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REPORT TO NHS WARWICKSHIRE BOARD

PUBLIC SESSION

12 January 2011

Agenda Item	**11.1**
Subject:	**Report on the consultation for North Warwickshire Intermediate Care and Bramcote Hospital**
Report by:	**Martin Turner, Director of Communications**
Author	**Martin Turner, Director of Communications**

PURPOSE OF THE REPORT:

To inform the Board of the results of the consultation 21 September 2010 – 7 January 2011, and to confirm that the Board has met the test of Enhanced Public Engagement.

KEY POINTS:

The balance of views indicates that Option 3 is in line with the aspirations of local people. However, a number of questions and issues were raised and the Board must satisfy itself that these are answered before proceeding.

RECOMMENDATIONS:

The Board is recommended to accept the consultation process as complete.
The Board is recommended to seek answers to the questions listed above before proceeding
The Board is recommended to consider its duty in regard to enhanced public engagement to be complete

PREVIOUS CONSIDERATION:

Committee	**Date**
Board	**15 Sept 2010**

IMPLICATIONS:

Link to Strategic Objectives	
Financial:	
HR / Personal:	

Healthcare / National Policy:	
Equality Diversity	
Patient experience	
Patient/public/staff involvement	**This satisfies the Board's requirement in relation to patient and public involvement**
Risk register/Assurance Framework	**This manages risk in relation to one of the Secretary of State's four tests for reconfiguration**

Report on the Consultation: Intermediate Care in North Warwickshire and the future of Bramcote Hospital

Executive Summary

An extended consultation on three varying proposals for the future of intermediate care in North Warwickshire, as proposed in the Board Paper 11.5 on 15 September 2010, gained 99 written responses, 302 survey responses, attendances at seven public meetings by an estimated 200 individuals, and responses from the statutory respondents. A petition was also received. The process was pre-scrutinised by NHS West Midlands and the plans accepted as valid.

As set out in the Board paper referenced above, the options were:

Option 1

Continue the service as now

Option 2

Use the hospital for admission prevention and rehabilitation

Option 3

Close Bramcote and re-provide the current service by the purchase of care home beds and enhancing the intermediate care service. In addition, opening an additional 100 places on the virtual ward in North Warwickshire, available to all General Practitioners (GP) Practices

Table 1 — means of response

Means	Response	Mode of response
Consultation Document	99 responses*	Letters, emails, comments written on documents: qualitative narrative information
Survey	302 responses	Statistically validated quantitative data
Public Meetings	Approx 200 individuals present	Through 7 public meetings and 3 Local Authority meetings
Statutory responses	Written response from LINK, formal meeting of Health Oversight and Scrutiny Committee	Letter, minutes

*A petition was also received, which is discussed below in the relevant section of this report.

- Evidence from the written responses indicates support for all three proposals.
- Evidence from the statutory respondents indicates support for Option 3, or a variant based on Option 3.
- Evidence from public meetings indicates strong support for Option 1 from a campaign group and from locally elected members, although a more open attitude to all options among other attendees.

- Evidence from the survey responses indicates overwhelming support for Option 3, with minimal support for other options.

In proceeding, the Board must satisfy itself that it can answer concrete objections, and be ready to disclose the answers to these to the general public. If it chooses to pursue option 3, it should answer questions in regard to:

- The question of overnight cover for those who are ill enough to require it
- The question of specialist rehabilitation equipment and its availability
- Questions of evidence and data in regard to the best cost option and the effectiveness of the Virtual Ward and other community approaches
- The question of impact on other NHS organisations and the system as a whole
- The question of the varying impact of Virtual Wards and other NHS at home approaches on carers and on those without carers
- The comparative allocation of funds in the north and south of the county

The Board should, however, consider that its duty of enhanced public engagement has been discharged, thereby meeting that element of the Secretary of State's four tests on reconfigurations.

Recommendations

- The Board is recommended to accept the consultation process as complete.
- The Board is recommended to seek answers to the questions listed above before proceeding
- The Board is recommended to consider its duty in regard to enhanced public engagement to be complete

Consultation Framework
The consultation was conducted under Section 242 of the NHS Act 2006, Section 233 of the Local Government and Public Involvement in Health Act 2007 and under the Four Tests set out by the Secretary of State for Health.

Within these frameworks and the subsequent guidance, the following bodies have a particular statutory function:

The **Strategic Health Authority** (NHS West Midlands) must approve the text of the consultation document and the consultation programme before commencement.
The relevant **Oversight and Scrutiny Committee** scrutinises both the process of consultation and the outcome.
The local **LINK** is the formal body for patient involvement.

Further, NHS Warwickshire is obligated to be mindful of the **Warwickshire Compact**.

Account of the consultation
The consultation was initiated on 21 September 2010, initially for a three month period. The consultation was later extended to end on 7 January 2011.

Prior to commencement, the consultation document was reviewed and approved by Julia Holding, accountable officer for consultation, at NHS West Midlands in accordance with recommendations of the Carruthers Review (Reconfiguration, 2007).

The issued consultation document was written to comply with the Cabinet Office Seven Consultation Criteria, available in the Code of Practice on Consultation. This includes a duty to set out the scope of costs and impact, and a duty to make the consultation document easy to understand, avoiding unnecessary technical detail and jargon, and reducing the burden of consultation on the public.

