NHS
North Staffordshire
Clinical Commissioning Group

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27 October 2016

Dear Mr Jones

Re: Request for information under the Freedom of Information Act 2000
Ref no: FOI-02000-C8J6-SOT

Thank you for your correspondence dated 7 October 2016 making a request under the Freedom of Information Act 2000 for access to information which may be held by NHS North Staffordshire Clinical Commissioning Group (CCG).

Please find detailed below NHS North Staffordshire CCG's response to your request, which is formatted as follows:

1. A schedule of all the records covered by your request.
2. Details of NHS North Staffordshire CCG's decision in regard to the information requested.
3. Details of how you can appeal this decision should you wish to do so.
4. A statement concerning copyright and re-use of public sector information.

This letter addresses each of these parts in turn:

1. Schedule of records

1) Could the NSCCG provide details of the 'point prevalence', and additional studies conducted at Bradwell hospital and mentioned as evidence to support the decision to decommission beds?

Recent point prevalence studies of the five community hospitals confirmed the findings of previous reviews carried out over a number of years. The AIRS beds have been commissioned to provide bed based intermediate care and by exception assessment where there is an ongoing medical or nursing need.

To provide context, the overarching points prevalence breakdown across the four community hospital AIRS bed bases is included below which covered a total of 198 available beds, of which 187 were occupied at the time of the audit.

Community Hospital Beds (Step Up and Down)

Type of Service	On the Day	%
Number of people who required a ***Community Hospital sub-acute bed***	16	9%
Number of people who required a ***bed*** that can manage ***challenging behaviour / people with dementia***	11	6%
Number of people who required an ***assessment / rehab bed*** ie: care home with MDT support	40	21%
Number of people who required a ***Palliative / Fast Track Palliative bed*** in a Care Home	11	6%
Number of people who required a ***Stroke ax / rehab bed*** but not sub-acute		
Number of people who could gone ***home*** with no ***support***	6	3%
Number of people who could of gone ***home*** / waiting to go home with ***Intermediate Care***	11	6%
Number of people who could of gone ***home*** / waiting to go home with ***Rapid District Nursing / Tissue Viability support***		
Number of people who could of gone ***home*** with ***community palliative care***	6	3%
Number of people who could of gone ***home*** / waiting to go home with a ***Package of Care (social care)***	46	25%
Number of people who are waiting to go ***home*** with ***EMI S@H***	5	3%
Number of people waiting to go to an ***Extra Care Facility / supported living***	6	3%
Number of people waiting to go into ***24 hour care***	13	7%
Number of people waiting to go into ***EMI 24 hour care***	16	9%
TOTAL	**187**	**100%**

The specific breakdown relating to Bradwell Hospital is as follows:

Bradwell

Type of Service	On the Day	%
Number of people who required a ***Community Hospital sub-acute bed***	5	8%
Number of people who required a ***bed*** that can manage ***challenging behaviour / people with dementia / learning difficulties***	6	10%
Number of people who required an ***assessment / rehab bed*** ie: care home with MDT support	9	15%
Number of people who required a ***Palliative / Fast Track Palliative bed*** in a Care Home	10	17%
Number of people who required a ***Stroke assessment / rehab bed*** but not sub-acute		
Number of people who could gone ***home*** with no ***support***	1	1%
Number of people who could of gone ***home*** with ***community palliative care***	2	3%
Number of people who could of gone ***home*** / waiting to go home with ***Intermediate Care***	4	7%
Number of people who could of gone ***home*** / waiting to go home with a ***Package of Care (social care)***	12	20%
Number of people who are waiting to go ***home*** with ***EMI S@H***		
Number of people waiting to go to an ***Extra Care Facility / supported living***	6	10%
Number of people waiting to go into ***24 hour care***	5	8%
Number of people waiting to go into ***EMI 24 hour care***	1	1%
TOTAL	**61**	**100%**

2) Could the NSCCG provide the Committee with statistics regarding the patients that have occupied these commissioned beds over the past 12 months, including time occupied, referral mode (Acute vs Community), care level required (Acute, Sub-acute, Primary)?

