

# Community Bed Review

Phase 1: Engagement, research & analysis  
Summary report of findings

October 2011

# Contents

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## **Executive summary**

## **Introduction**

Background and context

## **Research & analysis of existing services**

The current service map

Community hospital intelligence

Overview of findings

## **Benchmarking**

Local performance against benchmarks

## **Engagement**

## **Discussion**

## **Reference List**

## Executive summary

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This report explores the **current provision of community beds** across Coastal West Sussex and summarises the analysis undertaken during Phase 1 of the Community Bed Review. The report uses both qualitative and quantitative data to analyse activity, provision of services, profiles of patients requiring a community bed and existing estate.

**This report does not pass value judgements or draw conclusions on the current state of services but seeks to set a common evidence base to inform any future decision making.**

### **Key findings**

Across Coastal West Sussex we have 152 community beds available over 6 sites, this is around the national average number of beds per 100,000 weighted population, and equates to a **maximum capacity of 55,480 community bed days** per annum.

Analysis of the populations surrounding the community hospitals has highlighted an apparent geographical inequity in bed stock. Arun has the highest number of community beds (67 per 100k population) in CWS, against the rest of CWS (29 per 100k population). Whilst bed are not accessed in this strict manner, across **CWS community beds do tend to be used by relatively limited catchment areas**, with the exception of Darlington Court which is not used exclusively by Arun residents.

Additionally there is a **lack of correlation between acute and community bed capacity**, where community beds are available this appears to have little effect on the population's use of acute beds or in reducing acute length of stay.

**The analysis has also raised some important issues regarding staffing levels.** Specifically the **therapy workforce was approximately 29% lower than the national benchmarks**, which equates to an approximate shortage of 5 physiotherapists (incl. technicians). This shortage is reflected in concerns expressed by GPs and within secondary care during engagement. Nursing staff (including health care assistants) is also significantly below (36%) the national benchmark, equating to **nearly 80 too few nurses** within the community hospital inpatient areas. This is also supported and verified by comments from nurses during engagement.

Across all sites, the **average length of stay is 29 days**, which is just above the national benchmark with occupancy also slightly higher. However a feature of the analysis is **the variability of indicators** such as these. For example Midhurst has the shortest average length of stay (19.9 days) and Darlington Court has the longest (41.3 days). This leads to a **wide variation in cost of bed days (as capacity) and patient spells**. For example, the local average cost per bed day is £183.94 yet we see variation from nearly 20% above to 22% below. Additionally the lowest cost per patient is £3,671.01 highest cost per patient is £8,374.94. Variation is also marked with regard to **medical cover, staffing and estate**.

## **Key themes from engagement**

A number of significant themes arose from the engagement process, particularly around **variable admission criteria and rights**, access to rehabilitation services such as therapists, a feeling from some staff in community hospitals that patients are ‘dumped’ in community beds from the acute hospitals and difficulties in organising packages of care to support patients upon discharge. There was a strong feeling from the Acute Trust that a **‘whole system approach’ was needed to manage the availability of beds** with predicted bed availability being an important operational feature for them. Other themes include the Service Redesign for Quality process led by Western Sussex Hospitals Trust and the Arun Community Hospital campaign, both of which have received considerable publicity. **A passion for community beds to be used to ensure care closer to home was expressed by patients and staff alike.** Patients generally comment on how much they have valued the care they have received.

A number of concerns were raised regarding the problems encountered with some discharges, these included **lack of social worker availability to help facilitate care packages**, poor access to occupational therapy assessment, limited intermediate care provision, family/ choice and funding issues. All contribute to the delayed discharge of many patients, and made managing bed availability complex.

## **Patient profiles**

Virtually all patients in community beds are elderly, with the average age being just over 80 years old. Seven patient profiles have been identified as currently using the community beds:

- Sub acute e.g UTI or flu
- Intensive rehabilitation e.g. following fractured neck of femur, major surgery
- Specialist stroke e.g. rehabilitation
- Complex elderly with co-morbidity
- End of life care
- Neuro rehabilitation eg. Multiple Sclerosis or Parkinson’s Disease
- Respite

**These profiles have been reflected in other pieces of work across the country**, with the exception of the respite profile. A local audit has shown the most common profiles are **Intensive Rehabilitation** and **Sub Acute**, although the mix varies across sites as does the average patient dependency. Results are summarised in section 2.4 and are found in full within the supplementary paper, *Community Bed Review Patient Profiling: Audit Results*.

