Appendix A

NHS
Bedfordshire
Clinical Commissioning Group

Central Bedfordshire Council Social Care Health and Housing OSC 29 July 2013

Biggleswade Hospital Update following Review of Community Bed Provision in Central Bedfordshire

Executive Summary.

The Review of Community Bed Provision in Central Bedfordshire indicates that 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.

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.

BCCG is in discussion with South Essex Partnership Trust (SEPT) regarding the implementation of the model and recommendations which are reflected in the 2013/14 contract.

1. Future Model for Central Bedfordshire

Evidence Base

1.1 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[1]. This review identified a number of key messages:

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

- 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.

1.1 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.

1.2 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.

1.3 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**

1.4 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.

1.5 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.

1.6 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. .

1.7 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

1.8 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.

1.9 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.

1.10 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

1.11 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

1.12 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

1.13 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.

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

Increasing availability of Step Up / Step Down Services

1.15 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.

1.16 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

1.17 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

1.18 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.

1.19 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

1.20 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

1.21 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.

1.22 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

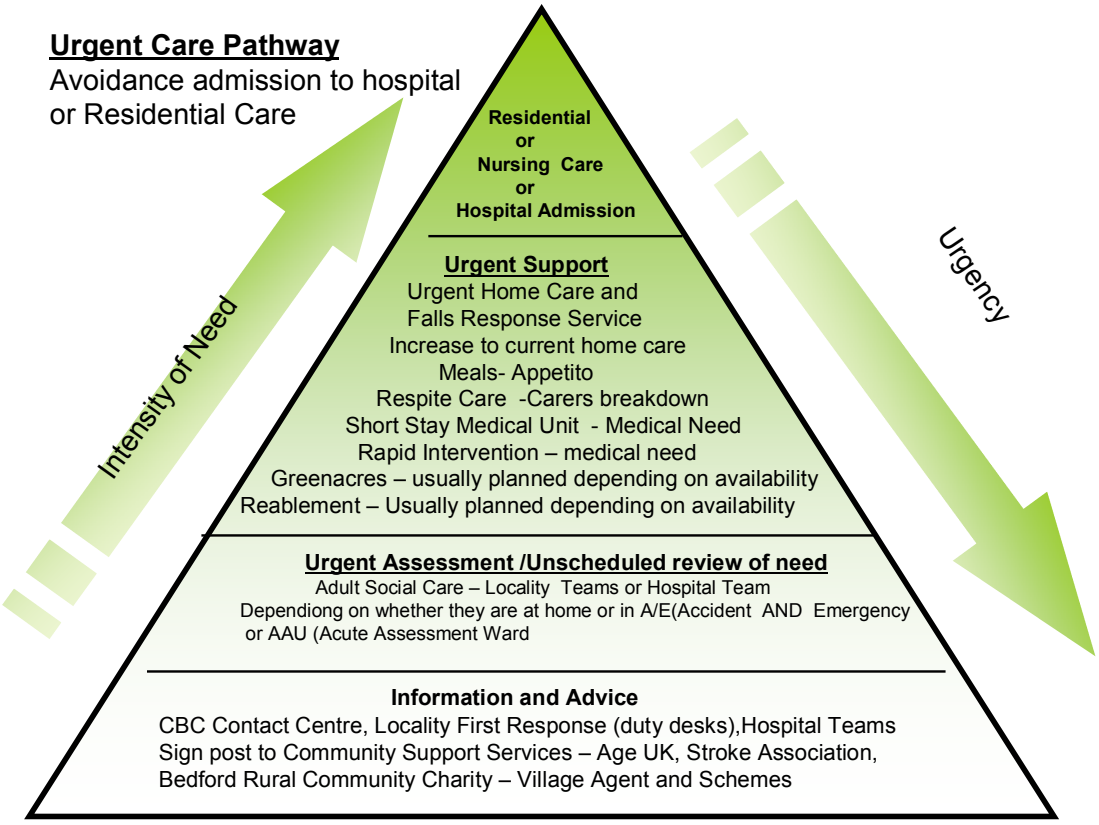
1.23 This is a 24 hour service that provides up to 72 hours of urgent social care (home care) and support, with some equipment, to older people following a fall. The referral for the falls component will only be from the East of England Ambulance Service Trust. The referral for the Urgent Home Care component 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.

1.24 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

1.25 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).