The consultation was widely promoted, through direct mail to over 1,000 local people who had previously expressed an interest in shaping health matters (NHS Warwickshire Active Members), through distribution to Warwickshire's voluntary organisations via WCAVA, via a series of seven public meetings in conjunction with local authority Neighbourhood Forums, through widespread promotion in local newspapers with 33 separate articles appearing by the end of November for an estimated 484,000 readers[1], and through individual meetings with interested members of the public. Officers attended the Warwickshire Health Oversight and Scrutiny Committee, the Area Committee for Nuneaton and Bedworth, and the Nuneaton and Bedworth Social Services Oversight Committee.
The consultation document was available online, supported by the suite of papers made available to the Board in its initial decision to consult.

[1] Readership based on Audit Bureau of Circulation figures discounted by estimated read-through based on article prominence, using the MIMESIS methodology.

In accordance with the duty to limit the burden of consultation, NHS Warwickshire opted to request permission from the relevant local authorities to attend neighbourhood forum meetings to present the options, rather than organising special consultation meetings. Initially only North Warwickshire Borough Council agreed to representation at these meetings, whereas Nuneaton and Bedworth Borough Council refused permission to present. However, subsequently, following a presentation at the Nuneaton and Bedworth Borough Council, councillors requested that representatives should attend all of the neighbourhood forums. In order to achieve this, NHS Warwickshire extended the consultation period.

The consultation was formally considered by the Warwickshire LINK and by the Warwickshire Health Oversight and Scrutiny Committee.

Additionally, in response to requests by councillors for a tabulated survey of public opinion, a poll was commissioned with a target sample size of 300, conducted in Nuneaton and in Atherstone.

Methodology

Notes were made at all public meetings, and all written responses received by the deadline were recorded in a database with notes on the issues raised. All substantive issues thus raised are considered in the discussion below.

In response to requests from councillors for some form of representative opinion gathering exercise, to supplement narrative and meeting-based responses, an objective survey was commissioned among a statistically significant sample, segmented by age and location, to answer specific questions raised in the narrative responses. It must be understood and emphasised that a consultation is not a referendum, and that the NHS has no powers to conduct such a referendum. The survey responses should therefore be understood as representative evidence, not a ‘vote’ by local people. Summary graphs of the responses are presented here. The full data set, and a detailed methodology, are available on request.

General Responses received

There were 99 written responses received at the close of the consultation. The responses ranged from single word responses to extended narratives. Some responses were from individuals writing on their own behalf, and some were on behalf of organisations. A number of responses were anonymous. Written responses were received by email, directly written on or attached to the consultation document via the Freepost address, or as separate letters or notes. Two responses were received from Members of Parliament, and one from an individual councillor writing as a councillor.

There were 302 survey responses, gathered through a commissioned non-NHS body in early December.
Additionally, photocopies of a petition were received on the closing date of the consultation. This has provided insufficient time for verification, but the Board is advised to consider the petition along with the other evidence.

Staff attended seven public meetings and three council committees. It is not possible to give a tally of how many individuals attended, since the same group

attended numerous meetings. However, it is our estimate that at least 200 different individuals attended one or more meetings.

Statutory responses received
The Health Oversight and Scrutiny Committee considered the proposals and the process, and communicated its decision in support of Option 3.

Warwickshire LINK submitted a report which supported a variant based on Option 3 which it described as 'Option 4'.

Questions raised in the narrative responses
Questions regarding the process of consultation
Brief responses regarding the process are presented in italics.

- A number of respondents argued that the consultation document was biased in favour of a particular proposal, principally through the inclusion of information about relative costings which they felt skewed responses towards the cheapest option.
  However, this information is a requirement based on the Cabinet Office Code of Practice on Consultations (see above).

- Several respondents queried the evidence either mentioned in the consultation document or in the supporting technical documents, including the financial data and the claim that most patients would prefer to be treated at home which it was claimed were national figures which did not apply to North Warwickshire.
  The Finance team has been asked to re-verify the figures.
  A survey was conducted in Nuneaton and in Atherstone to test the claim that local people preferred treatment in hospital rather than at home. Results are below.

- A limited number of respondents argued that the consultation process was insufficiently widely publicised.
  This view was principally put forward near the beginning of the consultation.
  On 7 January, we requested an opinion from a local journalist who covers health matters. The journalist view, which is supported by our MIMESIS data (op cit), is that the consultation gained very substantial coverage, with an estimated 484,000 readers up to the end of November.

- A number of respondents queried why the consultation was being conducted on existing bed numbers, rather than the larger numbers of beds previously operating at the hospital.

Issues and questions regarding the proposals

- A substantial number of respondents wrote to praise Bramcote hospital. However, there were also responses which detailed real concerns by patients and their relatives.

- One staff member wrote to complain that Bramcote was little known in the community.

- A substantial number of respondents indicated either directly or indirectly that they believed that services at home through the Virtual Ward and other means would be chargeable.

- A number of other respondents indicated that they believed the Virtual Ward would be delivered through social services, rather than through the NHS.