## **Conclusion**

This interim phase 1 report identifies the current issues surrounding the community bed provision across Coastal West Sussex Federation and gives an overview of the significant issues. To date, there has been considerable agreement from stakeholders about the main issues and cross referencing against national benchmarks has in general supported their thoughts and feelings. Difficult questions need to be addressed and decisions need to be made regarding further analysis, the next steps for the review and the future of community bed provision as a whole, especially as our population ages.

# Introduction

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## 1.1 Background and context

The NHS is facing one of its biggest challenges for decades, having to find £20bn worth of efficiency savings by 2015 through the Quality, Innovation, Productivity and Prevention (QIPP) programme, which are to be reinvested into patient care.

This follows a significant policy drive to see Care Closer to Home as detailed in Our Health, Our Care, Our Say (2006). Importantly not only must care be delivered locally and closer to home it should be delivered in an integrated way. As Liberating the NHS described, it is 'essential for patient outcomes that health and social care services are better integrated at all levels of the system' (2010).

In West Sussex the over 65 population will grow by around 38% and the over 85 population by 69% from 2001 to 2026 according to A Fair Old Age (2009). These three initiatives seek to tackle rising costs of healthcare delivery associated with this demographic shift, where people are living longer, often with co-morbidities and requiring longer term care and support as a consequence.

It is widely acknowledged by local healthcare professionals that our current community bed provision has some significant issues which are in need of urgent consideration and review.

This includes a lack of consistency in the approach to care such as variable admissions criteria and rights. Significantly there is no agreed patient profile, estate is varied in quality and financial and contractual arrangements are, generally complex.

This leads to a poor strategic fit with current clinical models and service developments across the local health and social care economy, with previous reviews of community beds being inconclusive in their recommendations.

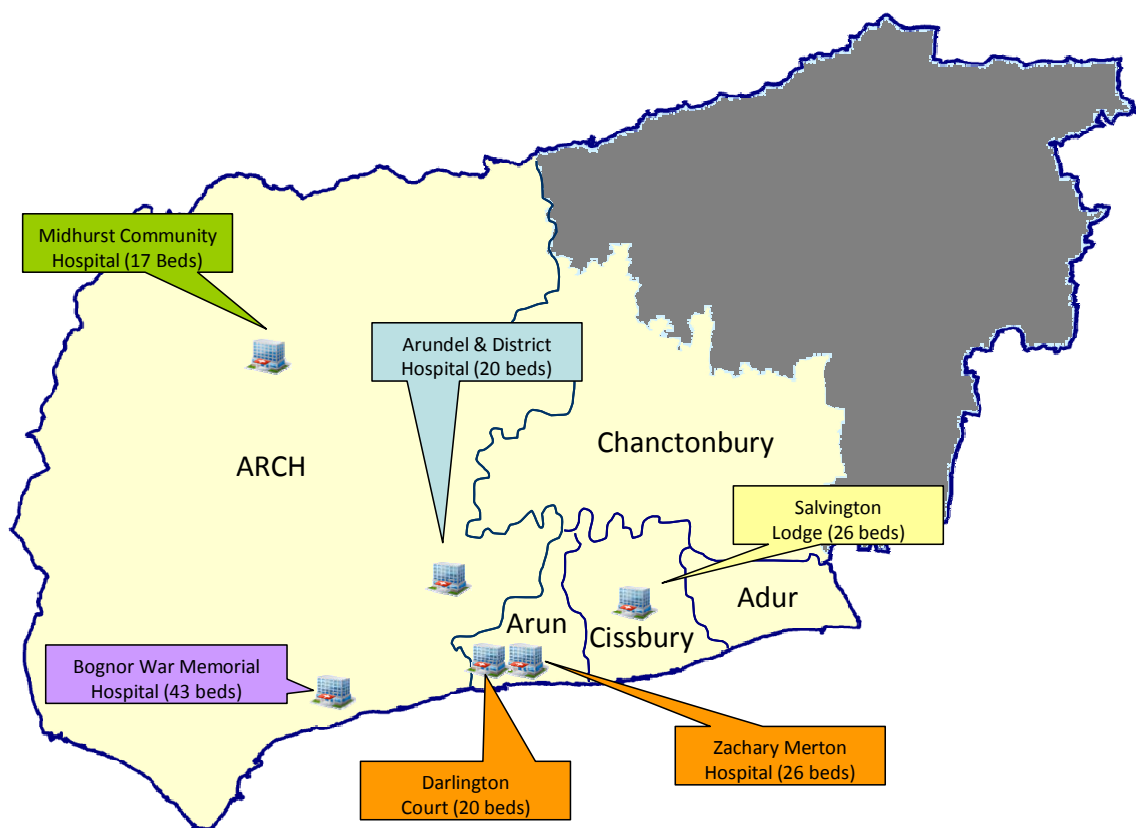
However, the ongoing Service Redesign for Quality process led by Western Sussex Hospitals NHS Trust proposes moving all elderly care beds from Southlands to Worthing and developing community services to accommodate the reduction in 'like for like' beds from 120 to 60. This provides an opportunity which the community bed review can make use of, designing the system of community beds making them reflective of local needs and allocating resources in the right place.

