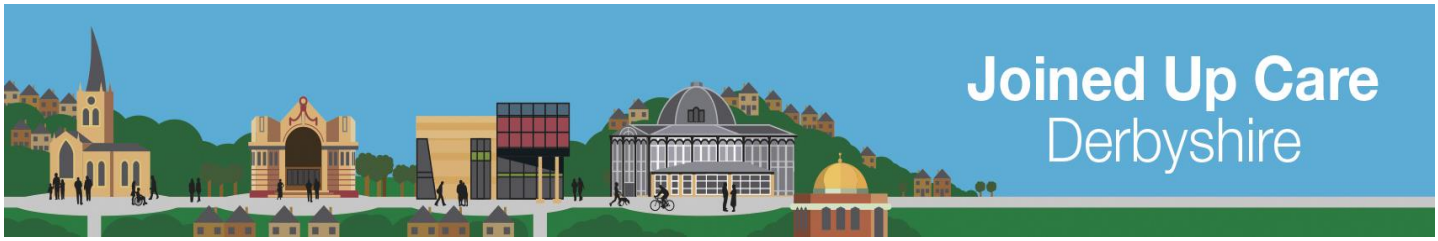

Case study – Better Care Closer to Home

Place – area of Derbyshire

The Better Care Closer to Home programme is being implemented in north Derbyshire. This covers the Joined Up Care Derbyshire 'place' areas of Bolsover and North East Derbyshire, Chesterfield, the northern Derbyshire Dales, and High Peak.

Background

Nationally and locally, the NHS and social care organisations need to consider the best ways of caring for older people. There is a growing number of older people in the country, many with one or more long-term conditions.

Organisations such as The King's Fund and NHS England have looked into the best way to care for older people in the future. All agree that there are serious drawbacks associated with unnecessarily long stays in hospital. It is also agreed that where possible it is better for patients mentally and physically if they avoid hospital admission or unnecessarily lengthy stays.

The King's Fund 'Paying the Price' report (2008)[i] said hospitalisation had a negative effect on people with dementia. It listed: increased risk of falls and urine infections, worsening confusion by removing someone from their usual environment, a loss of muscle strength due to inactivity, increasing risk of depression, and a greater risk of someone never regaining enough independence to return home.

The Emergency Care Improvement Partnership[ii], run by NHS Improvement, reported on the impact of bed rest on older people. It noted that in the first 24 hours a patient loses muscle strength of two to five per cent rising to ten per cent in seven days. Two separate studies have shown that ten days in a hospital bed leads to the equivalent of ten years of aging in the muscles of people over 80. Bed rest also means reduced mobility which may lead to a loss of independence.

There are about 6,000 people in north Derbyshire living with dementia. This is expected to rise to 7,000 in five years.

The challenge

People do better mentally and physically if they can be cared for closer to home by health and care staff based in the community. There is plenty of national expert evidence to support this. It has been the situation that too many older people in North Derbyshire have been in hospital beds when they might have been supported better if improved community-based services were in place.

Response to the challenge

In order to meet the challenges of improving the safety and quality of services, along with the need to address staff resources and skill mix, a large consultation was undertaken jointly led by NHS Hardwick Clinical Commissioning Group (CCG) and NHS North Derbyshire CCG. It included all relevant health and social care organisations and engaged with professionals, patients and the public. The consultation focused on community hospital services for older people with dementia and those recovering in a community hospital bed after an accident or illness requiring inpatient treatment at an acute hospital.

The review looked at services provided in community hospitals: Bolsover and Cavendish (in Buxton), Clay Cross and Newholme (in Bakewell), Walton (in Chesterfield) and Whitworth (in Darley Dale).

What is the new model of care?

The Better Care Closer to Home programme emerged from the consultation. This programme aims to provide more care closer to home for:

- Older people receiving inpatient care in a community hospital, usually following a spell in an acute hospital because of an illness or accident
- Older people with dementia who have tended to receive services in community hospitals

The outcome of the consultation was announced in July 2017 including the following decisions:

- Caring for people just out of acute hospital care or to prevent admission - more beds in the community (intermediate care / community support beds)
- Expanding local community integrated care teams
- Introducing new specialist rehabilitation unit at Chesterfield Royal, fewer beds remain at Cavendish
- Closing rehabilitation wards at Bolsover, Clay Cross, Newholme and Whitworth
- Expanding Integrated Care at Home teams of health and social care staff working together locally to provide seamless care for older people who have just left hospital or are becoming at risk of admission.
- Providing additional local community support beds in care homes in communities throughout north Derbyshire for older people who need extra support for a short time to regain their independence after an illness or accident
- Reducing the number of community hospital beds down to 32
- Introducing Dementia Rapid Response Teams to help when an older person is having a crisis that previously would have required a hospital admission
- Establishing Walton Hospital as a single specialist unit for older people’s inpatient mental healthcare and reducing to 30 beds
- Outreaching day services to more locations and delivering evidence-based programmes of care and support
- Closing community beds as the switch is made to increasing community-based care

Bolsover Hospital and Newholme Hospital will no longer be needed for NHS services and will close once other services (not affected by the consultation) delivered from those sites have been relocated locally.