- Several respondents questioned the ability of care at home to offer the kinds of heavy equipment used in rehabilitation in the hospital.

- Other respondents queried whether there was evidence that rehabilitation at home was successful.

- A number of respondents indicated that they believed that all home care services would be required to be provided from the existing District Nurse team, with no supplementary staff recruited. These responses were generally by letter or email, so that it is not clear whether they had seen the consultation document.

- A significant number of respondents indicated that they believed the process was solely about cost reduction, or was part of government austerity measures.
- A number of respondents suggested that money should be found by closing services in the south of the county, or indicated that they believed that money was being taken from the north.

- A significant number of respondents raised the question about overnight care between 10pm and 8am, since this is currently available in Bramcote hospital.

- Several respondents raised the issue of patients who did not have carers, questioning whether the virtual ward would be able to provide sufficient care for them. Additionally, the question of the impact on carers of having a virtual ward patient at home was raised.

- A number of respondents argued that by increasing the number of beds to 41 the cost per bed would be reduced.

- Some respondents argued that a move to close Bramcote would lead to increased bed blocking at George Eliot Hospital, and would lead to greater difficulties in regard to winter pressures.

- One respondent questioned infection control measures on the virtual ward.

- A significant number of respondents argued that, based on the evidence presented, option 3 should be the preferred option. However, a small

proportion of those argued that this was because of a failure to present a balanced picture.

- In arguing for option 3, a number of respondents suggested that the Bramcote estate should be retained for palliative care or for some cooperative programme with Social Services.

- Another NHS organisation sent several responses querying the impact of the prospective closure of the estate on that organisation.

- One MP wrote to argue that, if Option 3 were adopted, that money saved should be reinvested in the north of the county.

- Both MPs argued that there was an inequity of funding between the north and the south of the county.

- Two MPs wrote to say they understood that GPs were opposed to Option 3, and that the views of GPs should be binding.

- However, the prospective GP Consortium representing the largest number of GPs and the largest number of patients in the north of the county wrote to state it supported Option 3, subject to money saved being reinvested in the north of the county. It is our understanding that the smaller GP Consortium is opposed to Option 3.

- Although it is not meaningful to quantify narrative responses, it should be noted that there were significant numbers of responses (ie, greater than 20%) in favour of each of the options. No option gained a majority of responses.

Issues raised in public meetings not raised in written responses

Presentations were held as follows:

Area Forum North - 26 October at St Nicholas Church Hall, Baddesley Ensor
Arbury & Stockingford Community Forum - Tuesday 7 December
Whitestone & Bulkington Community Forum - Thursday 9 December
Bede & Poplar Community Forum - Tuesday 14 December

Presentations were held at community forums as follows

North Warwickshire
Area Forum East - 12 October at Partnership Centre, Coleshill Rd, Atherstone
Area Forum West - 14 October at Hurley Village Hall, Hurley
Area Forum South - 21 October at Arely Community Centre, New Arley

The principal issues raised in public meetings mirrored or echoed those given above.

The following issues were raised in public meetings which were not otherwise raised:

- A number of those who attended the last two public meetings argued that the virtual ward was too strongly presented. However, many more of those who attended the early public meetings expressed the view that insufficient information had been provided about the virtual ward, and that this should be addressed in the final meetings.

- One locally elected member argued that the views of locally elected members should take precedence over views received through the consultation process.

- A number of locally elected members argued that, although a consultation was not a referendum, there should be some kind of poll, survey or vote to determine the weight of popular feeling.

- A number of members of the public, while praising the concept of care at home and virtual wards, cited instances in the past where they or relatives had received care at home but it had been insufficient.

- Potential loss of front-line staff if Bramcote were to close

Petition response

A petition was delivered to NHS Warwickshire on the final day of the consultation.

National guidance indicates that petitions, to be valid, should not contain potentially false, libellous or defamatory statements and should contain verifiable contact information for the signatories. A national threshold has been set for petitions to local authorities to become substantive if they reach 5% of a local authority population. Additionally, guidance has been proposed indicating that a PCT should consider a petition substantive if it reaches 1% of the total population care for by the PCT. This would give required respondents as either 9215 or 5,500 for the petition to be considered substantive.

The petition received was stated to contain 3,089 signatures, though a number of these fail to state an address and a number are outside the area affected. Furthermore, there appear to be a number of cases where one individual has signed on their own behalf and written in someone else's name as well, with a signature in identical handwriting. On inspection, the delivered petition turned out to be two or more separate petitions, one with about 2,700 signatures and one with about 300 signatures, though it is not clear if this is itself one petition or a mixture of petition and canvas returns.

If the stated figure of 3,089 signatures is accepted, this falls short of 5% of the population of the affected area (122,000 Nuneaton and Bedworth + 62,300 North Warwickshire = 184,300, therefore threshold is 9,215) or 1% of the PCT population (5,500 signatures required).

The text of the main petition was: *"We the undersigned strongly object to the closure of Bramcote Hospital. This rehabilitation facility is the only one of its kind in North Warwickshire. If Bramcote closes the emphasis will be on care in the community and this service is already overstretched. Our residents deserve to have the best care services available and we believe this must also include Bramcote Hospital's facilities."*

A separate set of signatures, counted within the stated 3,089 by the individual who sent us the copies, had the text on the first page: "*We, the undersigned, are concerned citizens who urge our leaders to act now to stop the closure of Bramcote Hospital*." This set of signatures, however, did not state the petition on each page, and appeared to be a mixture of petition responses and canvas returns in different formats, including one comment "Close it".