Yet the configuration and provision of Community Beds is potentially highly sensitive. There has been intensive lobbying for the development of Arun Community Hospital since the demolition of Littlehampton Hospital in 2005, and following numerous statements of intent on behalf of the local NHS, as such this process must contribute its views on the business case for this site.

# Research & analysis of existing services

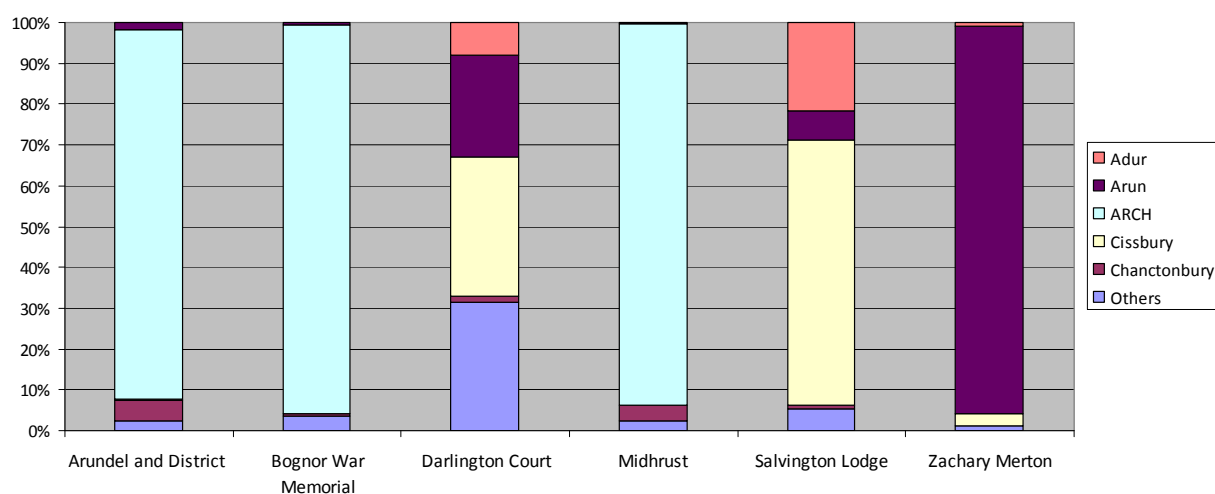
## 2.1 The current service map

### 2.1.1 Consortia boundaries and community beds



### 2.1.2 Consortia flow into community beds

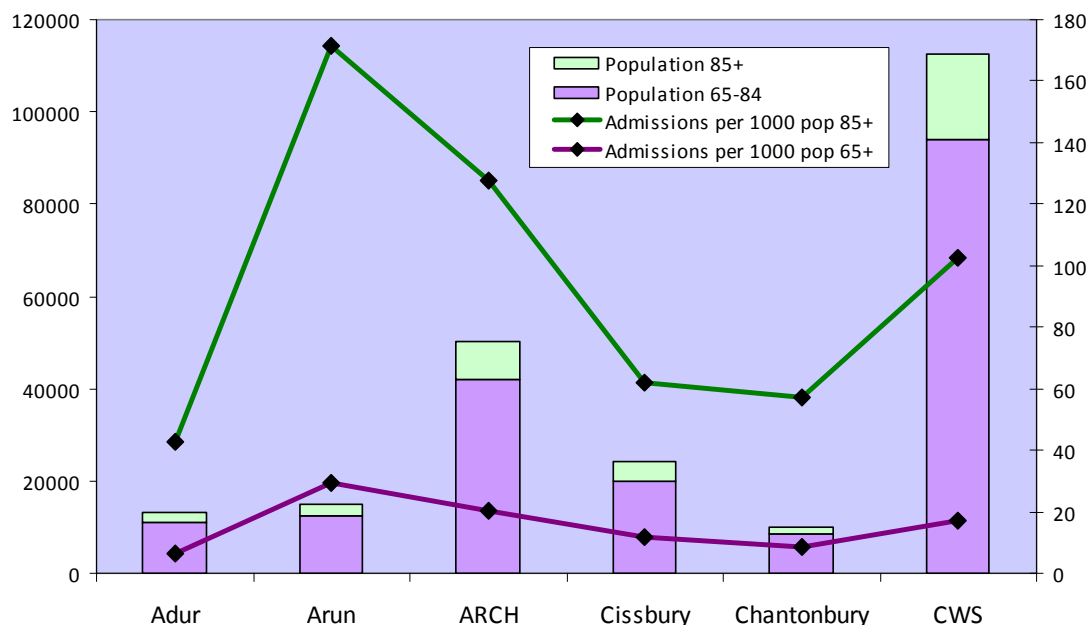
These charts show how each across each community bed sites patient mix is aligned to each of the CWS consortia 2010/11 as a percentage of total activity.



