

# West Hampshire Community Bed Strategic Review

August 2015



# Scope of the Review

## Key Questions to be answered

What are our population / localities needs now? And future?

What do local people and key stakeholders want to be in place?

What provision do we currently have?

What is the utilisation of the current provision?

What are the health and social care needs of our patients / clients?

Are we making the most efficient use of local resources?



# What do our Patients and Stakeholders want to be in place?

| Key Messages                       | See Appendix 1   |
|------------------------------------|--|
| High Quality Care                  | <ul style="list-style-type: none"><li>• To be supported at home or as close to home as possible</li><li>• Cared for by an appropriate workforce with the right skills and competencies</li><li>• Support to regain independence and remain fit and well at home</li><li>• Single assessment</li><li>• 7 day working</li><li>• Partnership across all sectors (primary, community, acute and voluntary)</li><li>• Direct access to diagnostics and rapid assessment</li></ul> |
| Meets health and social care needs | <ul style="list-style-type: none"><li>• Integrated care</li><li>• Seamless pathways</li><li>• Family Support – voluntary sector</li><li>• Shared records / information / assessment</li></ul>  |
| Geography                          | <ul style="list-style-type: none"><li>• Locality working and beds</li><li>• Delivered by Integrated Care Teams</li></ul>   |
| Access                             | <ul style="list-style-type: none"><li>• Single access criteria</li><li>• Admitting rights</li></ul>  |
| Successful discharge               | <ul style="list-style-type: none"><li>• Smart discharge planning</li><li>• Packages of care to commence on day of discharge</li><li>• Follow up care post discharge</li></ul>  |

*Quality services, better health*



# Current Community Bed Provision

- ★ Community Hospital Rehabilitation Bed
- ▲ Reablement Beds
- Intermediate Care Beds

|                         |    |
|-------------------------|----|
| <b>Andover Locality</b> |    |
| Andover Hospital        | 24 |

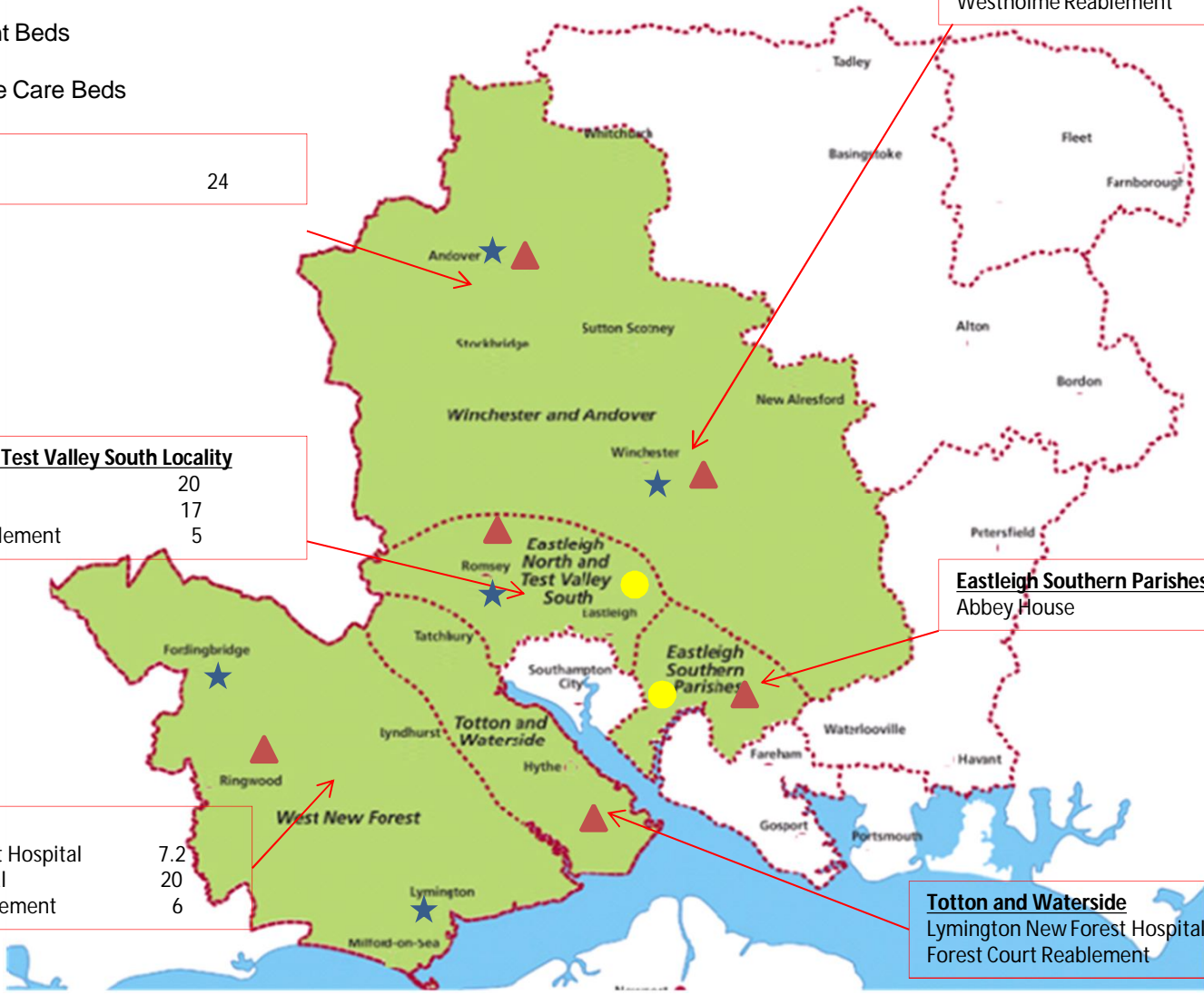
|                            |    |
|----------------------------|----|
| <b>Winchester Locality</b> |    |
| Winchester Hospital        | 26 |
| Westholme Reablement       | 10 |