Progress to date

Since summer 2017 there has been great progress in delivering the agreed changes to services. Some changes happened very quickly after the announcement in response to the fact that a few, already fragile, services became unsustainable as a small number of staff chose to leave soon after hearing the outcome. This was very challenging but provided an impetus to rapidly move towards the new balance of services.

The programme has required significant human resource expertise due to the numbers of staff impacted and the need to develop new approaches to support transition. Approximatively 400 people within Derbyshire Community Health Services were identified as potentially affected in some way either by the need to change base or role, and in some instances, change organisation.

Communication and staff engagement was critical and began with executive director-led briefings around the time of the announcement and over following weeks and months. This was supplemented with regular bulletins and specific team engagement by service managers. Working closely with staff partnership (union representatives) and health and wellbeing support was important to help staff deal with the uncertainty.

Organisations have worked together to support the transition, for example, Derbyshire Healthcare ringfenced roles within the new Dementia Rapid Response Teams for staff within the existing older people's mental health services at Derbyshire Community Health Services. Joint recruitment events have been held to help staff understand the way services would be delivered. Almost all roles in the first phase of the Dementia Rapid Response Teams have been successfully filled by Derbyshire Community Health Services staff.

Joint working can also be seen in finding suitable provision for a small number of patients who have historically received respite care on one of the older people's mental health wards. This is not an NHS service but the CCGs committed to not adversely impacting on existing care and so worked closely with ward staff and social care colleagues, alongside patients and carers, to set up new and ongoing arrangements for the individuals affected.

The two Dementia Rapid Response Teams are now in place serving north Derbyshire. They are building up their capacity to deliver the service but a review of bed use has already led to a reduction to 30 beds (from a designated 50) in line with the final plan.

There has been an increase in the number of day services sessions that are provided via outreach.

At the start of the programme there were 25 community support beds and an additional 19 were planned. There was also a need to ensure a more appropriate distribution of beds across the area to better meet local needs. The existing beds have not always worked consistently and so the programme gave an opportunity to address that too. An additional 12 beds are now in place and plans agreed for the final beds and redistribution. This has required an integrated approach between commissioners and providers within both health and social care. Further work is needed to build on some great 'place' led work to ensure beds are being used consistently and to maximum effect.

Two of the original five community rehabilitation wards have closed. Some of the bed capacity has transferred to the remaining three wards but there has been an overall reduction in the number of beds. There has (as of May 2018) been only minimal increase in the capacity within the integrated teams and addressing this forms a key part of the next phase of the implementation.

Viewpoint

Kate Brown, programme lead for Better Care Closer to Home:

Reasons for change:

"The previous model of care needed changing. There was a view that if you've got beds, you use beds. There was a clinical realisation that the level of acuity (how poorly people were) meant that these patients did not need to be in those beds. We were giving people nursing care when really what they needed was therapy and reablement support. While people remain in hospital there is a lot of evidence that they become more dependent on care services just by the virtue of being there.

"The type of care being provided was also inefficient and we needed to make better use of our resources. There were large sites which in their heyday would have had multiple wards and large numbers of beds. With an ageing estates infrastructure, these large sites were being kept open sometimes to provide just a single ward with 10 beds. It was inefficient due to the size of the sites and building maintenance costs. It was also not a good use of resources due to the levels of staffing required for the small bed numbers.

"Some people will always need a higher level of care in hospital. Some people might not be well enough to return home but with social care and intensive therapy could return in a short period of time. And some people will be well enough to return home with appropriate support. By helping people return home quicker we can support the acute hospitals in freeing up beds and reducing any delayed transfers of care and more importantly get people home - 'there's no bed like your own bed'. With the community beds that we have retained we must be really clear about their purpose and ensure the right staffing levels and processes."

Reflecting on progress to date:

"We have been able to work with a number of partner organisations which have all come together to ensure delivery of the aims of the programme. This has included Derbyshire Community Health Services, Derbyshire Healthcare, the CCGs, primary care, Chesterfield Royal, and social care. We have managed a significant transition for staff and successfully moved resources (i.e. money) around the system while changing the model of care for patients."

Learning lessons:

"You need to have a clear service model and an agreed plan. When things got tricky, it was useful to refer to the business case which had been consulted on and signed off. The programme has benefitted from having positive working relationships. It has also benefitted from clear and open communications between all of the organisations which have worked very collaboratively to deliver the significant changes so far."

Further information

The Better Care Closer to Home programmes publishes regular updates on the websites:

www.northderbyshireccg.nhs.uk/better-care-closer-to-home www.hardwickccg.nhs.uk/better-care-closer-to-home

[i] https://www.kingsfund.org.uk/sites/default/files/Paying-the-Price-the-cost-of-mental-health-care-England-2026-McCrone-Dhanasiri-Patel-Knapp-Lawton-Smith-Kings-Fund-May-2008_0.pdf
[ii] https://improvement.nhs.uk/improvement-offers/ecip/