Leicester
City Council

MEETING OF THE HEALTH SCRUTINY COMMITTEE

DATE: TUESDAY, 29 MARCH 2011
TIME: 6:00 pm
PLACE: OAK ROOM, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Committee

Councillor Bayford (Chair)
Councillor Manjula Sood (Vice-Chair)

Councillors Clayton, Cleaver, Gill and Newcombe
(One Labour Vacancy)

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

Elaine Baker

for Director of Corporate Governance

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PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business on the agenda, and/or indicate that Section 106 of the Local Government Finance Act 1992 applies to them.

3. MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 9 February 2011 have been circulated and Members are asked to confirm them as a correct record.

4. PETITIONS

The Director of Corporate Governance to report on the receipt of any petitions submitted in accordance with the Council's procedures.

5. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Director of Corporate Governance to report on the receipt of any questions, representations and statements of case submitted in accordance with the Council's procedures.

6. PLANS TO INCREASE INTERMEDIATE CARE BED CAPACITY WITHIN LEICESTER CITY **Appendix A**

The Director of Communications at NHS Leicester City presents a report on NHS Leicester City's tendering process to increase community based beds in the City.

7. CARE OF ELDERLY PATIENTS BY THE NHS **Appendix B**

Further to recent media coverage of the care received by elderly patients in local hospitals, the Committee is invited to consider:-

a) the issues raised; and

b) the complaints procedure used by local hospitals and how this is monitored.

Representatives of University Hospitals Leicester and NHS Leicester City have been invited to attend the meeting to assist the Committee in the scrutiny of these matters and to provide performance information on the care that elderly

patients receive in hospital.

8. PRIMARY CARE TRUSTS STRATEGIC OPERATING PLAN **Appendix C**

The Director of Finance with NHS Leicestershire County and Rutland will make a presentation on the Primary Care Trust Strategic Operating Plan, setting out its investment and disinvestment priorities for the year ahead, its approach to dealing with the financial challenges facing the local NHS and managing the transition to future arrangements as set out in the Health Bill.

9. IMPROVING HEALTH IN LEICESTER - THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH AND IMPROVEMENT 2010 **Appendix D**

The Annual Report of the Director of Public Health and Health Improvement 2010, “Improving Health in Leicester”, is presented to the Committee for scrutiny. The Committee is recommended to consider the report and comment as appropriate.

10. HEALTH SCRUTINY COMMITTEE WORK PROGRAMME 201/11 **Appendix E**

The Members’ Support Officer submits a document that outlines the Health Scrutiny Committee Work Programme for the municipal year 2010/11. The Committee is asked to consider the programme and make comments and/or amendments as it considers necessary.

11. ANY OTHER URGENT BUSINESS

Appendix A

NHS LEICESTER CITY

MEETING: **TRUST BOARD MEETING** **PAPER H**

DATE: **10 MARCH 2011**

REPORT TITLE: **Plans to Increase Intermediate Care Bed Capacity within Leicester City**

SECTION: **Public**

REPORT BY: **Ms Jo Yeaman, Programme Director**

PRESENTER: **Ms Jo Yeaman, Programme Director**

EXECUTIVE SUMMARY

At present 27 community-based intermediate care beds are commissioned within Leicester City, and an additional 18-26 beds are spot purchased from County community hospitals to cater for the needs of local residents registered with a City GP.

A number of capacity modelling and benchmarking exercises have been undertaken over the past 4 years, all of which demonstrate that Leicester City is significantly under-resourced in terms of intermediate care beds.

The most recent modelling exercise led by KPMG, followed by significant engagement with clinicians and other health and social care professionals, suggested that a figure of 57 would be the target number of beds required. This would enable the repatriation of beds from the county as well as a small increase in beds available to meet unmet demand; however, it is significantly less than the total number of beds required (c. 80) to meet demand in full assuming that existing services remain the same. It therefore reflects the need to expand and develop other areas of intermediate care including those led by health and social care, for example hospital at home, rapid intervention teams, and reablement services. This piece of work is being progressed alongside this programme in partnership with the local authority. It also sits together with the development of an improved pathway for Frail Older People.

The impact of not having sufficient beds within the City is significant. Particular areas of concern include poorer patient outcomes, higher lengths of stay in hospital and community beds, increased readmission rates, poor access to social care and GPs (when treated out of City), poor experience for patients and their relatives, and poorer and minority ethnic groups being disproportionately disadvantaged. Owing to

existing inefficiencies and difficulties in integrated working there is an opportunity to realise cost efficiencies across both health and social care.

It is expected that the new arrangements should be provided as far as possible within the current financial envelope, achieving a relative cost saving per bed commissioned. Any additional expenditure required is expected to be covered by the savings made in facilitating early supported discharge from UHL and this will need to be reflected in the contract. Full costings will be available following completion of the options appraisal, which will include estates options.

It is noted that any decommissioning of beds from county community hospitals will have an impact on this particular service provider and on future commissioning arrangements, particularly when considered together with the recent decommissioning of 7 stroke rehabilitation beds which have been relocated within the City.

The target date to have the new service up and running is November 2011 in time for winter pressures. However it should be noted that this is on the critical path and that a number of high risk factors could render this target unachievable.

RECOMMENDATION

The Board is requested to:

CONFIRM the intention to increase the City-bed base by up to a further 30 beds, incorporating the repatriation for beds currently commissioned within the County.

NOTE the decision not to proceed with the proposal to develop facilities at Leicester General Hospital at this time.

APPROVE the proposal to undertake a full options appraisal with a view to undertaking a procurement process.

APPROVE the proposed governance process.

NOTE the potential impact on County-based Community Hospitals.

NHS LEICESTER CITY AND NHS LEICESTERSHIRE COUNTY AND RUTLAND

BOARD MEETING
10 MARCH 2011

Progress report to NHS Leicester City Board on Plans to Increase Intermediate Care Bed Capacity within Leicester City

Introduction

1. This paper outlines developments in relation to the proposed increase of Intermediate Care Beds within Leicester City. This includes the repatriation of beds commissioned for City patients within County hospitals.