|   |    |
|---|----|
| <b>Eastleigh North and Test Valley South Locality</b> |    |
| Romsey Hospital                                       | 20 |
| Brendon Care  | 17 |
| Fleming House Reablement                              | 5  |

|                                    |   |
|------------------------------------|---|
| <b>Eastleigh Southern Parishes</b> |   |
| Abbey House                        | 9 |

|                               |     |
|-------------------------------|-----|
| <b>New Forest Locality</b>    |     |
| Lymington New Forest Hospital | 7.2 |
| Fordingbridge Hospital        | 20  |
| Bickerley Green Reablement    | 6   |

|                               |     |
|-------------------------------|-----|
| <b>Totton and Waterside</b>   |     |
| Lymington New Forest Hospital | 4.8 |
| Forest Court Reablement       | 5   |

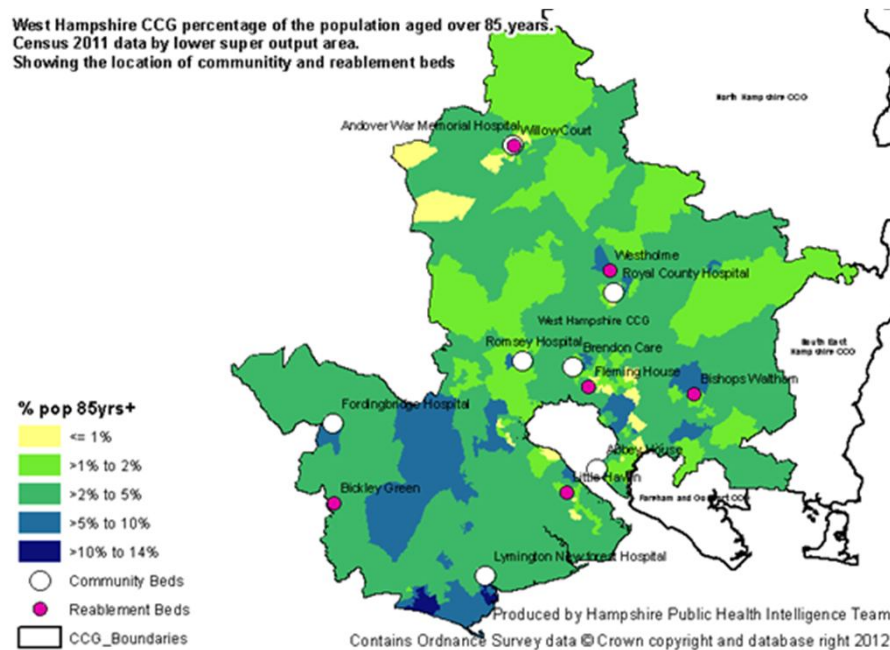


**Total West Hampshire Community Beds: 154**  
 Community Beds: 102  
 Intermediate Care Beds: 26  
 Reablement Beds: 26

# What are our population / localities needs now? And future?

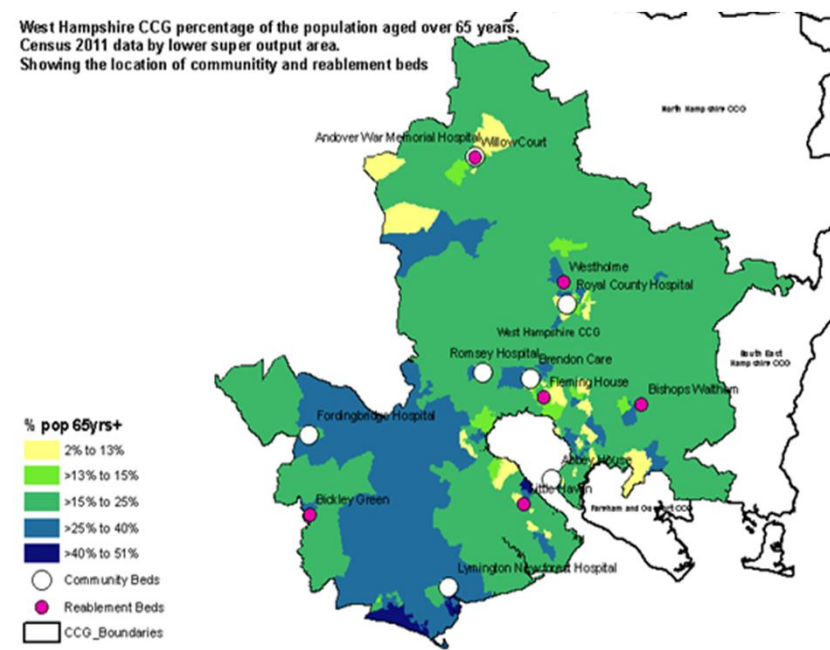
## Heat Map > 85 years

West Hampshire CCG percentage of the population aged over 85 years.  
 Census 2011 data by lower super output area.  
 Showing the location of community and reablement beds



## Heat Map > 65 years

West Hampshire CCG percentage of the population aged over 65 years.  
 Census 2011 data by lower super output area.  
 Showing the location of community and reablement beds



*Quality services, better health*



# Drivers for change

- Two Clinical Audits demonstrated that up to 40% of patients in current rehabilitation inpatient settings could be at home with support. This is reinforced by previous system and national audits
- Occupancy within community inpatient settings ranges from 42% - 100%
- People are remaining in acute and community hospitals longer than necessary
- Resources are currently not in the right place to support more people at home
- Many people are not admitted to a bed in their local area
- The complexity of the system (and three tiers of bed provision – community hospital, intermediate care and reablement) causes confusion. This is compounded by different access criteria
- Pathways are fragmented and complex
- Current capacity is not aligned to population need



# Patient Stories

"Thank you very much for the lovely care and food here, I could have gone straight home , I was waiting for a toilet seat, I think that there was a lack of communication"

**Patient discharged from Acute Trust to Community Hospital**

**Patient in Acute Hospital**

*"Patient admitted to Acute Ward with multiple complex medical needs, under care of Community Geriatrician, Locality Hospital Geriatrician and Community Care Team. Patient assessed in AMU by Locality Hospital Geriatrician as previously known admission avoided – fast access diagnostics that day and taken home with support from Integrated Community Care Team"*