**Notes:** Others include unrecorded and out of area GP Practices/Consortia.

### 2.1.3 Consortia population rate of admission to community beds

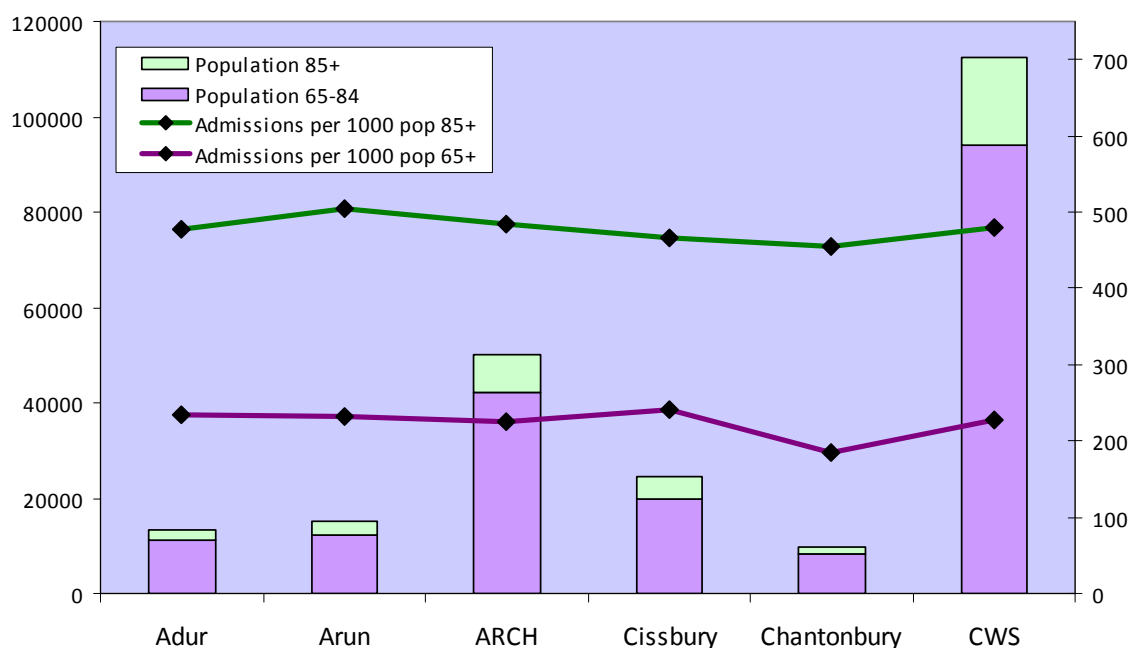
These charts show how each consortia's population used community beds during 2010/11. Both for the over 65 and over 85 cohort as a rate per 1000.



**Notes:** these also include admissions to community beds outside of CWS, including the Horizon Unit in Horsham which see the majority of Chanctonbury patients.

### 2.1.4 Consortia population rate of admission to acute beds

These charts show how each consortia's over 65 and over 85 population used non-elective acute beds during 2010/11, both in terms of raw count and also as a rate per 1000 population over 65 and over 85. Please note these are admissions to all hospital trusts.



### **2.1.5 Summary**

Across Coastal West Sussex we have 152 community beds available over 6 sites. This equates to a maximum capacity of 55,480 community bed days. However this capacity is not equitable across Coastal West Sussex, especially when considering consortia boundaries. Where Arun has a greater supply of beds within its boundaries (over twice the national average), Cissbury has below the average and ARCH around 7 beds above the national benchmark, whereas Adur or Chancetonbury have no supply within their boundaries.

Whilst the population does not utilise community beds in this strict manner (see 2.1.2), they are predominantly used by relatively limited catchment populations, with the exception of Darlington Court.

We can identify from the views provided in 2.1.3 and 2.1.4, that consortia populations utilise acute and community inpatient services differently. It is possible that this is as a result of varying supply.

