent at home through joined up health and social care services delivered in a person's own home wherever possible,
- Services should support the objective of avoiding or reducing hospital admissions and facilitating timely discharges,
- Services should support the objective of avoiding or reducing entry into long term residential care, residential nursing care and short term emergency respite care.
- Services should be flexibly focused around customer outcomes, less prescriptive about eligibility criteria and lengths of provision that act as barriers to provision and more focused on achieving independence for the customer,
- Simple and streamlined referral processes, joint health and care pathways and improved information sharing.

New and Enhanced Services for the Future

4.11 A rolling programme of improvements to the existing services is in place, focusing on improving the quality of the services provided and achieving better value for money. We are also aiming to improve the transparency of the services available to help older people make informed choices. The model shown below places the customer at the centre of the range of services provided and aims to illustrate both local and regional service types.

Future Care Model

4.12 Two themes should permeate all service delivery, prevention and enablement. In all contacts with customers preventative opportunities should be identified and customers supported in pursuing those that might result in improved health. Similarly, a philosophy of enablement should underpin care home and home care services so that people are encouraged to care for themselves and helped to feel confident about their abilities.

4.13 There are a number of key areas for improvement that are aimed specifically at the issues identified earlier and these are set out below.

<u>Increasing availability of Step Up / Step Down Services</u>

4.14 The pilot Step Up, Step Down service developed to support customers in the South of Central Bedfordshire leaving or avoiding admission to the Luton and Dunstable Hospital will be expanded in the future to provide a higher level of provision across all areas of Central Bedfordshire.

4.15 This will be achieved by using the existing care home and community bed resources more flexibly so as to provide for both permanent and temporary services in each locality. It has already been shown that care homes can provide rehabilitation and reablement services alongside more permanent placements and this capability should be expanded. Biggleswade hospital offers an opportunity for the existing service to be replaced with one that offers both short stay medical support alongside more medium term intensive rehabilitation. Over the longer term a more suitable central location for such a service should be considered.

Assessment Beds

4.16 When an older person leaves hospital it is sometimes not appropriate for them to return home. Instead a short period in a care home environment would allow for a full and objective assessment to be made of their future health and care needs. With professional advice they can consider, with their families, how best to meet their future needs and be supported to return home wherever possible. This might include adaptations to their home and a period of reablement alongside an appropriate care package.

Care Home Services

4.17 There is currently a shortfall in residential care home provision in the north of Central Bedfordshire and, conversely, there is a relative shortfall in nursing care home provision in the south. Efforts are being made to stimulate additional market provision through close engagement with planners and involvement in the drafting of the Development Plan. We expect to see the introduction of a new care home service in the Dunstable area during 2015. In addition, new commissioning arrangements will be introduced including a Framework Arrangement with local care home providers that will link fee rates to the quality of services provided as assessed using the ADASS Quality Framework. This Framework will aim to cover all bedded services for older people, both with and without nursing, in Central Bedfordshire. It will also enable greater transparency for customers seeking to take advantage of these services.

4.18 A recent survey conducted across nursing homes in Central Bedfordshire found that LA funded customers accounted for 48% of the total nursing places whilst Health accounted for 19% and self funded customers for 24%. It was also found that 9% of the 575 nursing places available were empty. This would suggest that, to meet the demand for all customers requiring nursing care, a total supply of over 900 (North:500, South: 400) would be required by 2025.

Extra Care Housing

4.19 Recognising the forecast increase in the older population we are working with planners and property developers to stimulate the development of a range of accommodation for older people, including Extra Care, to provide more choice for our older residents. We are also, as part of our

Landlord Services, reviewing the stock of sheltered accommodation and planning for new Extra Care provision. Extra Care Housing has the benefit of a 24-hour on-site care team able to provide planned, unplanned and emergency care to people living in their own flats which they rent or have purchased.

Dementia Care

4.20 There will be an increasing prevalence of dementia and in many cases a care home setting may provide the best possible support for an individual. A new Dementia Accreditation Scheme will be introduced in 2013 aimed at stimulating an increase in provision and improvements in quality of dementia care home services. In addition Central Bedfordshire Council has a Corporate target to achieve 60% of Council Commissioned dementia care home placements meeting the 'good' or 'excellent' quality rating by 2014.

4.21 There are also planned changes to the current Day Centre services to provide more appropriate provision for people with dementia. In addition, working jointly with hospital discharge teams, a new set of arrangements are being developed to improve the experience of people with dementia when being discharged from hospital. These discussions will include reablement services tailored to meet the needs of those with dementia.