2. As interpretations of intermediate care, rehabilitation and reablement vary between agencies and between different professional and clinical groups, some helpful definitions are provided within Appendix A. It should be noted that these form part of a draft document for discussion with clinicians and social care professionals across Leicester, Leicestershire and Rutland with a view to formally agreeing local definitions.

Background

3. Intermediate Care beds are currently commissioned for City patients as follows:

Rehabilitation Services (Clarendon Mews)	16	beds
Acute admission avoidance (Brookside Court)	11	beds
County community hospital – rehabilitation and step down	18	beds spot purchased, rising to 26 beds at peak times
TOTAL	45	beds (rising to 53 beds at peak times)

4. Over the past four years a number of modelling exercises have been undertaken to establish the ideal number of intermediate care beds for Leicester City. These include:

   - Local study between Leicester City's Community Health Services and Social Services (leading to the proposal of a Health & Social Care facility at Butterwick) 2007
   - PCT-led exercise with consultancy support (Sinead Brophy) 2007-2008
   - UHL bed modelling exercise led by UHL (Helen Seth) 2007-8
   - KPMG 2009
   - Building on the work of KPMG an extensive engagement exercise with clinicians and other professionals across health and social care led by Vikki Taylor, Director of Strategy, 2009/10

   All exercises concluded that increased community bed capacity was essential to meet demand within the City.

5. The most recent exercise undertaken by KPMG in 2009 and the subsequent engagement exercise identified a figure of 57 beds as being the ideal target to meet health needs. This would enable the repatriation of beds from the County and realise a small increase in beds available within the City to help address current unmet need and to respond to an increasing, ageing population. However it was somewhat less than the maximum figure identified by KPMG. This was to allow flexibility to address the possibility of increasing alternative intermediate and community-based care services such as reablement (social care-led) and at-home services including the Rapid Intervention Team and specialist nursing services.

6. The Board of NHS Leicester City approved the proposal to increase the City bed base in January 2010. An options appraisal was to be undertaken with the responsibility to approve and monitor plans delegated to the Commissioning Executive.

Reasons why more capacity is needed

7. There are many reasons why intermediate care beds should be repatriated and increased within the City. These include patient health and wellbeing, clinical, socio-economic, ethical, equality and efficiency factors. Appendix B provides detail on each other these. In summary these are:

    - Deterioration and loss of independence of frail older patients cared for inappropriately within an acute setting
    - Better patient outcomes and speedier recovery with reduced acute readmissions
    - Patient access to, and support from family and friends with ongoing links to the community
    - Significant unmet need as evidenced by KPMG and data from the bed bureau and SPA which shows that current capacity is inadequate leading to avoidable hospital admissions and increased length of stay within the acute setting
    - Reducing Length of Stay in community-beds
    - Ensuring access to key services provided by Social Care and reducing delays
    - Providing the opportunity to integrate services with Social Care within the City
    - Enabling GPs to offer continuous support to patients which is proven to reduce hospital admissions
    - Equality and Ethnicity considerations with existing discrimination of minority, and poorer social groups
    - Improving access by under-represented sections of the population such as ethnic minorities and those with poor mental health
    - Population growth with a predicted increase of 44% over the next 20 years in the predominant user group – older people.
    - Benchmarking which suggests that there is a higher population per bed than elsewhere
    - Co-terminosity with Local Authorities and emerging GP Consortia arrangements
    - Reducing Leicester City's carbon footprint
    - The opportunity for more flexibility and efficiency through Economies of Scale

- The opportunity to make relative cost savings
- Increasing bed capacity within the City has been earmarked by NHS Leicester City Board as a key priority
- Further Research and Evidence, including the 'Forget me Not' study and the NSF for Older People

Progress to date

8. In response to the Board's decision in January 2010 to increase intermediate care beds within the City and a further report to the Board in July 2010, significant work was undertaken to explore the possibility of developing former acute wards based on the Leicester General Hospital site. This would have provided 48 beds across two wards and would lead to the decommissioning of existing facilities within the City together with the beds spot-purchased within County community hospitals. Capital funding in the region of £3million was set aside for this purpose.

9. Although the proposal appeared at first to be feasible, progress was halted in January 2011 for the following reasons:
   - The work needed to develop the site and ongoing maintenance proved to be unaffordable, with costs significantly higher than current services commissioned
   - Evidence from elsewhere showed that despite strict criteria there was a temptation to use beds based on an acute site as an extension of the acute bed-base
   - Lack of universal clinical support from across primary and secondary care as well as lack of support from the local authority
   - The 4-bedded bay accommodation arrangements would be limiting in terms of optimising rehabilitation outcomes
   - The identification of other possible opportunities which were more likely to provide more appropriate accommodation at a lower cost
   - A change in economic circumstances which means that private and public-sector suppliers may be more interested in opportunities compared to this time last year
   - The need to undertake a full options appraisal
   - The need to consult fully with clinicians, partners and with patients and the public

10. The capital set aside for intermediate care developments has had to be returned to the Strategic Health Authority within 2010/11 in accordance with accounting protocols. A smaller amount has been set aside for 2011/12 and this is subject to approval. For commercially-sensitive reasons this figure is not stated within this paper.

11. A Programme Director, Jo Yeaman, has recently been identified to oversee the Intermediate Care developments. These link directly to other priorities also within the remit of the Programme Director, including developing a new pathway for Frail Older People and developing an integrated model of care for intermediate care and reablement within the City.

12. A full service specification has been drafted with support from leading clinicians, managers and geriatricians.

Next Steps

13. The service specification will be used to develop estates options.

14. The full service specification will be shared more widely with clinicians, social care and other professionals, and once finalised and agreed will be used to form the basis for an options appraisal and tending process. The expected completion date for this is the end of March 2011.