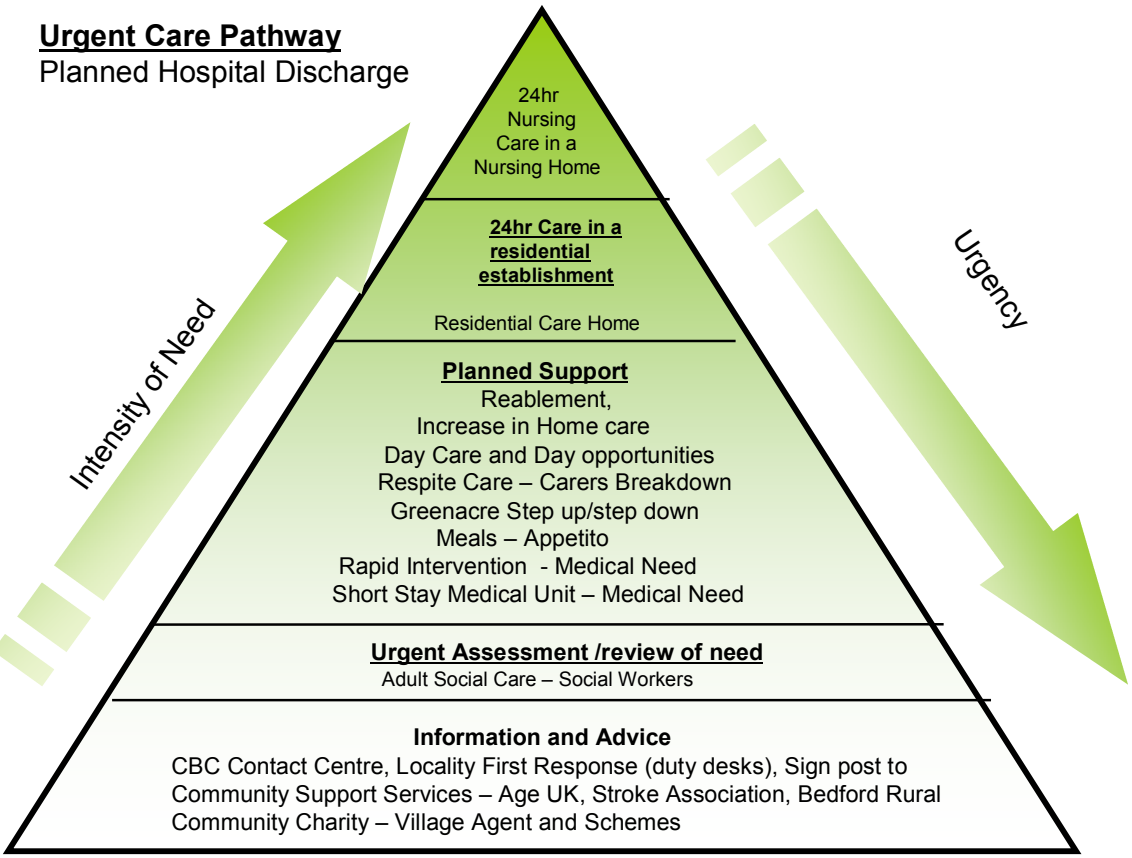


1.26 To enable people to remain in their own home or return to their own home from A&E or AAU with appropriate support, the following services can be provided:

- 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

1.27 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.

1.28 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.



1.29 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.

1.30 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.

1.31 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.

1.32 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.

2. Priorities for Joint Development

2.1 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

2.2 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.

2.3 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.

2.4 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.

2.5 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.

2.6 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.

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

3.0 Recommendations of the Joint Investigation between BCCG and September

On the completion of a Joint Investigation, the contract requires either that the:-

- Contract Query be closed; or,
- A Remedial Action Plan be agreed and implemented

The Joint Investigation considered the evidence presented and the recommendations are as follows:-

- The contract query be closed, and;
- The Parties undertake joint work, agreeing to:-

    - Maintain the status quo until such time as the future proposals regarding community inpatient services are considered and agreed
    - Communicate the issues leading to the current position to the wider health system detailing the actions that both Parties are undertaking in partnership to agree and present the case for the design of future community health services.
    - Agree the process for transforming services, including the process by which consultation will be undertaken and proposals taken through health overview and scrutiny and timescales for the same where required.
    - Review and agree the Admission Criteria 2009 & 2011 versions with clinical representation from the Commissioner and Provider and vary the revised criteria into the contract as a 2013 version.
    - Review and agree the Community Inpatient Specification with clinical representation from the Commissioner and Provider and vary the revised criteria into the contract as a 2013 version.
    - Build on the detail in the draft service development and improvement plan for 2013/14 so as to agree any changes to community services further to the bed review undertaken by Commissioners and to agree the steps required to effect change and agree timescales for agreed actions, alongside a consideration of the impact on other community services.
    - Agree terms of reference for the integrated performance review group, ensuring there is a standing item for escalation and actions logs from both the technical group and quality group are fed back.
    - Agree a process by which decisions relating to service redesign, which are not at the stage whereby they can be given effect by contract variation, be agreed and shared so that there is a clear understanding between the Parties.
    - SEPT will liaise with Chief Finance Officer for CCG to agree return of the £300k withheld, and agree any future mechanisms for sanctions or penalties within the terms of the contract