*"patient had been admitted acutely unwell to an Acute Medical Ward from a residential placement setting – already in receipt of CHC funding. Patient stabilised medically, however as checklist for CHC been updated was waiting for reassessment prior to going back to original place of residence. Patient was a delay of over three weeks since being declared medically fit for discharge"*

**Patient discharged from Rehabilitation Ward to Reablement Bed**

*"Patients records stated moved to Reablement setting for assessment of ADL, mobility and function, patient had a primary diagnosis of lung cancer with secondary tumours brain"*

**Patient discharged from Community Hospital to Reablement**

# Bed Demand and Capacity Modelling

## Capacity 2014 -15

### Acute Setting

- SITREPS Delays 57 patients suitable for discharge to community services each week.
- Clinical Audit demonstrates 25% (14) require a community bed, 75% (43) home with support.

### Community Beds

- Current 154 beds
- Clinical Audit demonstrates 40% patients could be at home with support
- Therefore: of the 154 patients:
  - 93 (60%) needed community bed
  - 61 (40%) home with support
- 14 patients from Acute Trust need community bed
- Total required = 107 (14 +93)

### Key Messages

- Patients are delayed in Acute Trusts
- 61 (40%) patients in Community beds could be at home with support
- Based on modelling 57 patients in Acute Trust do not need to be there
- 107 (14 +93) community beds required
- Capacity of 104 (43 + 61) Enhanced Support packages of care needed across West Hampshire