15. The target date to deliver the solution is November 2011 in order to increase capacity in time for the 2011/12 winter pressures. However, it should be noted that timescales to achieve this are very tight and whilst every effort will be made to achieve this target, the requirements of the procurement and contracting process together with the need for preferred suppliers to prepare for delivering the service may result in this not being possible.

Other considerations

16. It is important to note that any rehabilitation or step up/step down beds should operate as part of a wider health and social care solution to providing intermediate care to ensure effectiveness and efficiency, as indicated within the Kings Fund report: Avoiding Hospital Admissions (December 2010). It is fully intended that any increase in intermediate care bed capacity within the City would be part of a wider programme to develop integrated intermediate care and reablement services across health and social care. A multi-agency strategy group led by a City GP to address this has been formed and the first meeting took place on 22nd February 2011.

17. Alongside this particular piece of work are a number of sister programmes, all of which inter-relate. These include developing a pathway for Frail Older People; the allocation of reablement funding to new and existing services across Leicester, Leicestershire and Rutland to reduce hospital readmissions; improvements to the unscheduled care pathway; improving transfers of care; and the development of integrated health and social care arrangements for intermediate care and reablement within the City and across the County.

18. The landscape of intermediate care will therefore change in response to developments from these other programmes. All these programmes are co-ordinated with reporting through to the multi-agency Senior Operations Group and thence to the Emergency Care Network.

Governance Arrangements

19. It is proposed that the development of plans and recommendations is led by the new Integrated Intermediate Care and Reablement Strategy Group. The Terms of Reference for this multi-agency Group can be found within Appendix C. Recommendations from this group will then be subject to discussion and

agreement by the Commissioning Executive/new GP consortium arrangements, with progress being reported and monitored through the Senior Operations Group. Plans will also be shared with the City's Joint Executive Group which includes representation from other agencies including the Leicestershire Constabulary. It is proposed that key developments are fed through to the Board as they occur or on a quarterly basis, whichever happens sooner. The vehicle for this would be either through the Chief Executive's monthly update or through a separate briefing paper as appropriate.

Potential Impact on Community and Acute Hospitals

20. Although not at one single site, it should be noted that the repatriation of the 18 beds spot purchased within the County Community Hospitals will have a significant impact on the provider of these County services. This impact is even more significant when consideration is given to the 7 beds recently decommissioned to enable stroke rehabilitation services to take place within the City. The total impact of 35 beds being decommissioned will need to be considered by the providers of these services, including whether or not to reduce or permanently close these beds, which when added together amount to more than a ward.

21. In accordance with statutory obligations such a decision is likely to require a 90-day formal consultation with local clinicians and patients and the public, a factor which will need to be built both into the project plans for this programme, and into those of the existing provider of community hospital services within the County.

22. Depending on whether existing suppliers within the City choose to tender, and whether their proposals are successful, it should be noted that a decision to change location or supplier could result in the decommissioning of existing intermediate care beds within the City. Again this would require some local engagement and/or consultation. However because these beds would be re-located elsewhere, it is likely that consultation requirements might not be as formal as those outlined within 21 (above). Such requirements would largely depend on the nature of the changes and the potential impact on service users and staff.

23. The repatriation of beds into the City is intended to be cost neutral on a recurrent basis. However, the possible increase in beds may require additional funding which will need to be assessed as part of the options appraisal process. As the new community beds are intended to support early discharge from the acute hospital to facilitate shorter overall length of stay and better patient outcomes, it is anticipated that these costs will need to be sourced from the savings made in this area. This potential impact on University Hospitals of Leicester should therefore be noted.

24. Changes to bed-bases as indicated within this paper are being factored into the wider work being led by Vikki Taylor, Programme Director for Transforming Community Services, to determine the future bed provision across the NHS in Leicester, Leicestershire and Rutland.

25. Any requirements to engage and consult, together with any challenge which may arise from these activities, will have a significant impact on the ability to deliver the solution within Leicester City by November 2011. The responsibility to consult on the relocation of beds from existing providers to any new location, if applicable, would rest with NHS Leicester City as a legal entity. NHS Leicestershire County and Rutland would not need to undertake consultation for this particular element, but would have an obligation to consult on any subsequent proposals to reconfigure county community hospitals as a result.

Recommendation

The Board is requested to:

CONFIRM the intention to increase the City-bed base by up to a further 30 beds, incorporating the repatriation for beds currently commissioned within the County.

NOTE the decision not to proceed with the proposal to develop facilities at Leicester General Hospital at this time.

APPROVE the proposal to undertake a full options appraisal with a view to undertaking a procurement process.

APPROVE the proposed governance process.

NOTE the potential impact on County-based Community Hospitals.

Please note that these definitions are draft and subject to discussion and agreement with clinicians and health and social care professionals across LLR.

DRAFT Definitions and Inter-relationships between Intermediate Care and other Community-based services

As interpretation of terms is significantly different between organisations, and between professional and clinical groups, this paper seeks to identify a common definition of the following:

- Intermediate Care
- Rehabilitation
- Reablement
- Step Up
- Step Down

These draft definitions will be reviewed by various agencies and professional and clinical groups. They will then be revised and agreed as the formal definitions to be adopted by health and social care across Leicester, Leicestershire and Rutland.

The diagram at the foot of this section describes how these components are inter-linked.

Intermediate Care

Based on the definition provided by Kings Fund and NHS Wales

A short-term intervention to promote and preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays, or inappropriate admission to hospital or residential care. The care is person centred, focused on rehabilitation and delivered by a combination of professional groups with either a therapeutic or specialist medical lead where required.

Step Up

Health-led inpatient beds specifically for the purpose of avoiding acute hospital admissions where it is appropriate to do so. For example, this might include chest infections or exacerbation of long term conditions such as COPD where care or medical support is not appropriate within the existing care setting or at home. Although requiring medical support, the person is medically stable and therefore acute admission is not necessary.