The text of the main petition as given does not pertain to this consultation, which offers three options, two of which would see Bramcote remaining open, and the third would see significant new investment in community services to create the virtual ward. We have reviewed rejections of e-petitions by HM Government, which are published on the 10 Downing Street website, and our conclusion is that, if considered to relate to this consultation, the petition would be rejected under the rubric of 'potentially false… statements', since the petition text clearly suggests that there would be no new provision within the community if Bramcote Hospital were to close, in direct contradiction to the consultation document itself.

We received one narrative response to the consultation which referenced the petition, in which the respondent indicated that they had been assured by the

petitioners that the existing District Nursing service would be required to take up the Bramcote work if Bramcote closed. Although this is only one response, it goes to confirm that the petition was generally understood in this way.

In coming to its own conclusion, the Board should be mindful that the text of the petition as presented is against the closure of Bramcote without Option 3, and does not reference Option 3 at all.

For those considering running petitions in the future, we would emphasise the following points:

1) A petition statement should be a call to action. A petition statement which includes a claim of fact runs the risk of being overturned or bypassed if it turns out that this claim is itself untrue.
2) The statement should be printed on the piece of paper signed by the petitioners. A single cover sheet is not acceptable, as there is no way of linking the signature to the petition.
3) Each signature should be by the individual concerned. It is not acceptable for an individual to sign on behalf of someone else, even with their consent.
4) An address or other verifiable contact should be included for each person signing.
5) A petition should not be collated by NHS staff, or give an NHS address as the return address, as this could be seen to imply NHS endorsement of the petition, and would in any case constitute the use of NHS resources for a potentially political purpose.

Survey response

The commissioned survey attempted to establish the answers to three questions:

Where people would prefer to be treated if they were ill, but not ill enough to need to be in an acute hospital.

Where people would prefer their partner, close relative or friend to be treated.

Where people would like to be treated if they no longer needed to be in an acute hospital, but were not well enough to look after themselves.

The survey was conducted on the streets of Atherstone and Nuneaton by non-NHS employees who had received a printed briefing on how to conduct the survey. They were given no information on a preferred response, and those conducting the survey were not informed about other elements of the consultation, to avoid any introduction of bias. Six surveyors were employed, and they went through the survey face to face, asking the questions and noting down the responses. The surveyors were given no brief on the comparative costs or availability of treatment, and no information of this kind was included in the questions, so that respondents were free to make their decision in their own interests and in the perceived interests of those close to them, rather than altruistically for the benefit of the population as a whole.

It is important to understand that, unlike a petition, a properly conducted survey gives a statistically representative result, because respondents are given equal access to all options, and the presentation of those options is made neutrally. However, a survey is not a vote, and it does not provide a democratic mandate for any particular course of action.

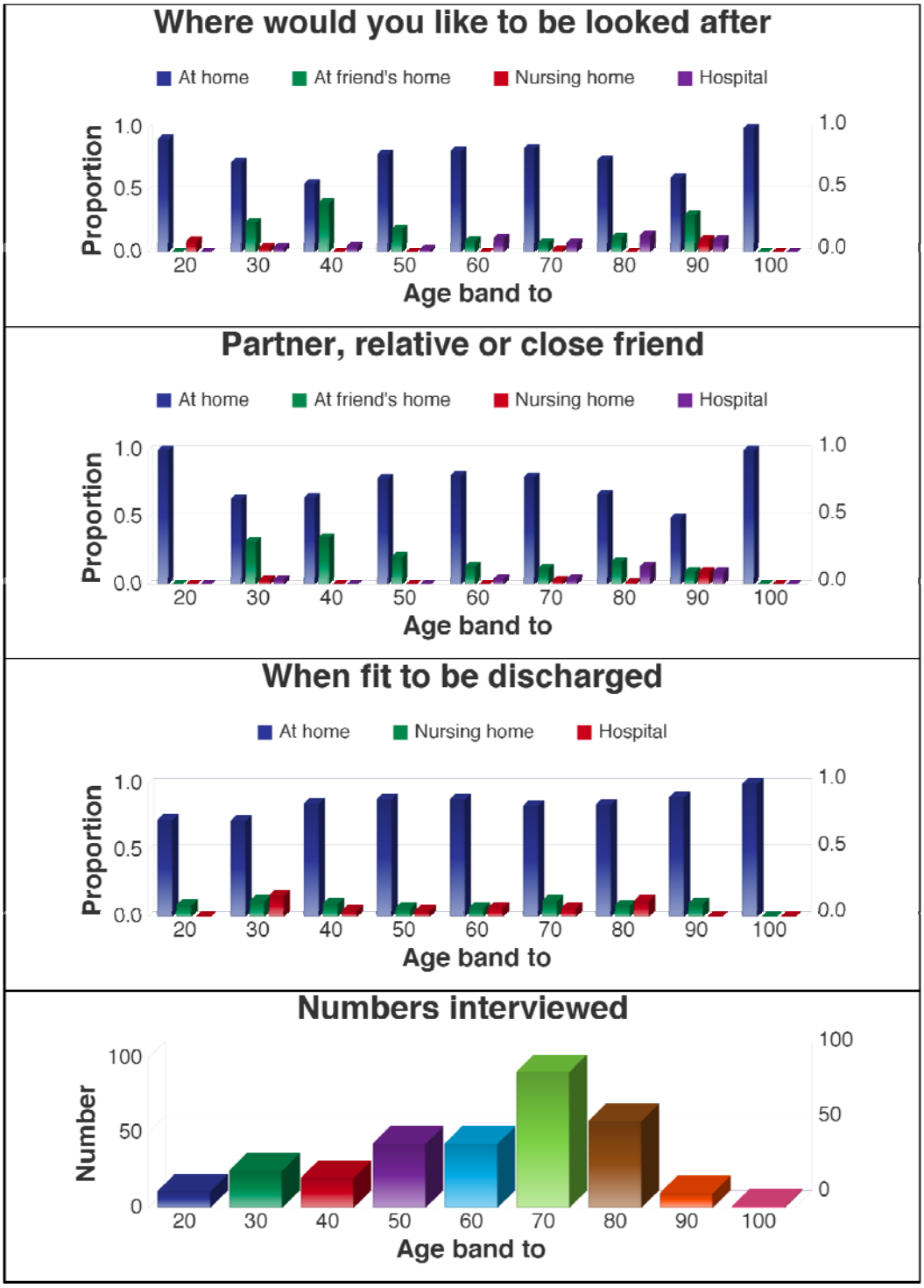
The sample size was 302 (n=302) against a total population of 184,000, giving a confidence interval of 5.65% for 95% confidence level or 7.44% for 99% confidence level on a 50% response to any particular question, with confidence intervals respectively of 3.4% and 4.5% respectively on a 10% response to a particular question.

