Derby and Derbyshire
Clinical Commissioning Group

Derbyshire County Adults Health Scrutiny & Improvement Committee 15 July 2019

Re-design of Clinical Pathways to support hospital discharge - Erewash

1. Purpose of the report

This report is designed to appraise Scrutiny Committee of changes to the community rehabilitation capacity in the Erewash area, subject to the outcome of a period of engagement.

We want to ensure that we have the right services in place to meet the needs of people discharged from acute hospital care who are not able to go straight home without additional rehabilitation or support. Ensuring care is delivered in the right settings and with the right care according to their needs supports people to have the best health outcomes, keeps them safe and independent and wherever possible, at home.

This paper gives an overview of the proposals, plus how and why we would like to engage with the Erewash community to explain the aims and implications of the proposed changes. We would like to utilise the engagement to explore the impacts from a public perspective (including patients and carers) so that we can better mitigate any issues that may arise.

The changes proposed include provision of beds in a local authority care home with additional care staff and health input to support rehabilitation, plus ensuring there is sufficient support for people able to go home with health and social care input. The types of people who would be able to benefit from this are currently being admitted to Ilkeston Hospital in the absence of suitable alternatives and so, with new services available, the number of beds required at the hospital would reduce.

We have shared our proposals with our partners across health and social care through our A&E Delivery Board and have received full support. It is recognised getting the capacity in the right place is a fundamental part of the system and needs to be coupled with effective operational delivery.

2. Background

The Derbyshire STP (Joined Up Care Derbyshire) has highlighted that the local system is overly reliant on bed based care. Whilst we know that good care in provided in the individual settings. Elderly patients sometimes spend too long in bed based care causing physical, psychological, cognitive and social deconditioning resulting in lost independence.

One of the STPs clear aspirations is to ensure that the '*right care is provided in the right setting by the right people'….that patients 'flow' effectively through their care pathway and are supported to stay at or near home wherever possible and return to safely living independently at home following a stay in hospital.*

This view is acknowledged and jointly agreed by all statutory and non-statutory social, health, voluntary and independent organisations across the whole system.

3. Case for Change

There is local and national evidence which demonstrates the benefits of patients being discharged to the right setting. At a national level, evidence gathered by the Kings Fund, and NHS England have looked into the best way to care for older people in the future and all evidence supports the notion that there are serious drawbacks associated with long stays in hospital. NHS Improvement cite studies that indicate that a stay in hospital over 10 days leads to 10 years of muscle ageing for some people who are most at risk. *https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf*

Work completed under the Better Care Closer to Home initiative in North Derbyshire has responded to this evidence and made changes that have been instrumental in enabling patients to be discharged into a pathway which matches their level of need. The work in Erewash looks to support enhanced discharge at the optimum time in a patients' pathway of care to have maximum impact on their ability to recover functionality after a hospital stay.

When a patient is assessed as no longer requiring acute hospital care their needs are reviewed for any ongoing support they may require. For 90% of people over 65 years they are able to go home without additional support. For the remainder of people, they are assessed as to which pathway of care may be most suitable for them. The box below gives the definitions of the three pathways referred to in the system as P1, P2 and P3. In the absence of care in the right setting the only option is for people to remain in acute hospital care or be transferred to the next highest care setting i.e. someone who could have gone home goes to a care home, or a patient who doesn't have 24 hour nursing goes to a community hospital ward.

Pathway 1 is care and rehabilitation provided **at home** by an integrated community team

Pathway 2 is managed by social care with medical oversight from an Advanced Care Practitioner with GP supervision, in **a less medicalised setting** where patients are able to demonstrate greater independence and mobility, with input from therapist and community nursing teams to meet any ongoing health needs

Pathway 3 is nurse-led where patients spend the majority of their time in a bed on a **medical ward** with some rehabilitation therapy input.

4. Local data

The Derbyshire system commissioned reviews of hospital discharge flow in the form of two analysis reports (Newton Europe Analysis 2017/18, Flow Reports - Sycamore Analysis 2018/19). Both reports have been used to help analyse the discharge pathways and help frame this approach. Data has been modelled and refreshed and will continue to be reviewed to ensure that the proposed capacity will be sufficient to meet needs

For those patients deemed as 'complex' i.e. not able to go straight home, an increasingly granular set of data is being collected to track their identified needs and the pathway they ultimately follow. This demonstrates that people are currently not ending up in the right place for their needs. As the table below shows, more patients are ending up in Community Hospital (P3) beds than those assessed as needing this pathway of care and less patients are going into Community Support Beds (P2) than those assessed as needing this pathway of care.