Step Down

Health-led inpatient beds specifically for the purpose of supporting a patient's discharge from an acute hospital where an acute environment is no longer appropriate, but where the patient is not yet fit enough to return home or to their original care setting. This might include intensive rehabilitation after a fall, and will include assessments to ensure the person can be fully discharged home safely and without significant risk of readmission. The person will be medically stable but may require medical input with immediate access to clinical support.

Rehabilitation

The process of restoration of skills by a person who has had an illness or injury so as to regain maximum self-sufficiency and function in a normal or as near normal manner as possible. These services would usually be led by health with possible input from social care. It involves the input from professional, qualified staff including nurses and therapists to undertake health assessments, medicine reviews and to help develop coping and self-management strategies to cope with long-term illnesses or conditions.

Inpatient rehabilitation is appropriate for patients who require intensive therapy, support and education in a relatively short period of time (3-6 weeks) and with regular input from clinically-trained staff, e.g. immediate access to nursing. This could therefore not be undertaken in a home environment.

Reablement

Based on The Department of Health's definition developed through councils' work on home-care reablement, and the Department of Health's department for ***Care Services Efficiency Delivery*** *(CSED)*

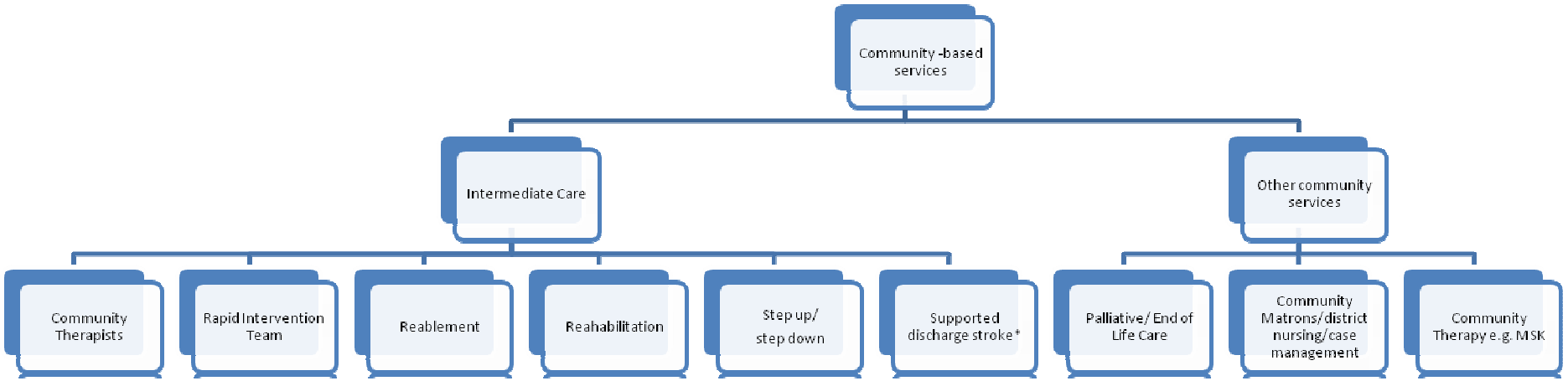
Reablement is an active period typically of up to 6 weeks of intense activity and support designed to promote people's independence. These services are aimed at people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. This is a preventative measure that can reduce people's need for both acute hospital care and can help people to continue living at home for longer. This can include recovery following the acute hospital episode, rehabilitation and homecare re-ablement in the sense of getting the person back to the position, or improving upon, the position that they were in before the acute hospital phase. It could involve physiotherapy, an intervention by a dietician or whatever the person needs following acute care. As those eligible for reablement are medically stable, reablement is commonly led by Social Care with input from health where required. However, more recently joint commissioning arrangements are being explored.

Scope of Intermediate Care and inter-relationships

The following chart outlines the services sitting under the umbrella of intermediate care and their relationship with other

Scope of Intermediate Care and inter-relationships

The following chart outlines the services sitting under the umbrella of intermediate care and their relationship with other community-based services.



**Please note that there is a separate pathway for stroke, therefore these beds are not considered in the proposed new intermediate care bed base considered within this paper*

Supporting evidence and rationale to increasing intermediate care bed capacity within Leicester City

Reasons why it's important to repatriate beds from the County to the City

1. **Poorer patient outcomes and increased avoidable costs:** A frail older person who does not need to be in an acute environment will deteriorate if they remain in an acute environment. This is because they become more dependent on 24/7 nursing care, are not benefiting from more intensive rehabilitation, and/or lose the confidence or inclination to care for themselves. They also have a heightened risk of acquiring infection. This leads not only to poorer patient outcomes but also to increased length of stay, a higher likelihood of hospital readmission, and more long-term health or social care packages becoming necessary. Care (namely comprehensive geriatric assessment) in a locality based community hospital is associated with greater independence for older people than care in wards for elderly people in a district general hospital.

   Sources:

   British Geriatrics Society 2008

   Green J, Young J, Forster A, Mallinder K, Bogle S, Lowson K, et al. Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial. BMJ 2005:bmj.38498.387569.8F.

2. **GP access and continuity of care:** City GPs would have easier access to patients should they choose to oversee their stays in community beds. It should be noted that at present medical cover is provided to the two units through two separate contracts. This also represents a cost-saving opportunity. The *Kings Fund Report: Reducing Hospital Admissions*, December 2010, shows that increasing the continuity of patient care by GPs in the community can have a significant effect on admissions and re-admissions.

3. **Access to Social Care:** It is far more difficult for social care to access City patients being treated within County hospitals . Currently patients treated within the county may be losing out on important support from social services. There are also cost implications for social care in accessing patients outside of the City. Such difficulties in accessing social care have been known to cause delays to transfers of care. Plans to develop integrated health and social care services within intermediate care and reablement will be far more effective if City patients were to be treated within the City.

4. **Lower length of stay:** Although Community Hospitals tend to take the more medically –dependent patients overall, for conditions that would be amenable to rehabilitation services within the city, e.g. falls and orthopaedics, the length of stay appears somewhat higher within the county than in the City. This could be due to a combination of factors including the patient's own social circumstances.