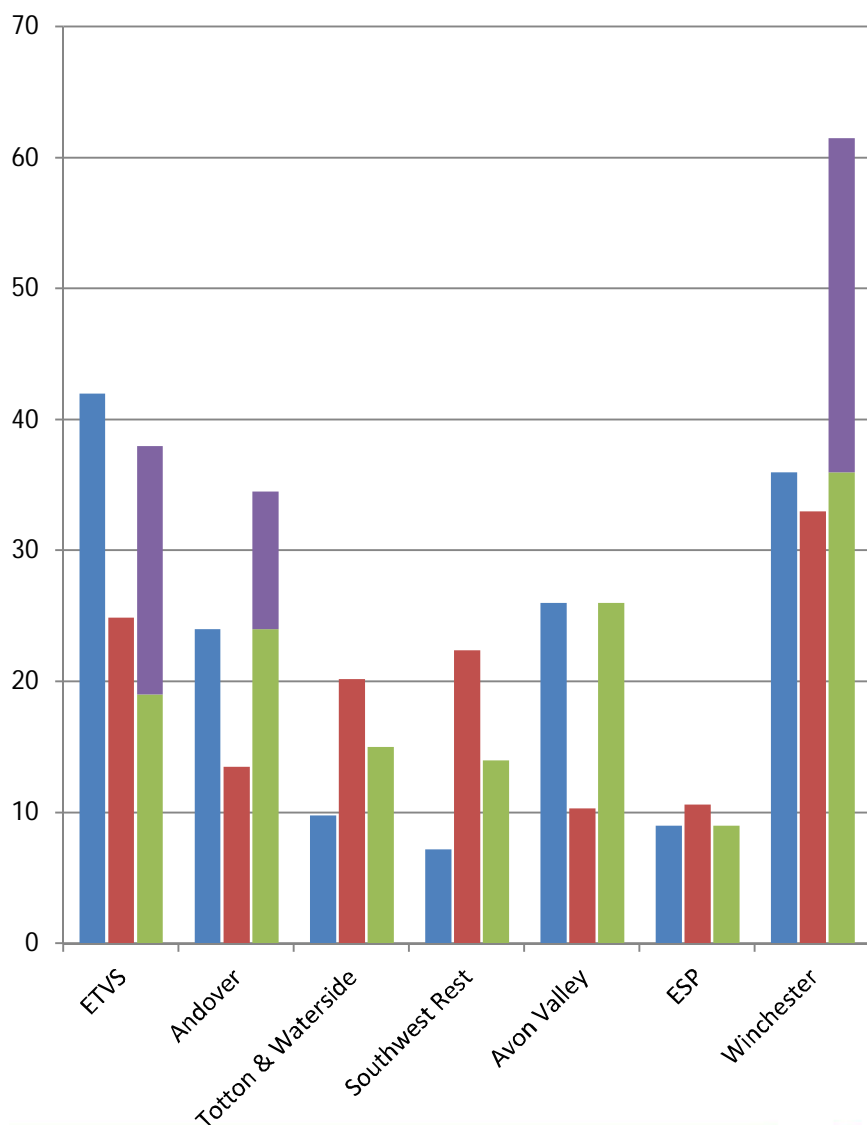
## Proposed New Model

- **132 Community Beds**
  - Core bed offer service specification
  - Universal admission criteria
- **Enhanced Recovery and Support @ Home**
  - Capacity for 957 patients per annum
  - 55 virtual beds
  - Initial focus on Mid-Hampshire

*Quality services, better health*



# What does this mean per locality?



- Increase in beds in areas of high demand – West New Forest, Totton and Waterside
- Decrease in beds in ENTVS and Avon Valley where high number of beds but lower demand
- Significant increase in ‘virtual’ beds in the community in ENTVS, Winchester and Andover
- **Overall increased capacity to support more people at home: Additional 1,372 patients within 132 community beds (average length of stay 20 days) and 55 “virtual beds” (average length of stay of 21 days) via ERS@H**

■ Proposal (Virtual)  
■ Proposal (Actual)  