Activity during 14 week period Feb- May 2019 – Erewash patients:

Pathway	Patients assessed as needing pathway	Patients discharged on pathway	Difference
P1	59	57	-2
P2	40	14	-26
P3	50	78	+28

The following table shows more detail of where the 40 people assessed as needing community support bed care (P2) were discharged to.

Community support bed Erewash or Amber Valley (P2)*	10
Community support bed other (P2)	4
Ilkeston Community Hospital (P3)	11
London Road Community Hospital (P3)	3
Ripley Community Hospital (P3)	8
Other	5
Total	**40**

*Florence Shipley and Ladycross House currently not fully operating as P2 – see additional information below

Modelling has utilised acute discharge data (2017/18) for the all acute hospital discharges for Erewash patients. In addition the activity for patients from Heanor has also been included. Heanor is within Amber Valley but borders Erewash. Admissions for patients from that area have been made to Ilkeston Hospital since Heanor hospital closed 5 years ago and the bed numbers at Ilkeston were increased at that time. It is anticipated that patients from that area will continue to access Ilkeston beds.

Each month has been modelled separately applying a set of assumptions:

- For the hospital beds occupancy has been modelled on 18 day length of stay (LOS) this reflects current levels, which are reducing consistently year on year. Percentage occupancy has been based on a level of 85%. In 18/19 occupancy at Ilkeston

Hospital was slightly above that on average and with some periods of pressure when it was much higher. So this level of modelling gives flexibility.

- For community support beds occupancy has been modelled on 14 day LOS and an 85% occupancy rate. Lengths of stay have been consistently reducing and the LOS aim is within current performance levels. 85% represents an realistic aspirational aim.
- A level of additional activity has been factored in for admissions directly from the community, as facilities can be used to 'step up' care and prevent an acute admission
- An aspiration has been set, based on practice elsewhere for the percentage of complex patients on each pathway (60%-P1, 30%-P2 and 10%-P3). This has been used to determine required capacity but then also tested using different assumptions to ensure resilience and also additional has been capacity built in, as the system is not yet functioning at those levels.

These assumptions lead to an average requirement and the proposed capacity as per the table below.

Type	**Modelled Requirement**	**Capacity 2018**	**Current capacity**	**Proposed capacity**
P1 (home)	29-40 new patients per month	Average 27 'slots' per month	27	37
P2 (support bed)	10 beds	3*	3 **	11
P3 (hospital bed)	12 beds (monthly requirement varied across year 9-19 beds, only one exceptional month at upper end)	32	24	16 - 18

* Beds available at Florence Shipley in Amber Valley

**There have been 4 additional beds at Ladycross in Erewash with additional social care support but not the full community support bed model which is proposed

It should be noted that since the closure of Heanor Hospital 8 community support beds have been opened in Heanor (Derbyshire County Council facility - Florence Shipley) which gives P2 capacity on the border of Erewash and Amber Valley. Due to the location this is utilised by Erewash and Amber Valley residents.

5. Proposal

a. Community Support Beds

Utilising the modelling above and taking into account the fact that there would continue to be access to Florence Shipley beds for Erewash patients (assumed at an average of 3) it is proposed to commission eight community support beds within Erewash.

Community support beds have 3 elements which distinguish them from standard care home beds. They have:

- Enhanced social staffing ratios with a focus on re-ablement
- Therapy input to support physical rehabilitation
- Additional clinical cover in the form of Advanced Clinical Practitioners supported by a General Practice with whom the patient is temporarily registered.

When considering future commissioning options to put the right capacity in the right places to meet patient need, the CCG is keen to work in partnership with the local authority to develop integrated and flexible services and make the best use of public estate. Options have been explored working closely with Derbyshire County Council and the option proposed is Ladycross House Care Home. As noted above some beds are already being staffed to the correct levels from a social care perspective and provided a level of capacity over the winter period, but have not been able to take the full cohort of suitable patients yet. Through a period of engagement on our proposals we will seek view from the public regarding this proposed facility.