   Sources: KPMG 2009 and research conducted by Ron Hsu, DMU 2010/11

5. **Equality and ethnicity:** the population within the City is significantly different from that of the County in terms of culture, diversity and ethnicity. Although specific research is yet to be done, there is a significant opinion that health improvements are more expedient when in an environment that is appropriate to an individual's social group. This applies not only to health and social aspects but also to basic functions such as food and nutrition.

6. **Family and Social:** Being treated within the county often creates significant difficulties for patient's families and carers. Those accessing services are typically within the lower-income brackets. Transport is often a challenge with public services limited in some locations and a journey often requiring several changes. For many patients, particularly those living within the City, access to family and ongoing links with their community are key factors in their

   recuperation, both socially and culturally. This arrangement therefore gives rise to inequalities in accessing services, discriminating against the poorer population with a greater impact also on minority groups.

7. **Care closer to home/patient choice:** When asked as part of the LLR Next Stage Review engagement process the majority of residents stated that access to local care was important to them. This view is also underpinned by the work led by Lord Darzi as part of the Next Stage Review programme.

8. **Co-terminosity:** City-based services would be co-terminus not only with the local authority but also with the new GP consortium.

9. **Carbon footprint:** Reducing unnecessary travel to the County by patients, relatives and carers, clinicians, social workers and other staff would contribute towards our 'green' environmental obligations.

Reasons why it's important to increase the intermediate care bed base for City patients

10. **Lower numbers of hospital admission avoidance beds for population:** 26.5% of those presenting at ED in Leicester are admitted to hospital versus an England average of 19%. Feedback from GPs and the Single Point of Access Team within the City demonstrates that capacity within hospital admission avoidance beds is insufficient leading to inappropriate acute hospital referrals/attendances and admissions.

11. **Insufficient beds to meet current demand for hospital avoidance and rehabilitation:** Occupancy rates for the rehabilitation facility within the City (Clarendon Mews) have averaged 90% over the year and more recently have increased to 100%. At peak times up to 8 additional beds have been spot purchased in county hospitals over and above the budgeted 18. Bed bureau statistics show that significant demand is required over and above the patients treated in both City and County facilities and that this need often goes unmet. This impacts on delayed transfers of care, length of acute hospital stay and hospital readmission rates, as well as patient outcomes and experience.

    UHL Bed bureau figures show an average delay of between 6 and 9 days for City patients accessing IC beds in City and County from UHL, compared to 3 days for County patients accessing County beds. The explanation for this is insufficient availability of beds for City patients.

    In December a new Frail Older Person's Advice and Liaison Service (FOPALS) and the Elderly Frailty Unit were introduced at UHL. Early indications show that these services are effective in preventing unnecessary hospital admissions as well as ensuring that care and treatment takes place in the most appropriate setting. These services can refer directly into community-based care and their success and effectiveness depends on having the appropriate community-based services available.

12. **Population growth:** Over the next 20 years the number of older people will increase within Leicester City by 44%. Of these around 53% are likely to be frail. KPMG modelling shows that based on predicted population growth and service configurations as they are, the bed base would need to be increased by around 4 beds per year to cope with rising demand.

13. **Opportunities to address further unmet need within the community and ensure right care in the most appropriate environment:** There will be opportunities to address needs currently being catered for by UHL, but which are clinically proven not to require an acute environment. These include ambulatory care sensitive conditions such as cellulitis, lower respiratory tract infections without COPD, congestive cardiac failure, COPD, UTI and dehydration. It is estimated that 30-40% of patients with these conditions could more appropriately be catered for in a community setting. When assessed in 2009 this equated to 5,145 acute admissions and 24,992 acute bed days, with these patients having a disproportionately long length of stay when compared to other patient groups. KPMG estimate that the number of admissions could be reduced by 1,800 and beds days could be reduced by 8,747 leading to the potential to free up 36 acute beds.

    Source: KPMG 2009

14. **Benchmarking:** Benchmarking in this area is limited and caution needs to be exercised because of the variations in local configurations of intermediate care services. However South East Essex PCT examined six other health and social care systems which showed an average of 3,720 heads of population per intermediate care bed. This compares to a population of 8,964 per rehabilitation bed, and 6,773 per bed when rehabilitation and hospital avoidance beds are combined, to meet the needs of those living within Leicester City.

    Source: South East Essex PCT Commissioning Case for Developing Intermediate Care, January 2010.

    Population basis: 304,800 taken from the 2009 mid-year population estimates from the Office for National Statistics.

Other considerations

15. **Flexibility, Efficiencies and Economies of Scale:** Having step up/step down and rehabilitation facilities within the same unit will give rise to significantly more

opportunity to be flexible with staffing and accommodation arrangements. This means we would avoid the current situation of earmarking beds in different locations for a specific purpose which sometimes leads to empty beds despite demand for similar services, e.g. rehabilitation vs. hospital admission avoidance. A larger, flexible and more responsive unit would also give rise to cost efficiencies through increased economies of scale.

16. **Access by under-represented sections of the population:** There would be more scope for under-represented sections of the population including BME and those with mental health problems to access appropriate care within the City which will have the potential to reduce inappropriate access to urgent or emergency services.

17. **Integration with Social Care:** A more integrated approach with social care is essential in improving patient outcomes and reducing costs for all agencies. Increasing intermediate care beds in the City increases accessibility and the opportunity to do this.

18. **Board priorities:** The Board of NHS Leicester City has continued to prioritise the repatriation and increase of City-based intermediate care beds over the past two years. Featuring as a key component of the World Class Commissioning Strategy, this was confirmed in a report to the Board in January 2010 and re-iterated at the more recent Board meeting in January 2011.

19. **Capacity modelling:** Significant funding has been expended on various capacity modelling and research programmes, most recently with KPMG in 2009. Previous exercises have also been undertaken by UHL and by the PCT/Community Health Services. All studies demonstrate that bed capacity is currently insufficient and needs to be increased. KPMG estimated a requirement for between 21 and 50* additional beds within the City. Following significant consultation with clinicians, social care and others the figure of 57 beds in total was identified and agreed. This figure is also echoed by an earlier, independent capacity modelling exercise undertaken by UHL.