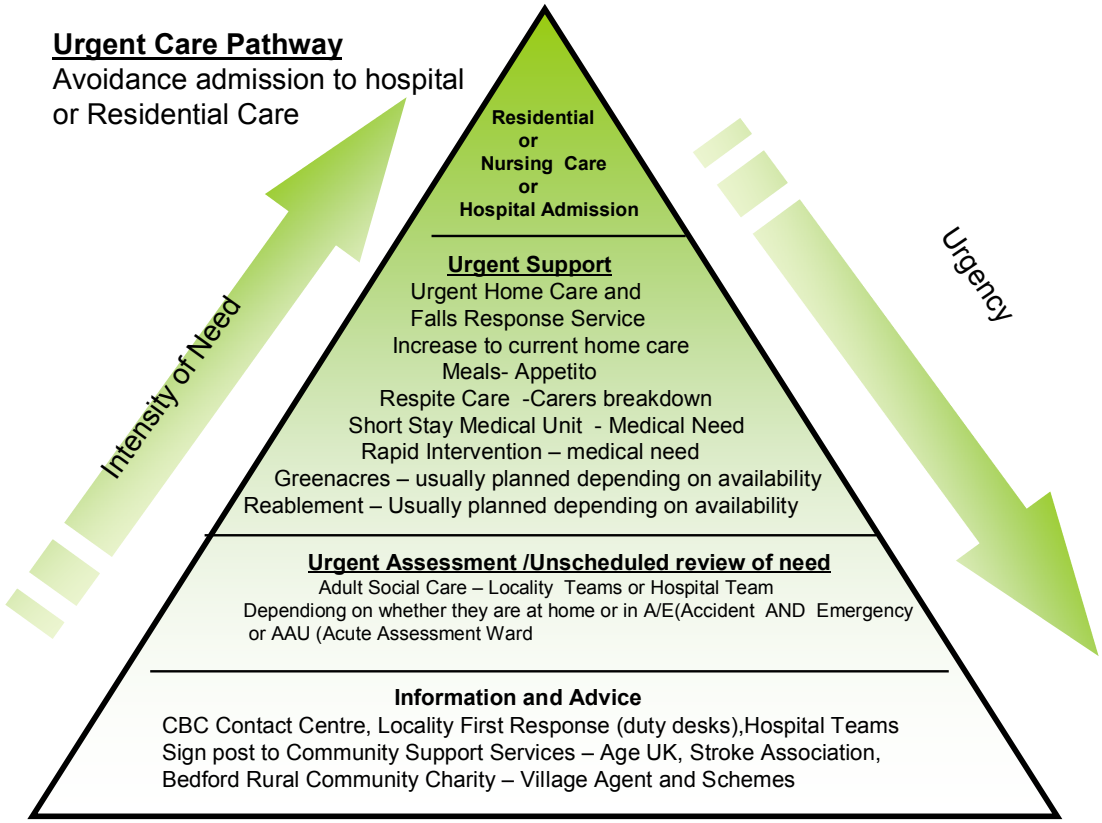
Urgent Home Care and Falls Response

4.22 This is a 24 hour service that provides up to 72 hours of urgent social care (home care) and support, with some equipment, to older people following a fall. The referral for the falls component will only be from the East of England Ambulance Service Trust. The referral for the Urgent Home Care component will be either via Contact Centre to the Social Work Teams or GP's and practice matrons directly. The aim of this service is admission avoidance to hospital and Residential Care. This is a new service that will be operational from January 2013. It is estimated it will provide for 2,912 falls related calls (North: 1602, South: 1310) and 2,190 urgent homecare visits (North: 1205, South: 985) per year. It has been estimated that it will cost £414,000pa to operate this service in 2013/14 and, with an estimated increase in customers to 7500 by 2025 (4281 falls related and 3,219 urgent homecare), £609,000 by 2025. It has also been assumed that this service will continue to be part funded by Health.

4.23 The locality based social worker Case Manager service that works with customers with at least 1 long term condition will be expanded to manage an increased caseload. There will be 2 FTE Case Managers in each locality (Chiltern Vale, Leighton Buzzard, West Mid Beds and Ivel Valley) who will be aligned to GP practices, Practice Matrons, and Community Health services. They will work to avoid unnecessary admission to hospital and residential care.

Urgent Care Pathway

4.24 The Urgent Care pathway covers two processes, one relating to inappropriate admissions to hospital and the other the effective discharge from hospital. Our main aim is to prevent inappropriate admission to hospital or residential care. Social Work Teams will complete an assessment/unscheduled review of need in a person's own home, Accident and Emergency (A&E) Unit or Acute Assessment Unit (AAU).