227 of the 302 questioned stated that they lived locally to the survey, while 67 stated that they lived nearby, where nearby was defined as Coventry, Leicestershire, Rugby, and other proximate areas. If only those who stated that they lived locally are considered, the confidence interval for a 90% or 10% response rises to +/- 5.1%.

93% of those questioned said they would prefer another option to hospital if not so ill that they needed to be in hospital (confidence interval +/- 3.8%), and 92% (+/- 4%) said they would prefer another environment than a hospital for rehabilitation, of whom 84% (+/- 5.5%) said they preferred to be at home.

Survey Questions:

If you were ill, but not ill enough to need to be in hospital, where would you most like to be cared for — assuming the care was appropriate and paid for by the NHS?
(At home; At the home of friends or relatives; In a nursing home; In a hospital anyway)
If you had a sick relative, partner or close friend who was not ill enough to be in hospital, where would you most like them to be cared for, again assuming care was appropriate and NHS-funded? *(Response set as above)*
If you were in hospital, and the doctors told you that you were well enough to leave, but still needed some care, which of the following would you choose? *(Care by NHS nurses at your home; Care in a nursing home paid for by the NHS; Longer stay in an NHS hospital)*



Conclusions

Before proceeding, the Board must satisfy itself that it has given due attention to genuine concerns raised by members of the public which relate to any specific course of action it wishes to undertake. The Board is not required to follow the majority view, though the Board may take account of evidence of overwhelming public opinion in considering what kind of services the population prefer.

In contrast to other consultations conducted recently, the overall tenor of this process was relatively adversarial, with individuals at times giving the impression that they had 'chosen a side' rather than being willing to consider the evidence. This led to a tendency to mischaracterise the proposals which is most clearly seen in the text of the petition.

Notwithstanding that, and repeated claims to the contrary, it is clear that the vast majority of respondents to the survey would prefer not to be treated in a hospital environment if this can be avoided — 93% of those questioned said they would prefer another option to hospital if not so ill that they needed to be in hospital, and 92% said they would prefer another environment than a hospital for rehabilitation, of whom 84% said they preferred to be at home. Equally, the narrative responses to the consultation indicated that, among the self-selecting group which chose to respond, there was support for each of the options.

The clear implication of the consultation process is that Option 3 is most in line with the wishes of the public in North Warwickshire as a whole. This is also supported by the statutory respondents. However, the Board must satisfy itself, if it wishes to proceed in that direction, that areas of concern raised by the public are satisfied. In particular, these include:

- The question of overnight cover for those who are ill enough to require it
- The question of specialist rehabilitation equipment and its availability
- Questions of evidence and data in regard to the best cost option and the effectiveness of the Virtual Ward and other community approaches
- The question of impact on other NHS organisations and the system as a whole
- The question of the varying impact of Virtual Wards and other NHS at home approaches on carers and on those without carers
- The comparative allocation of funds in the north and south of the county

Other issues highlighted should be addressed under questions of clinical safety, on which the Board must satisfy itself in regard to the Secretary of State's Four Tests, ie: Enhanced Public Engagement, GP Support, Clinical Safety and Patient Choice.