    **It should be noted that this increase in beds also assumed a capacity increase in Rapid Intervention Services of between 22% and 51%.*

20. **Cost:** Comparisons of existing cost demonstrate that there are opportunities to provide a more cost effective service with City bed days costing between £170 and £228 per bed against a County average of £246 per bed day.

21. **Other Research and Evidence:** Findings and recommendations detailed within the 'Forget me Not' study (Audit Commission 2002) and the NSF for Older People (Department of Health 2001); all detail the importance of community-based services provided close to home in promoting independence, and avoiding hospital admission and re-admission.

Integrated Intermediate Care and Reablement Strategy Group

DRAFT Terms of Reference (for discussion and agreement at the first meeting. Seen by Executive Teams)

GP Chair
Lead Adult Social Care
LLR Programme Director (health commissioning)
Leicester City Community Health Services
Adult Social Care (provider)
UHL
LPT
Public Health/Analytics
UHL Clinical Lead
Capacity Planning
Patient/Public representative
Therapies and Discharge
Care homes lead
Quality lead
Finance lead
Engagement lead

Objectives

- Develop an integrated health and social care strategy for intermediate care and reablement, building on existing work and modelling undertaken e.g. KPMG, and as part of the wider work on social care improvements
- Oversee the commissioning of the strategy, holding to account those responsible for delivery
- Develop an appropriate performance management framework – during and post-implementation
- Develop and agree the financial model, including allocation of funds from additional resources identified within the operational framework, new monies and existing budgets across health and social care; also ensure that funds are not used simply to 'plug' existing financial gaps within the health and social care system
- Support UHL, LPT and commissioners in developing plans for assuming the responsibility of the 30-day reablement period post-acute discharge
- Ensure the appropriate engagement and consultation with key stakeholders, in particular GPs and other clinicians, patients and members of the public
- Ensure links with other sister programmes including (but not limited to) the Dementia and Frail Older People's Pathway, QIPP and Adult Social Care Transformation

- Ensure appropriate actions to respond to potential risks and issues, including the management of a risk register

Success Criteria

- Improve the overall quality of care and clinical outcomes for patients/service users
- Improvements to the quality of hospital discharge
- Reduce the number of admissions by at least 10% (in number) in 2011/12, by focusing on those categories of patients that represent the greatest number and/or the costliest readmission type
- Reduce the cost of readmissions in 2011/12 with benefits outweighing costs by up to 50%
- Contribute towards the reduction in bed capacity and infrastructure cost in LLR in line with reductions in admissions and readmissions, by the provision of enhanced and integrated community services, spanning health and social care as part of a wider programme of work to support frail older people.

Key milestones and timescales (indicative)

Development of Strategy for integrated intermediate care and reablement services, which has universal support from all stakeholders. This is dependent on completion of process mapping as part of the Frail Older Person's Pathway Programme which is to be completed by 31st March 2011	30th April 2011
Agreement by stakeholders on allocation of DH reablement monies for 2010/11	31st March 2011
Delivery of early wins	Est. June to September 2011
Full implementation of plans completed	Est. January 2012

Resources

- Full-time project manager (implementation) to operate across health and social care

- Consultancy support to co-ordinate with partners and to draft the strategy (12 days over 6 weeks) – REIP (Angela Saganowska)
- Administrative support – to be sourced from existing arrangements

Key Relationships

- Boards/cabinets of each health and local authority partner
- GP Consortia
- LINks/Healthwatch

Supporting Officers/Other Support

Project Manager, PCTs

Head of Prevention and Early Intervention Commissioning

Public Health Analyst

PCT Informatics

Care Services Efficiency Department (CSED): Tom McDonald and David McKnee

Regional Improvement Efficiency Programme (RIEP): Margaret McGlade

Governance

- The Strategy group will report into both the Senior Operational Group (part of the Emergency Care Network) and the Transitional Health & Well-Being Board
- Regular reporting as appropriate to respective organisation's Executive Teams/Boards/cabinets and the Joint SMT as well as GP Consortia/existing Commissioning Executive

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Appendix B

Leicester Mercury

CARE FOR THE ELDERLY

CAMPAIGN

Article published in the "Leicester Mercury" 21 February 2011

By gemma peplow

The Leicester Mercury today launches a campaign to ensure all elderly people get the care and respect they deserve from the NHS.

It comes after a national investigation into the care of elderly hospital patients in England found evidence of an "indefensible casual indifference" to their dignity and welfare.

While the vast majority of NHS staff work incredibly hard and do a fantastic job under enormous pressure, there are real questionmarks over the quality of care some patients receive.

We want to find out how widespread the problem is in Leicestershire, and are calling on readers aged 65 and over – or their families – to tell us if they have experienced an unacceptable level of care while in hospital.

To make sure we get the full picture, we would also like to hear from those who have had exceptional care.

The Mercury has reported on several cases in recent months involving problems with elderly people's care while in hospital.

Today, we feature a distressing account of the care an elderly woman received, as told by her daughter, Rosalind Adam.

In it, she says she was "sickened" by the treatment her 88-year-old mother received during a recent stay at Leicester General Hospital.

But campaigners say most people who are unhappy with the care they or a loved one receive in hospital never make a complaint.

Our campaign, called Care for the Elderly, comes after a report last week by health service ombudsman Ann Abraham talked about a deplorable level of NHS care for elderly people nationally.

Leicester West MP and shadow health minister Liz Kendall is backing our campaign.

She said: "Like many MPs, I read the health ombudsman report and was appalled by the cases of the poor treatment of old people in the NHS.

"I know the vast majority of people receive excellent care, but I back the Mercury campaign because we want to hear of cases where elderly people have not been treated with the dignity and respect that they deserve.

"I know old people often do not want to complain or feel like they are making a fuss, but every single old person deserves the very best quality of care. That is why I am backing the Mercury campaign."