For example, the population of Adur who have less access to community beds (based on geography) and subsequently a lower rate of community bed admission, do not, as might be expected, have a higher rate of acute emergency admission to acute beds. Additionally there is no positive correlation, where community beds are available, one could expect a lower use of acute inpatient services, this is not apparent in any areas, particularly Arun and ARCH.

## 2.2 Community Hospital intelligence

### 2.2.1 Capacity and facilities

This section describes the capacity and facilities at each site. Importantly it describes the medical staffing and proximity to other services.

Site	Arundel	Bognor War Memorial	Darlington Court	Midhurst	Salvington Lodge	Zachary Merton
<b>Capacity</b>	<p><b>20 beds</b> currently commissioned</p> <p>Space for a <b>further 6 beds</b> if physiotherapy area is converted.</p>	<p><b>43 beds</b> currently commissioned across 2 wards 24 in Don Baines and 19 in Leslie Smith</p> <p>15 Rheumatology Beds are also on site which reportedly have a very low occupancy rate</p>	<p><b>20 beds</b> currently commissioned as step up and step down</p> <p>59 beds on the site in total with potential room for expansion</p>	<p><b>17 beds</b> currently commissioned</p> <p>With space for <b>at least 10 more beds</b></p>	<p><b>26 beds</b> currently commissioned</p> <p>The site has a maximum capacity of 36, however the remaining 10 bed are commissioned as a mix of Continuing Healthcare and Winter Step Down beds separately.</p>	<p><b>26 beds</b> currently commissioned (13 per ward)</p> <p>With space for around <b>3 more beds</b></p>
<b>Medical Cover</b>	<p>Medical cover is provided by <b>Arundel Surgery</b> for approx 2 hours per day.</p> <p>A GP <b>attends</b> weekly multi-disciplinary meetings alongside a Consultant from Western Sussex Hospitals Trust.</p> <p>Out of Hours medical cover is provided by Harmoni</p>	<p>Medical cover is provided by <b>St Richards Hospital</b>.</p> <p>There is no Primary Care Medical cover.</p> <p>Out of Hours medical cover is via the consultant-led on-call team.</p>	<p>Medical Cover is provided by a <b>local GP</b>, alongside a Consultant from Worthing Hospital who attends weekly (one session) MDT meetings and supports with complex discharges.</p> <p>Out of Hours medical cover is provided by Harmoni</p>	<p>Medical cover is provided by co-located <b>Riverbank Medical Group</b>.</p> <p>GP's cover their own patients and out of area patients are shared amongst them. GP's do not attend weekly MDTs.</p> <p>Out of Hours medical cover is provided by Harmoni</p>	<p>Medical cover is provided by <b>Limetree Surgery</b> who visit at least once a day.</p> <p>There is also a weekly MDT meeting which includes a local Hospital Consultant.</p> <p>Out of Hours medical cover is provided by Harmoni</p>	<p>Medical cover is provided by whomever the patients GP is.</p> <p>As such Medical cover and 'ward rounds' can be challenging for staff as a large number of GP's can visit at anyone time.</p> <p>Out of Hours medical cover is provided by Harmoni</p>

Site		Arundel	Bognor War Memorial	Darlington Court	Midhurst	Salvington Lodge	Zachary Merton
Proximity	Nearest Acute Hospital	St Richards or Worthing	St Richards	Worthing	St Richards/ Royal Surrey (Guildford)	Worthing	Worthing
	Nearest GP Surgery	Arundel Surgery	Bognor Medical Practice / Bersted Green	Willow Green Surgery	Riverbank Medical Group	Limetree Surgery/Mayflower Surgery	The Coppice/The Lawns
Additional facilities on site	X-ray/MRI	No/No	Yes/No (X-ray requires replacement)	No	No	No	No
	Ultra-sound	No	Yes	No	No	No	No
	Physiotherapy Gym	Yes – Used for outpatients also	Yes x 4	Yes	No	Yes	Yes
	Occupational therapy room	No	Yes	No	Yes – use kitchen	Yes	Yes
	Podiatry	Yes – Outpatient	Yes – Outpatient	No	Yes – Outpatient	No	No
	Hydrotherapy	No	Yes	No	No	No	No
	Phototherapy	No	Yes	No	No	No	No
	Speech & Language Therapy	No	Yes	Yes – Access to	No	No	Yes – Access to
	Treatment rooms	Yes	Yes	No	Yes – two	Yes	Yes

