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Clinical Commissioning Group

Community based care: providing care where people need it

Presented by Dr Neil Walden to Penwith Integrated Care Forum

27 May 2021

Shaping services we can all be proud of

Edward Hain Community Hospital engagement and service review:

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One recommendation was that:

- CCG commission the system modelling cell to undertake a review of the overall bedded capacity requirements in each integrated care area. This would take into account the 'non-COVID' position and the development of the model of care in each area. The modelling will describe the capacity needed to deliver the right levels of community based care, clearly linking its development to the then revised need for bedded capacity for the provision of rehabilitation and reablement. This will take into account the additional 28 care home reablement beds at the new care home in Penzance due to be operational by mid-January 2021.

Response

- We have evidence already that we have an over reliance on hospital beds and many people remain in hospital beds which is not achieving the best outcome for them. If hospital beds are used appropriately there is no system evidence that we require more hospital beds.

- 'Bedded care' includes the care we provide to people in their own beds, in care homes, in extra care housing, in hospices etc. The following slides focus on hospital beds.

- The system modelling cell does not have the capacity or capability to undertake additional system bed modelling due to the complexity of the ongoing COVID modelling.

- The system response to COVID continues to be a priority and our use of bedded and non-bedded care continues to fluctuate through necessity and in response to COVID-driven needs. This has accelerated and improved joint working in community based care.

- It should be noted: there is no national algorithm to establish how many beds, per head of population, are needed in a community setting. The complexity and nuances to consider the requirements for capacity are extensive and ever changing – COVID is an excellent example – the system came together to support more people to stay safe at home and hospital bed usage decreased.

- The 28 new care homes beds in Penzance are not all operational currently. They will provide additional discharge to assess capacity initially and then plan to focus on specialist dementia provision-as informed by the joint care home market position statement.

- Each integrated care area has enhancing out of hospital care as a local priority-in line with all national strategy. There is no evidence to suggest that we need an increase in hospital beds.

Key supporting evidence 1a: Embrace diagnostic – March 2020

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Current bed use does not reflect future bed need. The Embrace Care Diagnostic key findings, derived after 131 practitioners reviewed the 'next steps' for people in 943 acute and community beds, from 265 individual cases, were that:

- 41% of admissions for people over 65 years reviewed were documented as a less than ideal outcome for that individual.
- 43% of the cases reviewed were not felt to be ideal, whether that was an admission, a discharge decision or community provision.
- Only 56% of people were in residential or nursing placements, where that was the ideal outcome for them.
- When we discharge from the acute hospital into another short term setting (care home or community hospital), that is only the ideal outcome for half of the people.
- **22% of our acute beds and 67% of our community beds are occupied by people who would be better suited elsewhere. If we used our hospital beds for those people who required them we would have sufficient capacity.**

Key supporting evidence 1b: Embrace- Providing the right service, at the right time based on needs

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- Assumption: 22% of acute beds and 67% of community beds are occupied by people with no medical need to be there – and not achieving the best outcome for them. How many beds would be released with the appropriate services in place and people were in the right care setting to achieve their best outcomes?

	Average number of general and acute occupied hospital beds per day April-June-19 (pre-COVID)	Embrace assumption-% beds occupied and not achieving best outcome for person	**Scenario 1:** Embrace diagnostic assumption applied and assumed 'spare' bed capacity if 100% of people in right care setting	**Scenario 2:** Embrace diagnostic assumption applied and assumed 'spare' bed capacity if 75% of people in right care setting	**Scenario 3:** Embrace diagnostic assumption applied and assumed 'spare' bed capacity if 50% of people in right care setting	**Scenario 4:** Embrace diagnostic assumption applied and assumed 'spare' bed capacity if 25% of people in right care setting
RCHT-Treliske/WCH	624	22%	137	103	69	34
CFT-community hospitals	109	67%	73	55	37	18
Total	733		210 beds	158 beds	105 beds	53 beds

Summary assumptions: Even if we were only able to place 25% of the individuals who were in a hospital bed (which was not the ideal setting for them) to an appropriate care setting, this would 'release' 53 beds across the system. 50% in the ideal care setting would release 105 beds.