Additionally, the Board should issue a document aimed at the general public clarifying a number of issues of misunderstanding, to include:

- That virtual ward and other NHS at home care is provided by the NHS, rather than social services, and is free at the point of delivery
- How money is being reinvested in the north of the county

NHS Warwickshire

REPORT TO NHS WARWICKSHIRE BOARD
PUBLIC SESSION
Date : 12th January 2011

Agenda Item:	**11.2**
Subject:	**Consultation for North Warwickshire Intermediate Care and Bramcote Hospital**
Presented to the Board By:	**Jill Freer** **Director of Quality & Safety; Executive Nurse**
Author:	**Jill Freer – Director of Quality & Safety; Executive Nurse**

PURPOSE OF THE REPORT:

The paper informs the Board of the next steps in relation to the future of Bramcote Hospital and the development of Intermediate Care in North Warwickshire following a public consultation.

KEY POINTS:

The paper reminds the Board of the three options for the future of Bramcote and the development of Intermediate Care in North Warwickshire:

Option 1
Continue the current service provision at Bramcote Hospital
Option 2
Use Bramcote Hospital for admission prevention and rehabilitation
Option 3
Close Bramcote Hospital and re provide the current service by the purchase of up to 8 beds providing 24 hour care and enhancing the intermediate care service. In addition, opening an additional 100 places on the virtual ward in North Warwickshire, available to all General Practitioners (GP) Practices

The consultation and the application of the 'four tests' applicable to significant service change supports the adoption of option 3 which will provide better value for money than the current service provision and provide more services in the community to a larger number of the population of North Warwickshire.

RECOMMENDATIONS:

The Board is asked to approve option 3 and authorise the necessary work for implementation..

APPROVED BY:

Committee	**Date**

IMPLICATIONS:

Financial:	
HR / Personal:	
Healthcare / National Policy:	

NHS Warwickshire

Executive Summary: North Warwickshire Intermediate Care and Bramcote Hospital

Background:

Bramcote is a Community Hospital in North Warwickshire. Historically it has taken patients from George Eliot Hospital NHS Trust (GEH) whose 'acute' episode of care has been determined as complete across two pathways one medical, one orthopaedic. Medical cover is provided by GEH consultants who are supported by General Practitioners (GP) who work as clinical assistants to the consultants.

The service provision is therefore vulnerable to cost duplication, as patients could be transferred to Bramcote from GEH while within tariff 'trim point'

Following audits of bed usage which demonstrated more than half the beds were being used for social not health needs, Bramcote bed capacity was reduced from 41 to 20 on 1st April 2010. The use of the remaining beds was then reviewed, leading to the development of three options for its future.

Options for the future

1. Continuing to use the Bramcote Hospital facility in its current format.
2. Recommissioning the beds with GP medical cover to provide admission prevention and rehabilitation services.
3. Closing the Hospital, reproviding the current service by the purchase of 24 hour care beds, enhancing the Intermediate Care Service and opening an additional 100 places on the virtual ward, in North Warwickshire, available to all GP Practices.

There are advantages and disadvantages attached to all the available options outlined in the paper.

Following a public consultation and the application of the the four tests necessary to predicate service change option 3 has been identified as the chosen option providing better value for money than the current service provision and extending more services in the community to the population of North Warwickshire.

Recommendation

The Board is asked to approve the adoption of option 3 and its implementation.

1. Purpose

This paper builds on a previous paper presented to the Board of NHS Warwickshire in September 2010 which outlined three options for the future of Bramcote Hospital. The Board was asked to approve a Public Consultation on these proposals and this concluded on 7th January 2011.

2. Context

Bramcote is a Community Hospital in North Warwickshire. It provides a good standard of care within the National Performance Metric for this type of provision. It has historically taken patients from George Eliot Hospital NHS Trust (GEH) whose 'acute' episode of care has been determined as complete across two pathways one medical, one orthopaedic. It is geographically isolated and has traditionally been subject to the extended lengths of stay associated with frail older people, who potentially have health and social care needs.

The hospital is managed by Warwickshire Community Health (WCH). Medical cover is provided by GEH consultants who are supported by General Practitioners (GPs) at Spring Hill Medical Centre who support the consultants working as clinical assistants.

In the recent past the inpatient service has comprised 41 beds across 2 wards. In April 2010 bed numbers were reduced to 20 following analysis of the patient cohort. This showed that at least half the beds were not being used by patients who required 24 hour nursing care. Many were awaiting care home placements and/or had social care needs.

When the bed numbers were reduced it was on the understanding that full closure of Bramcote would be considered later this year.

3. Options for the future

The Board of NHS Warwickshire was asked to consider the three options for the future of Bramcote set out below.

Option 1: To continue the service as now

This means 20 beds would remain designated for orthopaedic and medical rehabilitation for patients beginning their episode of care in George Eliot NHS Hospital (GEH).

Benefits

Number of people supported between 228 – 261 per annum.

A census in August 2010 showed that since bed numbers have reduced and admission criteria are strictly adhered to the hospital has been running well. There is good leadership from WCH, lengths of stay (LOS) have reduced and throughput has improved.

Currently, the average length of stay is 32 days over a full year, this option would support 228 people annually.

This option would mean there would be no redundancies of non clinical support staff. There are 19 people providing catering, domestic and portering services on the site.