## 2.3 Overview of findings

		Arundel & District	Bognor War Memorial	Darlington Court	Midhurst	Salvington Lodge	Zachary Merton
<b>Provider and Estate</b>		SCT Services PCT owned freehold SCT rent	SCT Services PCT owned SCT rent	CareUK Services CareUK Estate	SCT Services SPFT PFI owned SCT rent	SCT Services SPFT owned SCT rent	SCT Services PCT owned SCT rent
<b>Capacity and Medical Cover</b>		20 community beds Medical cover provided by Arundel Surgery and local Consultants <i>6 more potential beds</i>	43 community beds 15 Rheumatology beds Medical cover provided by St Richards <i>11 more potential beds</i>	20 community beds Medical cover provided by named GP and Consultant <i>Potential for expansion</i>	17 community beds Medical cover provided by Riverbank Surgery <i>10 more potential beds</i>	26 community beds Medical cover provided by Lime Tree Surgery <i>No more potential beds</i>	26 community beds Medical cover provided by patients own GP (GP SLA being procured) <i>3 more potential beds</i>
<b>Average System Performance</b>	Length of Stay		<b>29.10 days</b>	Admission Source	<b>76% ↓ Step Down</b>	Nursing WTE per 1000 bed days	<b>2.28 WTE</b>
	Occupancy		<b>88.8%</b>		<b>24 % ↑ Step Up</b>	Admission rate	<b>360 per 100k pop</b>
<b>Strengths and Weaknesses</b>		Difficult to manage infections due to location of outpatient gym Opportunity for greater space utilisation Well liked by local people	Capacity to reorganise to use space effectively Co-location with other services Takes only step down patients	Provider willing to expand Modern & purpose built Dementia unit onsite	Modern facilities but isolated from other services Very near GP surgery Macmillan base co-located	Modern building Some capacity for expansion All single en-suite rooms Co-located with dementia services	Difficult to manage infection outbreaks Limited life expectancy of building Poor interior layout eg. Door width Well liked by local people
<b>Accessibility</b>		Relatively near bus stops Not near rail routes Limited free parking On A27	Ample free parking Near bus stops On A259 and A29	Near bus routes Adequate free parking On A259	Near bus routes Accessible to local population only On A272	Very near bus stop and pedestrian crossing Ample free parking Near A27	Near bus stops Near local facilities Adequate free parking In residential area
<b>Cost</b>	Per Pt	<b>£3,671.01</b>	<b>£5,343.94</b>	<b>£8,374.94</b>	<b>£5,262.04</b>	<b>£5,986.31</b>	<b>£5,031.11</b>

# Benchmarking

## 3.1 Local performance against benchmarks

This section uses the NHS Benchmarking Network's recent report (2011) into Community Hospitals to position local performance against a national average. It should be noted that Sussex Community NHS Trust took part in this benchmarking exercise. These are not 'best practice' benchmarks but national averages.

Indicator	Benchmark (Avg)	Local performance	Variance
Community Bed capacity as a % of total bed capacity	14%-20%	Total beds : 1170 Community beds: 152 12.99%	Slightly under lowest range
Community Beds per 100,000 weighted population	29	29	The same
Admissions to community hospitals per 100,000 weighted population	282	360	22% above
Average length of stay in community hospitals	27.6 days	29.1 days	5% above
Rate of Step Down vs Step Up admissions	72% ↓ Step Down 28% ↑ Step Up	76% ↓ Step Down 24% ↑ Step Up	Slightly below
Delayed transfers of care as % of occupied bed days	7%	Applying this to the local picture equates to 3494 bed days	-
Average cost per commissioned bed day	£237.46	£183.94	23% below
Pay cost as % of total cost	60%	56%	4% below
Nursing workforce per 1000 bed days	3.98 WTE	2.28 WTE	36% below
Nursing workforce required for 152 beds (55,480 bed days)	220.81 WTE	141.80 WTE	
Physiotherapist's per 1000 bed days	0.3 WTE	0.19 WTE	29% below
Physiotherapist's required for 152 beds (55,480 bed days)	16.64 WTE	11.86 WTE	

# Engagement

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## 4.1 Primary Care

This section summarises the findings from Primary Care. Statements were drawn from a mix of consortia meetings and also individual practice and GP meetings.