In her report, Ms Abraham said a series of failures had been revealed in 10 often "harrowing" complaints she investigated relating to the care of older patients.

While none of the 10 incidents investigated happened in Leicestershire, we know, from the stories we have printed, that it does sometimes happen here.

We will compile the stories you send in to us into a dossier, which we will present to the Department of Health and local NHS officials.

We will be pressing for changes and improvements to ensure every elderly patient – not just the majority – receives the exemplary level of care from the NHS that they deserve.

Sir Peter Soulsby, Leicester South MP, said: "I fully support the Mercury's campaign and what Rosalind is doing to raise awareness of this issue.

"Although much of the NHS is brilliant and the staff wonderful, it's clear from this case and from the recent report of the ombudsman that there is far too often neglect and low standards in the care for the elderly.

"This is something that all members of hospital trusts need to deal with.

"They need to be asking tough questions of their chief executives about how they are looking after the elderly people in their care."

Leicester East MP Keith Vaz said: "Complaints from residents highlight a concerning gap in care for the elderly. Ensuring good quality healthcare for the elderly in our communities is essential.

"I fully support this campaign and will be working with the Leicester Mercury to get this message across to hospitals in Leicester and the Department of Health."

Leicestershire Age Concern chief executive Tony Donovan said he believes improvements have been made in Leicester's hospitals over the past two to three years, but he urged any patients or relatives who had experienced problems to make their voices heard.

Mr Donovan said: "In the last few years, our view is that we are not getting the level of complaints and concerns that we used to.

"However, there will be occasions when the level of support and care people get isn't good enough.

"Our advice is that we would urge anyone in that position to lodge a complaint through the proper channels.

"In doing so, they are hopefully protecting other older people.

"When you go into hospital or long-term care it is intimidating enough as it is, and you just want assurance that you are going to be treated with dignity and respect.

"There are organisations that can help people take a complaint forward, including Age Concern."

Patient watchdog Leicester City local involvement network is also backing our campaign.

Chairman Darren Hines said: "In light of what was said nationally last week, I think this campaign is a very good idea. This is an ongoing situation that needs resolving."

Brian Adams, 72, of Broughton Astley, fought for two years to find out why his 92-year-old mother, Joan, was allowed to suffer unnecessary pain and distress in hospital.

He took his complaints about the University Hospitals of Leicester NHS Trust to the ombudsman.

He said: "There must be loads of people in the county who have had similar problems, but a lot throw in the towel because they don't think it's worth it."

To share your story, call the Mercury newsdesk on 0116 222 4241, write to Leicester Mercury Elderly Health Campaign, Newsdesk, Leicester Mercury, St George Street, Leicester LE1 9FQ, or e-mail:

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Appendix C

NHS
Leicestershire County and Rutland

The NHS Operating Framework for England 2011/12

Sue Bishop
Director of Finance
NHS Leicestershire County and Rutland

Leading Leicestershire and Rutland to become the healthiest place in the UK

Content

Main themes

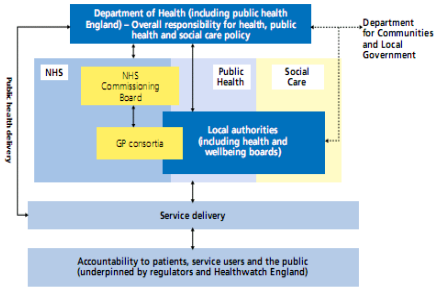
- Transition and reform
- Transparency and local accountability
- Service quality

These themes are supported by:

- Finance and business rules
- Accountability

Transition and Reform

Fig 1: The *Equity and Excellence* system



Transition and Reform

- Formation of PCT clusters by June 2011 with single Executive Team
- Authorised consortia to take on full statutory responsibilities by April 2013
- Development of health and wellbeing boards by April 2012
- Progression of NHS foundation trust status – All to become foundation trusts by the end of 2013/14
- Transforming community services – By 1 April 2011 all PCT directly provided community services must have been separated from PCT commissioning

Transparency and local accountability

- New Outcomes Framework – focus on the health improvement
- Better Patient experience – collection and action
- Better information – new information strategy Quality accounts – will cover CHS.
- Local publication – greater clarity of how expenditure translates into local achievements.
- Extended choice for patients

Key new commitments for 2011/12

- Increase in health visitors
- Family nurse practitioners
- Cancer drugs fund
- Military and veterans health
- Autism
- Dementia strategy
- Support for carers

Maintaining quality improvements

- Referral to treatment times
- A&E services
- Ambulance services
- Healthcare associated infections (HCAI)
- Eliminating mixed sex accommodation
- End of life care
- Cancer reform
- Cancer screening
- Stroke
- Mental health
- Increasing access to psychological therapies (IAPT)
- Safeguarding children
- Dentistry

Areas for improvement

- Healthcare for people with learning disabilities
- Children and young people's physical and mental health
- Diabetes
- Sharing non-confidential information to tackle violence
- Violence against women and girls
- Regional trauma networks
- Respiratory disease

PCT Allocations 2011/12

PCT allocations 11/12

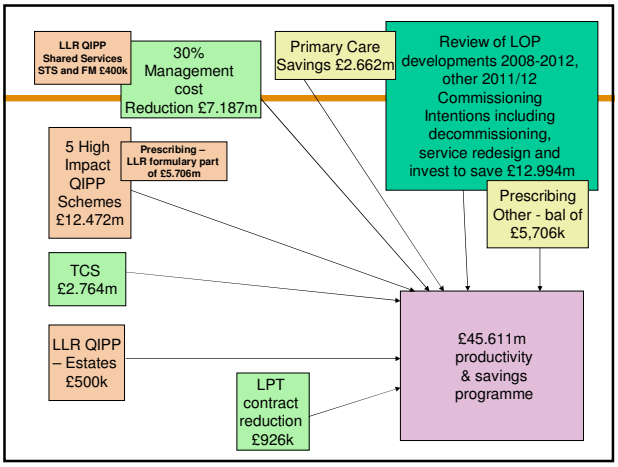
	NHSLC £'000	NHSLCR £'000	Total £'000
Total 11/12 revenue allocation	548,060	932,080	1,480,141
Funding specifically allocated to support joint working	-4,250	-6,793	-11,043
	543,810	**925,287**	**1,469,098**
Anticipated Allocation as per October Plan	530,496	905,028	
	13,314	**20,259**	

Health and Social Care Funding

- In 2011/12 there is additional non-recurrent funding allocated to PCTs to support joint working between health and social care.
- PCTs will transfer this funding to Local Authorities to supplement investment in social care services to benefit health and improve overall health gain
- PCTs will need to work together with Local Authorities' to jointly agree on appropriate areas for social care investment and the outcomes expected from this investment.