Risks

However the service does not represent value for money. It is possible that Commissioners pay twice for the episode of care, both on an acute setting and then again as the patient is moved from GEH to Bramcote under the contract with Warwickshire Community Health (WCH).

Finally choosing this option would mean a lost opportunity to reorganise community services in line with NHS Warwickshire's strategic aims to provide responsive, flexible care to people in their own homes, where appropriate, so that they have the opportunity to retain independence for as long as possible.

This option does not support NHS Warwickshire's strategic intentions to transform community services in line with national guidance to deliver services as close to home as possible. Patients cared for in their usual place of residence are more likely to retain their independence than if admitted to hospital. Also, rehabilitation after an acute episode of care is best achieved outside the hospital environment.

Costs

No additional costs.

Opportunity costs

- Continued potential for 'double payment' for episodes of care at GEH/Bramcote.
- Loss of potential savings from more streamlined alternative model of care.

Option 2: To use Bramcote Hospital for admission prevention and rehabilitation

This would mean that the 20 beds are used in a similar way to those at Ellen Badger Hospital in Shipston and on Arden Ward at Royal Leamington Spa Rehabilitation Hospital.

Benefits

As in Option 1, this would mean there would be no redundancies of support staff on the site.

The option gives the local population admission prevention beds which have previously not been available. The average length of stay in similar health care settings, using this model, is 37 days because there are often complex and social care issues associated with discharge. Therefore, this option supports 197 people per year.

Risks

Evidence from Shipston and Arden Ward does not demonstrate that admission prevention beds have an impact on the number of unplanned medical emergency admissions to acute hospitals. Often the beds become blocked by patients moved from acute care who are awaiting local authority assessments or care home placement.

As in Option 1, this option does not support NHS Warwickshire's strategic intentions to transform community services in line with national guidance to deliver services as close to home as possible. Patients cared for in their usual place of residence are more likely to retain their independence than if admitted to hospital. Also, rehabilitation after an acute episode of care is best achieved outside the hospital environment.

This would cost more than option 1. Re negotiation of medical cover for the hospital would increase the running costs of Bramcote, which are already high.

Costs

Additional costs of enhanced Medical model for GP cover estimated at c£50k-£100K*

Exit costs for existing medical cover arrangements, up to £1m*

**There would be a requirement to decommission other services to cover this funding gap.*

Option 3: Close Bramcote Hospital and re provide the current service

On the basis of inpatient analysis the care currently provided at Bramcote could be replicated by commissioning up to 10, 24 hour beds and an extended Intermediate Care Service (ICS). The ICS would provide nursing and therapy support to patients in the nursing home beds or in their own homes. Nurses and Health Care Assistants (HCAs) would work in the ICS between 8.30am -10.00pm, 7 days a week. Therapists would work between 8.30am – 6.30pm, 7 days a week.

Benefits

This reorganisation of services offers an opportunity to build the foundations of modernised community services in North Warwickshire. It is difficult to see how this could be achieved without closing Bramcote given the financial situation across the health economy at present.

The proposals support NHS Warwickshire's commissioning strategy to transform community services, and deliver care closer to home. Feedback from patients receiving care from the new virtual ward services in the community is overwhelmingly positive and a very strong endorsement that patients feel better able to manage their own care if they have confidence in the community support available,

This new ICS provision could provide support to an average 300 patients per annum. The 24 hour care on a LOS of 32 days, support 114 patients per annum.

Therefore, this proposed service represents better value for money, delivering care to more people than in Option 1.

Risks

It is intended that all clinical staff currently employed at Bramcote are redeployed within the health economy with many being given the opportunity to work in the new services being developed. Where possible, the 19 non-clinical support staff will also be redeployed**.** However some people in this staff group may be made redundant if these proposals are implemented.

Opening an extra 100 places on the virtual ward

This option means that the existing services at Bramcote will be provided in a different way. In addition, funding released from the closure means that a new service can be extended to the whole of North Warwickshire, with the opening of 100 new places in a virtual ward setting, to give 200 in total across the north accessible to all GP practices.

The population of North Warwickshire has higher rates of Chronic Obstructive Pulmonary Disease (COPD), and Heart Disease, than the national average. The Virtual Ward team targets people with long term conditions, at high risk of an acute admission to hospital, using the BUPA Healthdialog predictive risk tool. Those identified by the risk tool are offered assessment and support to help them manage their own condition at home. Last year pilots in the north and south of the County identified that people admitted to the ward had an average of 60% fewer emergency admissions than in the 12 months prior to them being admitted to the ward.

Benefits

On the basis of a 12 week length of stay 200 places gives the opportunity for 600 high risk patients to be supported in the community.

Risks

The savings predicted from avoided admissions do not materialise as the additional capacity released in GEH is replaced with other acute activity.

It is intended that clinical staff currently employed at Bramcote are redeployed within the health economy and where possible, non clinical staff will also be redeployed, however management of the redundancy risk and associated costs represent a key challenge of implementation of this option.

Failure to secure impairment cover (see below) would make the option unaffordable for the health economy.

Costs & Savings

Savings
Revenue savings from Bramcote Closure £2,021,000

Costs (Recurrent)
Re-provisioned beds £292,000
Enhanced Intermediate Care service & related community service costs £602,000 Virtual Ward Costs £437,000. It is assumed that the cost of Virtual Ward would be offset by reduction in emergency admissions, thus a net nil cost of implementing the Virtual Ward in the North of the county.