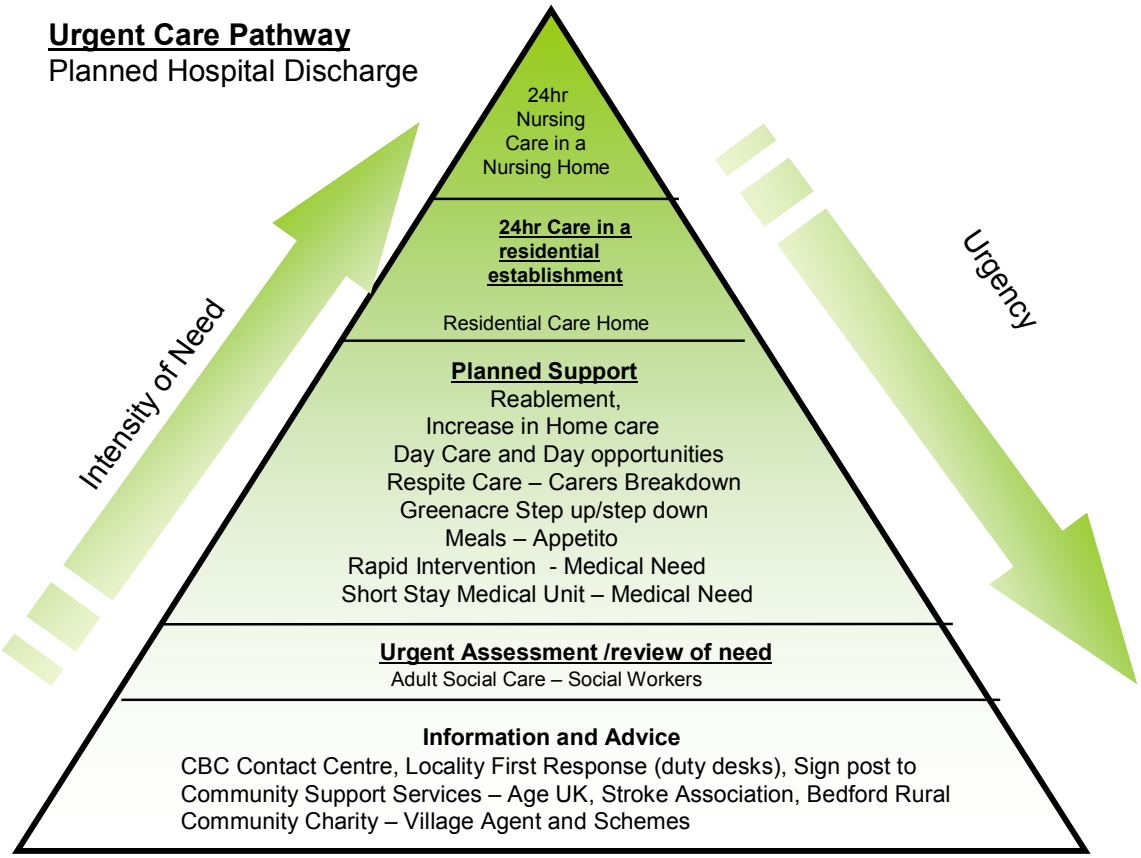


4.25 To enable people to remain in their own home or return to their own home from A&E or AAU with appropriate support, the following services can be provided:

- Information and Advice
- Referral to Universal Service
- Urgent Home Care and Falls Service
- Increase in current support
- Meals - Hot or Frozen Service Appetito
- Rapid Intervention (Health)
- Step Up / Step Down – Usually a planned admission depending on availability
- Reablement - Usually a planned service depending on availability
- Short Stay Medical Unit - Medical needs with joint working
- Respite Care - to support carer needs

4.26 As our aim is to prevent inappropriate admission to residential care we would only place someone in a residential care home or nursing home where their needs can no longer be met in their own home even with intense support.

4.27 In some cases it is necessary for an older person to have a spell in hospital and therefore the arrangements to ensure effective discharge is an important factor in allowing people to re-establish independence and avoid admission to long term residential care.



4.28 To enable planned discharge from Base Wards in hospital by Social Work Teams following an assessment /unscheduled review of their need the following services could be provided:

- Reablement
- Rapid Intervention
- Short Stay Medical Unit
- Step Up / Step Down
- Increase to current home care support
- Meal Service Hot /Frozen - Appetito
- Day Care and Day Opportunities
- Respite Care – to support carer needs

- Residential Care Home – where the person has all the above and they are still not safe to remain at home.
- Nursing Care Home - where the person's medical needs and social needs are so complex and they have had all the above and it is not appropriate to return to their own home or enter residential care.