Derbyshire County Council is also finalising proposals for a purpose built facility in the Ilkeston area to replace some of the existing adult social care bed provision. The CCG will continue to consider the best location for the P2 beds in the future. Suitability will also be informed by the engagement process to be undertaken.

A reduction in the community hospital beds (as set out in section b below), would release the Advanced Clinical Practitioner capacity to be able to support the community support beds. Discussions are progressing with the GP practices that currently support the hospital beds to consider transferring their responsibilities to cover the community support beds and maintain the effective clinical team working established on the wards. Contingency provision is being explored should this not be possible.

b. Community Hospital Beds

It is proposed that a full ward of 16 beds be commissioned with the flexibility to expand to 18 beds during times of pressure. The hospital is currently operating with 24 beds. Previously there were 32 beds; however 8 were temporarily closed by the Community Provider Derbyshire Community Health Services NHS Foundation Trust (DCHS) in December 2018 due to operational staffing difficulties at that time. A small number of beds were commissioned from Ladycross House to coincide with the ward reduction but they have not been functioning at full capacity as the clinical model has not been in place (as above).

c. Integrated Community Team

To be able to increase the number of patients supported at home (pathway 1) and to provide therapy support to the other pathways, our proposals include commissioning an appropriate number of therapy staff to ensure the health rehabilitation needs can be met.

In addition to the changes in the numbers of beds and home support as described above we wish to support an approach whereby nursing and therapy teams are able to respond to needs and can flex during the busiest times by reprioritising the routine and urgent workloads of the teams. In addition if they work across services that can support the transition of patients who may move from hospital into the community and vice versa.

There is significant planning and service improvement between health and social care, across the city and county which is focussed on making the best use of all facilities and

ensuring patients can move quickly and easily between settings and services and aren't delayed. This work includes activities such as early planning for discharge to identify and plan for ongoing needs, flexing capacity and more intensively tracking data to predict demand. These actions will support reducing lengths of stay and enable even more patients to be cared for within the same resources. We believe that the changes proposed in this paper support the ongoing delivery of this work.

6. Proposed Engagement

DDCCG recognises the importance of ensuring public, staff, patients and the wider Ilkeston community are informed about and involved in the development of health services in their area. The CCG started a period of engagement on 26 June 2019 to run for 60 days. The engagement approach will consist of the following elements:

- Engagement launch and publication of the engagement documents via the DDCCG website
- Sharing of the engagement documents with key stakeholders (see target audiences), using a range of distribution methods e.g. briefings, email, post, survey, telephone and face to face
- Launch of the digital/media campaign including social media, events, press release
- Publish intranet articles and homepage carousel
- Develop an enquiries log
- Holding engagement events including drop in sessions and public sessions
- Communicating with all staff about the engagement methods
- Distribution of materials to key venues
- Analysis of the feedback

The aim of the engagement is to explore the impact of implementing changes in the provision of community rehabilitation in the Erewash area and to understand fully any unintended consequences of implementing the proposed changes. The final decision will be taken after the engagement feedback has been fully considered by the Governing Body in September 2019.

Target audiences

A full stakeholder list has been created and will inform a detailed communications and engagement plan. Key stakeholders in this project will include:

- Ilkeston residents and patients (and surrounding areas)
- Ilkeston GP community and pharmacists
- Ilkeston Patient Participation Group Chairs
- Key local stakeholders: Councillors, MPs, Healthwatch and Derbyshire County Council
- DCHS staff and tenants
- Ilkeston Hospital League Of Friends
- Derbyshire County Council Adult Services Staff
- Local Community Groups in Ilkeston (Council for Voluntary Services and other voluntary groups)
- Erewash Borough Council

7. Next Steps

The CCG Governing Body agree to the following actions being taken at its meeting in June 2019:

a) Public launch of engagement in June 2019 and running for 60 days
b) Develop plans to operationalise the changes
c) Identifying and mitigating risks
d) Engagement feedback analysed and presented to GB in September 2019 along with any operational issues identified and mitigation plans
e) Final decision in light of engagement outcome and implementation plan
f) If no issues identified that cannot be mitigated – mobilise delivery plan September onwards.