■ Beds required from modelling based on PBRA  
■ Current community beds in system

# Proposed Model

## Principles:

- The right care will be provided at the right time and in the right place
- Care will be **personalised** and tailored to meet individual health and social need
- A **recovery culture**, with people supported to maximise their independence
- Care will be delivered **locally** either at home or as close to home as possible
- No patient will be admitted to a bed who could safely be supported at home. Care at home will always be the default for care delivery
- Patients will only remain in an acute hospital for the acute phase of their illness
- Care will be delivered by **integrated** health and social care teams that are co-located and work with a network of Practices, with access to specialist support

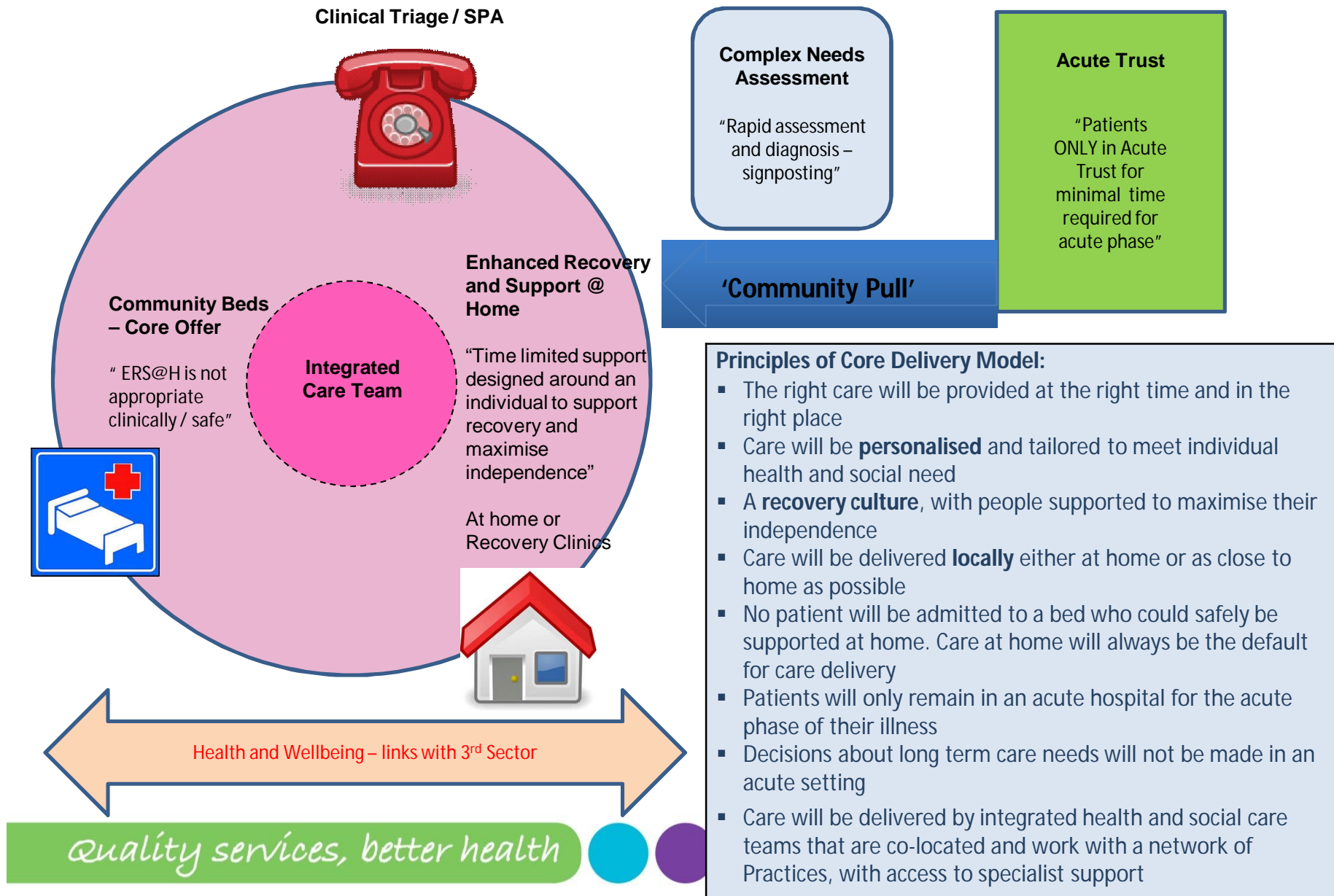
## Provided through:

- **Trusted assessment**
- **Integrated health and social care single point of access**
- **Enhanced access to rapid assessment and diagnostics**
- **Enhanced recovery and support at home** – building on Integrated Care Teams (and learning from the Joint Hospital Prevention Scheme) to provide rapid health and social care packages based on individual need to support people at home. (Including increased skills / competencies e.g IV)
- **Universal admission criteria** to community beds, whether care is provided in a community hospital or nursing home. **Core offer** includes patients with acute confusion expected to improve, non-weight bearing, discharge to assess, patients with reablement needs with underlying cognitive impairment
- Admission rights across all sectors for key professionals

*Quality services, better health*



# Supporting Recovery and Maximising Independence




# Proposed Model – Principles

- Maintain sustainable community hospital provision and ensure effective utilisation
- Ensure a critical mass of beds for safe, effective care
- A more flexible model which supports increased care either at home or as close to home as possible
- Create community hubs for step-up / step-down care which enable the co-location of multi-disciplinary health and social care teams
- Avoid the destabilisation of broader community services, for example, care homes where there is high demand and a wider market



# What changes are proposed?

| Locality           | PBRA Population | Current Beds | Population per bed | Proposed Beds | Population per bed | Difference Beds | ERS&H                               |
|--------------------|-----------------|--------------|--------------------|---------------|--------------------|-----------------|-------------------------------------|
| Avon Valley        | 41,501          | 26           | 1,596              | 15            | 2,767              | (11)            |                                     |
| SW New Forest      | 90,212          | 7            | 12,529             | 14            | 6,444              | 7               |                                     |
| Totton & Waterside | 81,222          | 10           | 8,288              | 15            | 5,415              | 5               |                                     |
| ESP                | 42,675          | 9            | 4,742              | 9             | 4,742              | 0               |                                     |
| ENTVS              | 100,119         | 42           | 2,384              | 19            | 5,269              | (23)            | Enhanced Recovery & Support at Home |
| Andover            | 54,494          | 24           | 2,271              | 24            | 2,271              | 0               |                                     |
| Winchester         | 132,736         | 36           | 3,687              | 36            | 3,687              | 0               |                                     |
|                    | 542,959         | 154          | 3,525.71           | 132           | 4,082              | (22)            |                                     |

 Enhanced Recovery and Support at Home to be established covering ENTVS, Winchester and Andover localities to facilitate early supported discharge.