The beds at Bradwell have been utilised as Step Down capacity for the past 12 months and all patients will have been admitted directly from the acute portals or wards.

The throughput equates to 16 patients per week/832 patients per year, with only 9% being admitted with an Intermediate care/reablement requirement with the remainder requiring palliative care, awaiting a package of care or awaiting an assessment for 24 hour nursing or residential care.

The average length of stay within the beds equates to 25 days.

3) Has the NSCCG performed any impact studies regarding the knock on effect of decommissioning sub-acute beds at community hospitals on provision of beds at the Royal Stoke Hospital? Notably, is there any risk of 'bed-blocking' identified from decommissioning these beds, and as a consequence a cost comparison of provision of these community beds verses cost of delays in discharge of patients from acute service beds.

   Using the recent implementation of temporary bed closures at Cheadle, the patients in the 47 beds were discharged over a four week period in September 2016. Every patient was medically fit for discharge when the point prevalence was carried out. 48% of patients were discharged in line with plans already in place. 52% of patients were discharged in line with plans put in place during the four week period. Alternative services were commissioned and in place to enable the eight admissions a week from UHNM to Cheadle to be managed and the beds closed to new admissions. There is no evidence that there has been an adverse impact on the system since Cheadle closed to new admissions in late August and we have seen no evidence of an increase in a length of stay or excess bed days to date.

   The CCGs have also commissioned a number of nursing home beds which came on line from the 24th September 2016 in a phased approach to support those patients who still require a bed based service. These beds have been commissioned specifically in line with demand for DST assessments, Palliative care and patients with EMI needs requiring a period of assessment and modelling has been undertaken to understand the weekly and annual demand based upon the past three years data. The length of stay has also been modelled and agreed which will result in greater throughput.

   The CCG has also made available investment into social care to increase reablement at home services which will be made recurrent in 2017-18 full year effect.

4) Has the NSCCG commissioned any studies to identify the potential increased need for beds within the Nursing Home setting for patients that will be discharged from acute care, yet still require wrap around nursing home care? If so, could the NSCCG provide the Committee with the details of such studies, and identification of potential costs of acquiring nursing home care for patients discharged into nursing home facilities.

   As mentioned above, North Staffordshire CCG alongside Stoke on Trent CCG has commissioned a number of nursing homes to support patients with assessment and/or palliative care needs. There is no evidence to demonstrate that a reduction in beds will increase the health economies reliance on beds and in fact, it is anticipated that there will actually be a decrease in the requirements for longer term care through ensuring patients are discharged home with the support in place or are discharged into the most appropriate bed base first time in line with need.

   Evidence demonstrates that people recover more quickly when they are at home or an appropriate care home environment as opposed to a hospital ward, with their own clothes and personal items and a sense of independence and if required, rehabilitation, reablement and care packages that support their recovery.

   Current system configuration also conspires to create a sub-optimal clinical experience. Patients should be managed in the most appropriate clinical setting for their needs and receive what they need when they need it. Delays cause patients health to deteriorate, they can quickly lose independence and it becomes more difficult for them to return home. In many cases, acute and community beds have become places people wit for the right services.

   From a cost perspective, the average care package/bed placements are outlined below:

Community hospital bed costs around £2,100 /week
An average domiciliary care package costs around £210 /week.
An average residential home bed costs around £600 per week
Nursing home bed £700 per week and with intensive therapies support it can be up to £1,000 per week.

5) Could the NSCCG provide details regarding the reasoning for decommissioning nursing home beds, against a backdrop of decommissioning sub-acute beds at community hospitals, with the potential knock on requirement of increased demand for nursing home beds?

As mentioned above, the CCGs are commissioning nursing home beds in line with need and have not directly commissioned any nursing homes prior to the recently procured beds for the past 18 months therefore have not decommissioned any beds.

6) Can the NSCCG provide the committee with any impact studies that have taken place to identify the potential increased pressure on the Staffordshire Social Services regarding the decommissioning of sub-acute beds at community hospitals, and potential increased costs in provision of in home care for patients discharged to home from acute care?

