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.