Key supporting evidence 2a: Changes due to COVID pandemic

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Local response to the COVID pandemic has accelerated the integration of health and care together with the delivery of enhanced community based services:

- Community and care home virtual wards-active recruitment of advanced nurse practitioners
- Community assessment and treatment units
- Community coordination centres
- Increase in digital and remote appointments
- Local teams working together should address the need for local provision where a bed is still needed.

Bed use also decreased during COVID-reduction of 283 beds in 1st COVID 'spike' (238 acute beds, 45 community beds), and latterly (Oct-Dec 2020) an improved position, but still a reduction of 118 beds (77 acute beds and 41 community beds).

	General and acute beds (excl maternity)			
	Q1 19/20 (Pre COVID) bed occupancy	Q1 20/21 1st COVID Spike	% Bed reduction	Equivalent occupied reduction of beds
RCHT	89.4%	54.5%	34.9%	238
CFT	93.1%	74.0%	19.1%	45

	Improved position post COVID spike 1: Occupied beds (Q3 20/21)	reduction in Beds post COVID spike 1
RCHT	547	77
CFT	68	41
	615	118

Key supporting evidence 3a: Policy and strategic direction

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- National and local strategy:
  - Boost out of hospital care-reduce reliance on hospital beds.
  - Invest in primary and community services.
  - Provide joined up care at the right time in the best place for the person's needs.
  - Provide more digital care where appropriate.
  - Provision of temporary bedded care for rehab and reablement-but outside of hospital.

Key supporting evidence 3b: Policy and strategic direction: 2021/22 priorities

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- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Continuing to meet the needs of patients with Covid-19
- Maximise elective activity, taking full advantage of the opportunities to transform the delivery of service
- Restore full operation of all cancer services
- Expand and improve mental health services
- Expand and improve services for people with a learning disability and/or autism
- Deliver improvements in maternity care
- Restoring and increasing access to primary care services
- Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities
- Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments
- **Transforming community services and improve discharge**
- Working collaboratively across systems to deliver on these priorities

Key supporting evidence 3c: Policy and strategic direction: Transforming community services and improve discharge

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- Deliver an improvement in average length of stay with a particular focus on stays of more than 14 and 21 days.
- Establish a programme to deliver Discharge to Assess – key aims are:
  - The person's normal place of residence as the default pathway for assessment.
  - 95% of people 18 or over who are clinically optimised go home within 24 hours.
  - To initiate improved independence with increased access to reablement support.
- Implement a discharge to assess model that meets the expectations of the Hospital Discharge Policy (for over 65's):
  - Pathway 0 - 50% of people – simple discharge, no formal input from health or social care needed once home.
  - Pathway 1 - 45% of people – support to recover at home; able to return home with support from health and/or social care.
  - Pathway 2 - 4% of people – rehabilitation or short-term care in a 24-hour bed-based setting.
  - Pathway 3 - 1% of people – require ongoing 24-hour nursing care, often in a bedded setting.

- Ageing Well urgent community response programme
  - Delivering a 2 hour response between 8am – 8pm.

Conclusions

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- We have evidence that we have an over reliance on hospital beds and many people remain in hospital beds which is not achieving the best outcome for them. If hospital beds are used appropriately there is no system evidence that we require more hospital beds.
- ‘Bedded care’ includes the care we provide to people in their own beds, in care homes, in extra care housing, in hospices etc.
- National and local strategy continues to require the focus on out of hospital care.
- Local communities have expressed the wish to see improvements in out of hospital care - people only want to be in a hospital bed for as long as they need to, but if they have to local communities wish to see them placed as near to home as possible.
- West integrated care area and Penwith model of care development continues to develop local services, and the Penwith Integrated Care Forum remains an important engagement point for local planning, discussion and decision making.