As outlined above and evidenced through the points prevalence, the beds are not commissioned to provide capacity to admit patients awaiting a package of care. The CCGs have commissioned 3382 spells of home based intermediate care along with an additional 2000 hours per week of reablement care during 2016-17 which heavily support patients whilst domiciliary care packages are being sourced. This is based upon lessons learned from the implementation of the 'home first' model of care and is sufficient to meet demand.

Evidence shows that if patients are discharged into the most appropriate place to meet their needs with home being the default option, and if assessments are undertaken at a time where patients are recovered and in a place of comfort, there is a lesser requirement for extensive packages of domiciliary care. A recent pilot has demonstrated that 52% of patients discharged home for assessment for a domiciliary package actually didn't require any support following a 72 day intensive package to help them settle back into home with the right support and it is expected that this will be built upon as the model expands and is fully embedded.

The CCGs are also making additional investment available to community services including reablement in 2017-18

7) The Committee would appreciate any further details on the work carried out by the NSCCG in conjunction with partner organisations to ensure that once patients are discharged to their own homes from acute care, they received the support they require.

The CCGs have invested extensively into community services over the past three years to commission high quality services within the community. We have close working relationships with SSOTP and the local authorities to ensure that services are aligned with a move towards integration to remove barriers to access. The principles of Home First are widely accepted and are signed up to across the Local Health Economy and are discussed in numerous stakeholder meetings to drive forwards the discharge to assess programme of work.

8) Could the NSCCG provide further details regarding the wide ranging and consultation and engagement conducted on "My Care My Way – Home First"? Specifically, you mention that such consultation supported the delivery of this plan. In the Consultation and Engagement Feedback Summary Report, published by the NSCCG, there are 261 survey respondents reported during phase 1, with a further 28 during the publicity event. Unfortunately, this report

only provides a snapshot of the collated evidence from these engagement activities, and as a consequence it is difficult to ascertain how such responses can be construed as support for delivery of the plan. The Committee would appreciate the NSCCG providing further details of the responses to the engagement survey and in particular the reasoning behind the interpretation of supportive for the delivery of this plan?

The first phase of engagement about My Care, My Way – Home First began in December 2015 with a briefing to MPs and local health, voluntary and local authority organisations. We also talked to the public at a series of events, public, local authority and health meetings, not just the online survey that you quote above.

The Case for Change set out the proposed model of care designed around a 'home first' philosophy. The documentation which was consulted on made it specifically clear that "The likely impact is that fewer community intermediate care beds will be required."

Details about the consultation can be found here http://www.northstaffsccg.nhs.uk/my-care-my-way

The CCGs are in the process of planning a four week engagement exercise to enable people to engage further with the implementation of the model. The Case for Change to inform this exercise is currently with NHS England. Once we have their approval, we will be communicating about how people can get involved. We are planning to commence this work in November.

2. Decision

I can confirm that NHS North Staffordshire CCG does hold the information requested, and this is detailed above:

3. Right of appeal

If you are dissatisfied with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you are entitled to complain in the following way:

Initially you should complain in writing to the freedom of information officer, either by email on MLCSU.FOITeam@nhs.net or post to Jubilee House, Lancashire Business Park, Leyland, PR26 6TR, specifying why you feel you have been wrongly denied access to the information requested. The freedom of information officer will ensure your complaint is investigated under NHS North Staffordshire CCG's internal processes and provide you with a written response within 20 working days.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner's Office (ICO) for a decision. Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by NHS North Staffordshire CCG.

4. Copy and reuse of public sector information

Most of the information provided by NHS North Staffordshire CCG in response to Freedom of Information Act 2000 requests will be subject to copyright protection. In the majority of cases the information will be owned by NHS North Staffordshire CCG. The copyright for other information may be owned by another person or organisation, as indicated in the information itself: in this case you must apply to the copyright owner to obtain their permission.

Yours sincerely

Sandra Chadwick on behalf of Marcus Warnes
NHS North Staffordshire CCG