Planning Assumptions

	%	
Resources Available	100	
DEDUCT		
Resources to be held by DH – national requirement	2	This funding is available for service transformation, double running and restructuring costs.
To provide for local transformation	1	Fund set aside to support local delivery of significant CIP's (paid non-recurrently)
To provide for in year contingency	1	Provide for in year pressures.
Generate surplus	1	Requirement. Provide for future years.
BALANCE AVAILABLE TO COMMISSION SERVICES	**95**	



Strategic and Operational Plan process

- Integrated plan – Local Operating Plan and QIPP Plan
- **20 January** – 1st Draft to include - Workforce, contract assurance, finance, activity as well as assurance that operating plan commitments are being addressed
- **17 March** -Final submission to SHA
- New performance framework and outcomes framework being developed for Board scrutiny
- Prioritisation process underway to identify:
  - Investments/redesign to meet performance framework, outcomes framework priorities and statutory requirements
  - QIPP Plan to release £13m – by reviewing existing LOP schemes (2008 -2011) and identifying disinvestments via the commissioning intentions process

Challenges/Risks

- Approval by GP Consortia critical and ratification by Trustboard as difficult decisions will need to be made.
- Large scale review of current expenditure to make a £13m saving as part of the Productivity and Savings Plan
- Deliver more with less staff – 'work smarter' in a time of transition
- Long-term strategic priorities need to align with new operating plan requirements
- Deliver more with reduced funds – growing demand for services is not affordable if patterns of care remain the same
- Prioritisation process designed to allow confirm and challenge by numerous stakeholders at each stage
- The impact of our productivity and savings plan will be clearly identified to the Board and stakeholders
- Assurance process in place to ensure alignment with strategic plans.

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Appendix E

Health Scrutiny Committee Work Programme 2010-11

March 2011

SUBJECT	PRESENTED BY:	DATE FOR	THEME / COMMENTS
Focus on Health Inequalities (2) Annual Report of the Director of Public Health *(Health Inequalities Audit 2009 – R8)*	Deb Watson Director of Public Health & Health Improvement	March 2011	Focus on revised analysis of health inequalities in Leicester including use of the following shared data - Typology analysis - Leicester lifestyle survey 2010 results This should form the basis of consideration of the <u>impact</u> of inequalities for this committee and relates to the presentation received in October 2010
Joint Commissioning / Personalisation Agenda	Kim Curry Strategic Director - Adults & Communities	March 2011	Deferred from August 2010 due to the release of the new Health White Paper in July 2010

Health Scrutiny Task Group Topic(s)

SUBJECT	ISSUES RAISED	START & COMPLETION DATE	COMMENTS
Adult Mental Health Services	A review of how adult mental health services mare delivered across the City taking into account the experiences of the following groups	Feb - Dec 2010	Child and Adolescent Mental Health Services to be excluded from this review
Women's Health Issues	Members Support Officer to carry out desk top research into health issues affecting women in the city to gain an understanding of how services are currently being delivered	On-going	This was requested by Councillor Mrs Sood (Vice Chair)

Areas of Future Interest / Requiring a Watching Brief

SUBJECT	ISSUES RAISED	START & COMPLETION DATE	COMMENTS
Health White Paper	Re-configuring of NHS services – potential abolition of SHAs / PCTs	July 2010 onwards	Watching brief at the moment
Public Health White paper	Focuses on the role & responsibilities of Local Authorities and the tackling of health inequalities	December onwards	

Health Scrutiny Committee Work Programme 2010-11

Topics Completed in 2010/11

• Presentation by the Cabinet Member for Health & Community (LCC)	Feb 2010
• Update on Swine Flu (LPT)	Feb 2010
• Smear Testing + Detection for Cervical Cancer (LPT)	Feb 2010
• Introduction to GP Balanced Scorecards (PCT)	Apr 2010
• Leicester LinK (LCC)	Apr 2010
• New Management Arrangements for Leicester City PCT	Apr 2010
• LIFT Project Update (PCT)	Apr 2010
• Presentation by the Cabinet Member for Health & Community (LCC)	Jun 2010
• Public & Patient Involvement (LINk)	Jun 2010
• Healthy Lifestyles (LCC)	Jun 2010
• Alcohol-Related Harm Strategy (LCC)	Aug 2010
• Consolidation of Community Nursing Clinic Provision (PCT)	Aug 2010
• Presentation from the Cabinet Member for Environment (LCC)	Aug 2010
• Medical Practice Closures (PCT)	Oct 2010
• Intermediate Care (UHL)	Oct 2010
• Focus on Health Inequalities – Part 1 (LCC)	Oct 2010
• GP Balanced Scorecards (PCT)	Dec 2010
• Annual Health Check (Vital Signs) NHS & Leicester City –	Feb 2011
2009/10 Performance Indicators	Feb 2011
• Results of the Life Style Survey	Feb 2011
• NHS Dentistry Update	Feb 2011
• The Future of Public Health	Feb 2011

Special HSC Meetings / Workshops

• Tim Rideout – an overview of the Health White Paper	Aug 2010
• Professor Mandy Ashton - GP Commission / Govt Health Agenda for LA's	Jan / Feb 2011