4.29 A locality based Multi-disciplinary Team (MDT) approach will be developed to encompass existing Community Nursing, Community Matrons, Rehabilitation and Enablement, Rapid Intervention and locality based caseload managers. The roles of the MDT will be to:

- Avoid inappropriate hospital admissions, support hospital discharge, avoid readmission to hospital and placements into long term care homes;
- Assess risks and customer health and care needs;
- Respond to crisis situations, providing 24/7 services and a single point of access;
- Work with customers and professionals to develop appropriate health and care plans;
- Provide hospital in-reach to support timely discharge and effective transition to community based services;
- Support customers in the navigation of health and care services to help them make appropriate decisions about future health and social care provisions;
- Provide a close link with local GP services, getting early warning of potential customer needs and seeking to deliver or arrange preventative services where necessary.

4.30 The MDT will have access to a consultant geriatrician to provide any necessary clinical expertise. This will enhance confidence in the MDT with hospital clinicians and GPs and support the team in taking customers that might otherwise have been referred to hospital.

4.31 The community based MDT will have better knowledge of their customers and the close liaison with local GPs will enable more effective preventative support and more timely community intervention. This will allow for a more seamless service to customers and a reduction in the inappropriate demands made on acute hospital services.

5. Priorities for Joint Development

5.1 Central Bedfordshire Council have a number of key areas for development over the next few years and some of these depend on close collaboration with Health and offer real and immediate opportunities. Of these, there are three that stand out.

Community Bed based services in the North of Central Bedfordshire

5.2 The Step Up / Down pilot operating in the South of Central Bedfordshire has shown that there are benefits to customers and potential for reducing inappropriate care home admissions. There is a need for a similar

service in the North of Central Bedfordshire. This service would support timely discharge from hospital and provide more intensive reablement in a safe environment.

5.3 The aim of this service would be to help older people recovering from a hospital stay improve their mobility and confidence. Over a maximum of six weeks people would be reabled sufficiently to allow them to return home and live independently. This service should be focused around the achievement of customer outcomes and be integrated with other supporting services within the hospital and community and aligned with local short stay medical unit services.

5.4 The success of the Short Stay Medical Unit in Houghton Regis should be mirrored in the North of Central Bedfordshire. The unit would focus on avoiding inappropriate hospital admissions and providing a locus for a multi-disciplinary team supporting the community.

5.5 Biggleswade Hospital provides an immediate opportunity to provide a home for both a short stay medical unit and a step up / down facility. The facility has 29 beds arranged in two units and could be remodelled to provide the necessary accommodation to support rehabilitation and reablement. Additionally the site could provide a locus for a recommissioned multi-disciplined team that would provide support to people within the facility and to those in the community needing such help at home.

5.6 The criteria for admission to Biggleswade Hospital will be amended to reflect the need to cater for people recovering from ill health, including those that are non-weight bearing. The new service will mirror that provided at both the Houghton Regis Short Stay Medical Unit and the Step up, Step Down Reablement service at Greenacre and customer outcomes will be monitored throughout 2013/14.

5.7 In 2013/14 we will scope out the remodelling of services to form MDT as described above.

<u>Urgent Care Pathway</u>

5.8 The Urgent Care Pathway will rely on an effective collaborative working arrangement as has already been done in relation to the Urgent Home Care and Falls Response pilot. A coordinated approach to the delivery of a number of the services shown in the pathway illustrated at paragraphs 4.24 and 4.27 would deliver a number of potential benefits to both customer experience and service effectiveness.

<u>Single Approach to Commissioning Care Home Services</u>

5.9 A single commissioning arrangement to provide for residential and nursing care home provisions to cover both Health and Social Care needs would allow greater clarity for providers and a clearer fee structure. This arrangement would need to provide for places currently funded through

Continuing Health Care (CHC) funds and should also enable Health to move away from block based provisioning.

5.10 To cater for commissioning of CHC provision it would be necessary to agree with Health the fee rate structure for customers covered by these arrangements.

5.11 The current CHC block provisions provide care for customers with challenging behavioural needs. Including this service within a single commission arrangement may stimulate interest in the market and result in a wider range of opportunities for these customers.

5.12 A single commissioning arrangement should allow for one joint team to administer the contracted framework, enable a single performance management framework and utilise a unified engagement route with providers.

5.13 Central Bedfordshire Council are about to put in place a framework arrangement with care home providers that will last for the next four years. The specification for these services is currently being reviewed and so there is an immediate opportunity for them to be shaped to accommodate a joint commissioning approach.