The key issues raised were:

- Patient choice is very important, although this can cause issues with Social Services when patients are out of area
- Therapies are of real concerns, when 'intensive' therapy can often mean just a few minutes per day, and only 5 days per week, this also delays the set up of care packages
- The focus of community beds must be admission avoidance and early discharge from acute hospitals
- Often families cause delays in discharges when the patient is discharged to a Care Home, CHC and issues of funding exist or if the family are required to support the patient in their own home
- Community beds appear a very variable and expensive service
- Community Beds are too often a 'dumping ground' from Acute Wards, they must be available for Step Up as well as Step Down patients
- The Service Redesign for Quality process which focuses on Southland Hospital is an important issue for the Adur locality
- Community hospitals should provide care closer to home, however there are financial and political costs associated with lots of buildings. Unit size is critical
- Patients awaiting investigations should not be admitted to Community Beds
- Patients in community beds should not need consultant supervision
- The size of community hospitals, not just beds, is important in terms of delivering economies of scale, there is a need for aggregation of services
- Delays to discharge often relate to social care however this shifts cost onto the NHS services
- Services 'around' community beds are very important to support ongoing pathways
- Availability of beds for GPs to admit/utilise is important to address
- Has the case for maintaining them been made? Could further community services including community geriatrics, with nursing homes and social care be able to support these patients?

## 4.2 Secondary Care

This section summarises the themes from discussions and feedback from Western Sussex Hospitals NHS Trust. The discussion raised some key issues including:

- Access to therapies are of real concerns, when 'intensive' therapy can often mean just a few minutes per day
- The acute trust perceives a lack of information on forthcoming bed capacity in community hospitals
- Access to social services is an issue and the acute trust acknowledge this in relation to discharge from community beds
- Yet, whilst it is perceived that the community hospitals can 'close their doors', the acute trust cannot, so whole system approach to managing patient flow would be beneficial, information sharing is integral to this
- The community beds would benefit from aligning the wider community services ie. community nursing around the community beds to enable a greater emphasis on 'drawing through' patients from acute beds to community beds and back into their own homes
- Importantly, admissions for the elderly (both acute and community) can often be the trigger for a transition in care needs, which needs to be planned for at the earliest possible opportunity. Finding out this through questioning the existing packages of care and families would be beneficial
- Improving the reporting of information and activity should ensure that the health and social care economy can identify where issues and blocks are arising in this part of the system and enable appropriate response
- There is a national framework which allows for the NHS to 'fine' social services where delayed transfers of care from acute hospitals are seen as delays in social service provision, this is not used locally
- Specifically at the west end of the county and around St Richards there is no access to Intermediate Care

## 4.2 Sussex Community NHS Trust

Sussex Community NHS Trust considers the community hospital provision to be integral to their portfolio of services. The key issues and opportunities of the services, include:

- To ensure legal compliance Sussex Community NHS Trust runs the bedded units at a loss, as the service is under-funded. This is not sustainable and would require investment from commissioners to appropriate levels of nursing and therapy services.
- A number of locations require maintenance investment to improve the standards of the premises. This has been raised with the commissioners in their role as landlord of the estate.
- In the past year, Sussex Community NHS Trust has had five CQC visits to inspect the community hospital services. All reports have demonstrated the Sussex Community NHS Trust are fully compliant with all standards.
- Sussex Community NHS Trust seek to maintain and improve the operational performance of community hospital provision. In order to support the

service, the Trust looks forward to understanding more about the likely service model and outcomes the commissioners are likely to achieve.

## **4.4 Community Hospital Staff**

This section summarises the themes from discussions and feedback from Community Hospital Matrons. The discussions raised some key issues including:

### **Admission criteria**

- Need for admission criteria especially from acute hospitals
- Need clarification over admission rights for GPs
- Feels like patients are 'dumped'
- Community beds sometimes reject patients from acute hospitals as they haven't been assessed properly/fully
- Patients can be too ill for rehab when admitted
- Most patients are step down rather than step up
- More patients could be cared for at home

### **GP cover**

- Need a dedicated GP service
- Some patients covered by their individual GP rather than a dedicated service
- GPs don't attend MDT meetings (Midhurst) but Darlington Court both the GP and consultant cover MDT meetings to help with complex discharges

### **Discharge**

- Patients should arrive with a discharge plan
- Complex care packages can take up to a week to set up causing blockages
- No allocation of a dedicated social worker
- Lack of nursing home placements can cause blocks
- Blocks in discharge from social services who see the patients as 'safe' in a community hospital so not a priority
- Blocks from patient's families who are self-funding in finding a residential placement

### **Nursing staff also responded to questionnaires and highlighted the following:**

- Staffing levels are of significant and consistent concern to all qualified and unqualified nursing staff
- Effective social work and occupational therapy input is vital to robust discharge, some care packages cause delays
- Families can often be the biggest barrier to discharge

## 4.5 Social services

This section summarises the themes from discussions and feedback from representatives of the Local Authority. The discussions raised some key issues including:

- Opportunities to tighten up discharge planning for community hospitals, through named and assigned Social Workers
- Reporting of delayed discharges from community beds must be improved
- Accessibility of Domiciliary Care services will be important as more care moves outside of the hospital setting
- There is a reliance on Regaining Independence Support Services (RISS) where there is no Intermediate Care provision
- Patient and family choice is often a cause of delays where private funding is required for longer term care
- The value of multidisciplinary teams working in this environment

## 4.6 Patients

This section summarises the themes from discussions and feedback from patients within community hospitals. Some of this research was carried out by Student Nurses as well using Productive Ward Patient Experience Data.

