NHS Calderdale CCG: Integrated Community Beds

Additional Information

Current Commissioning
Within Calderdale there are currently 28 Intermediate Care Nursing Beds and Discharge to Assess (D2A) beds block and spot purchased. The block arrangements support 7 people at a time: 5 in residential beds and 2 in nursing beds. D2A placements typically last for up to 6 weeks.

A definition of each bed type can be found at Appendix One. There are different eligibility criteria for all the different types of beds currently in the system.

Therapy support to Intermediate Care is provided by Calderdale and Huddersfield Foundation Trust (CHFT) via a dedicated team; wider therapy input is available also from CHFT via the Community Rehabilitation Team.

Future Commissioning
Integrated Community Beds
It is proposed that future commissioning would establish a more flexible nursing bed base which meets both Intermediate Care and Discharge to Assess requirements for step up and step down referrals.

The Provider will be expected to work with commissioners and the wider health and social care system to develop a category of bedded care known as 'Integrated Community Beds'. This could include attendance and contribution to local workshops to further develop the service and the community model for Calderdale.

The proposed **exclusion** criteria for Integrated Community Beds would comprise:
- Meet the Reason to Reside (in hospital) criteria/not medically fit for discharge
- People under 18 years of age.
- Not registered with a Calderdale CCG GP for healthcare services.
- Specific, achievable goals within the period of service availability cannot be defined within the agreed period of care. Specific exclusions include:
    - If needs can only be met in a specialist environment, e.g. specialist mental health support including moderate and advanced dementia, or specialist rehabilitation needs.
    - If a medical condition requires acute care.
- Covid positive
- Diagnosed Dementia, prevalent mental health needs or needs associated with a Learning Disability if dementia also diagnosed where resident capacity or cognitive ability does not allow compliance with self-isolation approaches.
- Suspected delirium without clear treatment plan for underlying cause, or a delirium not responding to treatment requiring further investigation.
- EOL/Palliative people who are awaiting POC/24 hour placement
- People who will not comply with the guidelines outlined by the home in relation to alcohol, smoking

Community Model
Care Closer to Home has been engaging with professionals and the public to increase understanding of the needs of our patients.

Examples of people who might benefit from a more flexible community bed model include those who are:

- Recovering from a period of acute care who will be appropriate for Intermediate Care later, e.g. people who cannot support their full body weight, are recovering from an illness or who are suffering from a short-term episode of confusion.
- Discharged from acute care and require further assessment for social care needs but are not suitable for Intermediate Care, i.e. meet the 'discharge to assess' criteria.
- Discharged from acute care and waiting for a package of care or reablement start date or a home adaptation to be completed.
- Waiting for a suitable placement in a residential or nursing home following a period of IC and would otherwise be considered for a short stay or transitional bed.
- Where there is a specific safeguarding concern about a person returning to their usual place of residence.

We are looking for a new way of working with community beds. Providers will be expected to work within the system to develop flexible and deliverable processes that ensure that patient flow is improved through all bedded accommodation.

APPENDIX ONE
INTERMEDIATE CARE

NICE guidance 74 states: People should not be excluded from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison, residential care or temporary accommodation.

People are eligible for intermediate care if it is likely that specific support and rehabilitation would improve their ability to live independently and they:

- are at risk of hospital admission or have been in hospital and need help to regain independence or
- are living at home and having increasing difficulty with daily life through illness or disability.

DISCHARGE TO ASSESS

NHS England (2016) provides the following definition of D2A:

"*Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person."*

Reason to Reside - a person is clinically optimised and no longer needs an acute hospital bed	
• Requiring ITU or HDU Care	• Last hours of life?
• Requiring oxygen therapy/NIV	• Requiring intravenous medication >b.d (including analgesia)?
• Requiring intravenous fluids	• Undergone lower limb surgery within 48 hours
• NEWS2>3 (clinical judgement required in person with AF and/or chronic respiratory disease)	• Undergone thorax-abdominal/pelvic surgery within 72 hours?
• Diminished level of consciousness where recovery realistic?	• Within 24 hours of in invasive procedure? (with attendant risk of acute life-threatening deterioration)
• Acute function impairment in excess of home/community care provision	•