*Quality services, better health*



# Impact on available capacity – new model

|   | Actual Provision<br>14/15  | Proposed New<br>Model  | Comments   | Variance<br>Bed Days     |
|---|--|------------------------|--|--------------------------|
| <b>Number of Beds Open</b>  | 151 Beds<br>(Reduced from 154 due to Fordingbridge and Romsey bed reduction) | 132                    | Reduction in 19 community beds   | <b>- 6,935</b>           |
|   | 55,115 Total bed days  | 48,180 Total bed days  |  |                          |
| <b>Average Occupancy</b>  | 81%<br>(Variance 42% - 100%)   | 85%                    | Minimum 85%  | <b>+ 8,134</b>           |
| <b>Average Length of stay</b>   | 26.5 days<br>(Variance 18 – 37 days)   | 19.6 days              | 80% 14 days LOS<br>20% 42 days LOS<br>Accommodates the D2A / non weight bearing patients |                          |
| <b>Enhanced Recovery and Support @ Home Capacity number of Patients</b> | 0  | 957 patient throughput | Average LOS on caseload 21 days  | <b>+ 20,097</b>          |
| <b>TOTAL</b>  |  |                        |  | <b>+ 21,296 Bed Days</b> |

# Monitoring and Evaluation

- Key Performance Metrics including occupancy levels, average length of stay, readmission rates and patient experience
- Contract management - monthly monitoring via Contract Review Meetings and Clinical Quality Review Meetings
- Monitoring of impact on system resilience
- Repeat clinical audit and baseline assessment - Dec 15 and April 16



# Proposed Timescales

| Month         | Action   |
|---------------|--|
| Jun-15        | <ul style="list-style-type: none"><li>○ Establish Enhanced Recovery &amp; Support at Home covering ENTVS</li></ul>               |
| Jun-Sept-15   | <ul style="list-style-type: none"><li>○ Consultation on proposed model</li><li>○ Presentation to HASC Sept-15</li></ul>          |
| Oct-15        | <ul style="list-style-type: none"><li>○ Expand Enhanced Recovery &amp; Support at Home to cover Winchester and Andover</li></ul> |
| Oct to Dec-15 | <ul style="list-style-type: none"><li>○ Implementation of proposed model and move to core bed offer</li></ul>                    |
| Apr-16        | <ul style="list-style-type: none"><li>○ Full model in place</li><li>○ Monitoring and evaluation</li></ul>                        |



# Stakeholder Engagement – Appendix 1

| Event  | When                     | Who involved  |
|--|--------------------------|---|
| Community Bed Review Workshop  | Oct 2013                 | Patients, League of Friends, Clinicians, HCC, GP's, Acute Trusts, All providers of current community beds |
| Stakeholder Meeting  | August 2014              | League of Friends representatives, HCC, Clinicians, SHFT  |
| Lymington – Building on Success<br>- Patient Focus Group, PPI Groups, Voluntary Groups, Clinical Reference Group | From June 2013 - ongoing | Stakeholders, patients, voluntary organisations, GP's, Clinicians   |
| Hythe Stakeholders Group   | From June 2013 – ongoing | Patients, representatives Parish and District Council, League of Friends, HCC                             |
| Romsey Development Group   | From June 2013 – ongoing | League of Friends, SHFT   |
| Support our Community Hospitals  | From June 2013 – ongoing | MP's, League of Friends   |
| Acute Trusts meeting with UHS / HHFT/ SHFT   | From June 2013 – ongoing | Acute Trust Consultants, clinicians, managers   |
| Winchester and Eastleigh Locality Workshop   | January 2014             | GP's  |
| Patient Involvement on Steering Group  | October 2013 - ongoing   | Patient representative  |
| Out of Hospital Strategy Engagement  |                          | Patients, Carers, Voluntary Sector, Clinicians, GP's  |
| Acute Services Review Engagement   | May 2015                 | Patients, Carers, Voluntary Sector, Clinicians, GP's, Acute Trusts  |
| Locality meetings  | Monthly                  | GP's  |