Recurrent Savings Net Of Additional Costs **£1,127,000**

Costs (Non Recurrent)
Redundancy Risk (medical and other staff) £1,200,000*

**estimates only*

Impairment Costs

Closure of the facility would necessitate financial impairment of the Bramcote premises asset at a cost of £3.2m.

Financial coverage of the impairment cost has been requested from the Department of Health. Based on previous experience, such a request is likely to be approved.

Approval of this would be a pre-requisite of any decision to close the facility.

4. The Four Tests

In July 2010 David Nicholson wrote to all Chief Executives requiring four configuration tests to be applied to service change. These are:

1) There has been real engagement of public and patients.

The consultation report presented to the Board represents the extent to which patients and the public have been involved in the consultation. NHS Warwickshire has also received a formal response to the consultation from LINKS, an organisation which represents the pubic and patients.

2) GPs, particularly in their commissioning role, have been actively involved in shaping the options, they support the overall approach and increasingly 'own the process'.

There are two GP commissioning consortia in the north of the county and they have both been fully engaged in working through options for the future of Bramcote. This has been through discussions with the consortia boards and through a half day

workshop, specifically set up for the consortia. The GPs in North Warwickshire support option 3 with the caveat that following closure of Bramcote the investment into community services needs to be made in the north of the county of Warwickshire. The GPs in Nuneaton support option 1 and maintaining the status quo. This is a difficult situation in that the two consortia have different views. It is suggested that the Board accepts the support of the North Warwickshire GPs in that they have a majority of GPs in their consortia.

3) There has been full use of the evidence base for service change by clinical leaders across the continuum of care:

Clinical colleagues in GEH have been fully engaged in the options appraisal and consultation as has Professor Ian Philp, Medical Director at NHS Warwickshire, Jill Freer Executive Nurse at NHS Warwickshire and a range of clinicians within WCH. There is little research evidence associated with the use of community hospital beds or the use of virtual wards therefore commissioners have used local audit and analysis of the audit outcomes to inform the options presented to the Board.

4) Commissioners have properly considered how the proposals affect choice of provider, setting and intervention, making a strong case for the quality of the proposed service and improvements in patient care.

If option 3 is approved by the Board potential service users will lose the opportunity to use Bramcote as part of their rehabilitation pathway from GEH but more service users will be able to access the virtual ward in North Warwickshire, more patients will have the opportunity to use Intermediate Care which will be extended and enhanced from the current provision and there will be a third option of accessing 24 hour care, when appropriate, in another setting.

5. Feedback from the Consultation

The report on consultation; Intermediate Care in North Warwickshire and the future of Bramcote Hospital, describes the extended consultation on this topic. Several questions were posed as a result of the consultation which can be answered as below:

(1) The question of overnight cover for those who are ill enough to require it

This cover will be provided by commissioning up to 10 beds, providing 24 hour care in the north of the county. The number of beds is a generous estimate using current and retrospective bed usage at Bramcote Hospital.

NB: Rugby with a population of approximately 117,000 has access to 2 care home beds for ICS, and there are no community hospital beds.

(2) The question of specialist rehabilitation equipment and its availability.

The definition of specialist rehabilitation equipment is not clear in the question. However, as elsewhere in Warwickshire, patients will be able to access rehabilitation equipment appropriate to their need.

(3) Questions of evidence and data in regard to the best cost option and the effectiveness of the Virtual Ward and other community approaches.

The answers to this question are set out in the paper. e.g. pilots of virtual wards in the north and south of the county, identified that people admitted to the ward had an average of 60% fewer admissions than in the 12 months prior to them being admitted to the ward.

(4) The question of impact on other NHS organisations and the system, as a whole

Option 3, would provide more care to more of the population in North Warwickshire and should support the work of other NHS organisations.

(5) The question of the varying impact of Virtual Wards and other NHS at home approaches on carers and those without carers.

Option 3, should support more patients and carers in the community than those in Options 1 and 2. Health and Social Care, is and will be provided to service users in the community on the basis of need. Carers needs are taken account of in assessment processes.

(6) Recent analysis was undertaken to provide a comparison of expenditure per registered patient for each of the Warwickshire GP consortia groupings.

The average rate was £1,496 per registered patient per annum, the rate for individual consortia were Nuneaton & Bedworth £1549, North Warwickshire £1454, Rugby £1523, and South Warwickshire £1499. The analysis also indicated that expenditure on community based services was higher in the North of the County (£112) than the South at (£97). Whilst this analysis only represents a provision view, it indicates that expenditure rates for each consortia are broadly similar.

6. Conclusion

NHS Warwickshire has consulted widely on the future of Bramcote Hospital and listened to a number of views in relation to its potential for the future. However, option 3, which is supported by the majority of GPs in the north and passes the four tests of service change, is the preferred option providing better value for money than the current service provision and providing more services in the community for a greater number of North Warwickshire's population.

6 Recommendation

The Board is asked to approve option 3, and authorise the necessary consultation with staff, and reprovision of services in the north of the County.

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