### Patient Discussions

- Patients always described their stay in the community hospitals in very positive terms
- Of particular note was the patients gratitude for their care and staff were often singled out for praise

### Patient Productive Ward Questionnaire

- All sites scored well on the standard question regarding dignity and respect, (During your admission did you feel that you were treated with dignity and respect by all staff?) results are as follows:

Site	Percentage of patients with a positive response in 2010/11	
Arundel & District	88.6%	
Bognor War Memorial	Don Baines	92.3%
	Leslie Smith	98.5%
Midhurst	95.5%	
Salvington Lodge	Ferring	84.7%
	Offington	95.0%
Zachary Merton	Mewsbrook	No data
	Swanbourne	

## 4.7 The public

This section summarises the themes from discussions and feedback from the public, who were represented by members of the Coastal West Sussex Public Reference Panel and the Local Involvement Network (LINK) Stewardship Group. The discussions raised some key issues including:

- It is important to utilise key indicators including occupancy and length of stay
- This must be supplemented with a strong understand of the types of patients who are admitted to a community hospital and why
- Social care is a critical final step in a patients journey
- How estate is used and how it might be rationalised is also important to ensure that we have appropriate usage
- A strong understanding of community services and how care is, and could be provided in patient homes is important
- Patient choice and location of services/beds plays a key role in care for this population

# Discussion

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## 5.1 Discussion topics

### **Bed Configuration**

There is an apparent inequity of beds and capacity, especially when considering a populations use of beds predominantly comes from limited catchment areas.

### **Admission rates**

There is wide variation in admission rates to community beds. For example, where beds are more limited, the admission rate is lower, where there is greater supply, so are admission rates, without identifiable impact on acute hospital activity.

### **Community beds as an alternative to acute inpatient beds**

There appears to be no correlation between access or usage of community beds and a decrease in use of acute beds or reductions in length of stay.

### **Key performance indicators (KPIs)**

All sites perform variably against a variety of KPIs including, length of stay, occupancy rate and admission source (step up/down).

### **Cost**

Costs vary greatly, both in terms of capacity and productivity and against national averages.

### **Nursing and Therapy Cover**

Nursing and therapy time is limited due to below average WTE per 1000 bed days. This is reflected in the proportion of cost attributed to staff, where a lower proportion of total spend is attributed to staff than might be expected.

### **Medical Cover**

Medical cover is variable across sites based on local arrangement with no consistent specification. The providers of medical cover also vary between primary and secondary care, however on some sites both sectors effectively work together.

### **Patient Profiles**

There is no agreed patient profile, the audit highlights the variation in this between sites and variation between patient dependency and length of stay by profile.

### **Estate**

Estate varies greatly, with some under utilised and some less than fit for purpose. There is also variation in estate cost and ownership and tenancy arrangements.

## 5.2 Short term wins

### **Pathways and Specification**

Development of referral pathways and mechanisms (including admission criteria with patient profiles) between primary care and community beds as well as acute hospitals and community beds, within a specification for Community Beds.

Specifically the alignment of One Call pathways supporting admission avoidance and Early Supported Discharge pathways reducing acute length of stay.

### **Medical Services Specification**

Specification for medical cover supporting community beds.

### **Improved Reporting**

Improved reporting of delayed discharges to enable effective response, as well as improved routine reporting of performance and admission data set against agreed patient profiles, to be set within the specification for Community Beds.

### **Discharge Co-ordination**

Exploring the options to utilise discharge coordinators at all sites to improve discharge planning and transfers of care.

## 5.3 Next steps

### **Develop an options appraisal**

Based on stakeholder ideas and views, develop a set of options for the future of community beds for modelling and analysis.

### **Contracting**

Consider the options for early reduction in the number of beds where contracts are due to expire in the next 18-24 months.

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## Data Sources

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All Community Hospital activity data is drawn from the local admission data available through the Sussex Commissioning Support Unit.

All workforce information was collated by the service providers, Sussex Community NHS Trust and CareUK.

All Acute Trust data is available through the SUS2 Database and Provider Monitoring.

All other data sources are shown with the relevant presentation.

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