NHS
Havering
Clinical Commissioning Group

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Dear Anne-Marie

Thank you for taking the time to consider the consultation on 'Making Intermediate Care Better' and for the response received on behalf of Havering Healthwatch.

With respect to your request for additional information/clarification, please find as follows:

1. **The bed modelling is based on 95% occupancy, the model has been future proofed against the ageing profile for Havering and that Queens hospital has confirmed that they can accommodate 61 beds if required**

   More information about bed modelling is available on our website: http://www.redbridgeccg.nhs.uk/ONELRedbridge/Downloads/About-us/Improving%20Intermediate%20care%20Services/Bed%20Modelling%20Methodology.pdf

   The bed modelling has been formulated on a number of assumptions (detailed in the above) which includes the assumption of 95% occupancy.

   The link above also includes forward projection of required community beds for the next 5 years, taking into account changing demographics, particularly anticipated increases in the older population of Barking and Dagenham, Havering and Redbridge. If the preferred model of the CCGs (option 5) was to be agreed we anticipate an additional 2 community beds may be required by year 5.

   To ensure our bed modelling is robust we have had this work independently verified by NHS England.

   BHRUT has confirmed it can accommodate 61 intermediate care beds on the King George Hospital site (not Queen's Hospital).

2. **The increased staffing in the CTT and IRS allows for the bed reduction to be safely managed**

   Yes. With the preferred option of the CCG more people will have access to services than they have done previously and where they have told us they want to receive this, within their own homes.

   Since we started the trial of the new services in November, over 9000 patients have been supported (to August 2014). In our previous model (community beds only) only 1324 patients were admitted to community beds.

   During the trial, because more people have been seen at home, we have found we have not used the community beds as much. In the first six months of the trial (November 2013 to April 2014) our evidence has demonstrated that on average 29 of the 104 community beds were completely unused-in August 2014 this has increased to 49 beds unused (47% of the total capacity).

3. **The outreach teams are fully integrated clinically and managerially to ensure that care at home is as 'leading edge' as the care received in the proposed King George's model**

   The outreach teams are fully integrated clinically and managerially to ensure patients receive high quality, effective care and a smooth patient journey to recovery.
   Since the trial, there is now a single point of access to intermediate care via the community treatment team who will assess the patient's needs, and in partnership with the patient and their family, determine the most appropriate service (CTT, IRS or a community bed) to meet their needs.

   There are social workers within the team to ensure that both a patient's health and social care needs are assessed and appropriate support provided.

   The care that patients receive in CTT/IRS is overseen by a consultant community geriatrician.

   Managerially, the Deputy Director of Integrated Care is responsible for the performance and management of CTT, IRS and the community bed base to ensure effective and flexible use of resources in order to meet local needs in partnership with commissioners.

   During the trial we have established effective pathways with the acute hospital, London Ambulance Service, GPs and others to ensure that patients receive the right care, in the right place and at the right time.

4. **There are good relationships with primary care providers such as pharmacy, ie. easy access for medication needs**

   Through the course of the trial we have established good relationships with primary care providers.

   GPs locally are aware of the new services and refer to these every day. The teams work with the patients GP to ensure appropriate, effective and co-ordinated care for the patient. At the completion of treatment the patients' GP also receives a discharge summary detailing the care provided, outcomes and ongoing support needs as appropriate.

   The doctors and non-medical prescribers in the community teams prescribe medications, and work with local pharmacies-generally those closest to the patient- to access medications as required.

5. **A detailed and supportive transport policy is developed for relatives and carers and those residents living in the south of the Havering Borough**

   The preferred option of the CCGs would mean the majority of people will be cared for in their own home, requiring no travel, so this will be an improvement.

   The preferred option of the CCGs would not mean any changes to the location of the community beds for Havering patients - they currently use Foxglove ward, the community rehabilitation unit based at King George Hospital if required, and relatives and carers have been travelling there since St George's Hospital closed in 2012.

6. **Attracting staff into north east London is proving a challenge for all health and social care providers, what plans are in place to recruit the number of staff needed for both the King Georges beds and the community teams?**

   Both community teams are fully staffed with medical cover seven days per week. NELFT has found that it has been able to attract high calibre and qualified staff into the BHR economy attracted by the new model and approach that the services offer. It had a very successful national recruitment campaign to recruit highly skilled staff to both CTT and IRS.

   Should the preferred option of the CCGs be agreed we would not need to recruit additional staff to the King George community beds as we currently have suitably qualified and experienced staff providing services in the three existing community rehab units.

   More generally, the CCG is working with providers and local authorities to look at how to promote the local area, and to encourage people to live and work here.

7. **How the risk is assessed and staff allocation managed in the event of a shortfall in either King Georges or the community teams, what impact does this have on patients and other services and providers?**

   The availability and demand for community beds is assessed daily, and the performance, capacity and outcomes of CTT and IRS is monitored on a weekly basis and more frequently if required e.g. in times of pressure in the system.

   Commissioners and NELFT work in partnership to ensure effective and flexible use of resources in order to meet local needs and demand. The impact of this is that patients, other services/providers receive responsive services, providing the right care for their needs at the right time.

8. **How the plans for increasing public awareness of these schemes can be achieved?**

   Since the beginning of the trial, BHR CCGs and NELFT have sent regular briefings to stakeholders about the new services, their performance and patients' experience of using them.

   We have met with social care teams, community groups, nursing homes, GPs and domiciliary care providers to talk about the new services and who they are suitable for.

   We have developed information leaflets explaining the new service, how they work and how to access. These have been widely distributed through GP practices, social care and community groups.

   GPs are referring patients into CTT/IRS every day and the services have been promoted to them. Local residents can self-refer by calling the team's contact number which has been widely

advertised and is included in the service leaflet. Should it be agreed that the services will be offered on a permanent basis, we would work with NELFT to further promote them.

9. **We welcome the continued good news regarding St. George's site, it would be helpful to have a clearer definition of the term 'short-term' beds within the overall concept of this integrated care model.**

   The final model for a proposed new health and wellbeing centre on the St George hospital site in Hornchurch (still in development) will take into consideration strategic alignment with recent developments including CTT/IRS, developments in primary care and re-procurement of the urgent care pathway.

   'Beds' being considered in the model of care for the proposed new Hornchurch facility would be used for short term GP assessment only, as appropriate.

   Intermediate care beds are consultant led provision which provide rehabilitation services and sub-acute care.

Once again, thank you for your interest in the consultation and we hope our response provide the additional information and clarification required.

Yours sincerely

Dr Gurdev Saini
Clinical director, frail elders