Meeting	Community Care Partnership (CCP)	**Date**	Tuesday 10th Dec 24
Title	**LLR Long-Term Pathway 2 Options Appraisal**		
Author	Verity Marlow: LLR D2A Programme Manager (secondment ICS post) and LLR System Discharge Lead (substantive ICS post)		
Presented By	Tasneem Lakdawala: ICB Head of Transformation UEC and Home First and ICTSG SRO Lisa Carter: County Service Manager for Health and Care Integration		
Endorsed by (added)	Tracy Ward: County Assistant Director for Integration, Access, and Prevention and ICTSG SRO		
Collaborators	Intermediate Care Transformation Steering Group (ICTSG) and the three ICT subgroups: P1 Subgroup, P2 Subgroup, and the Decision-Making Subgroup CHS Flow Group Discharge Cell		
Executive Leads for CCP	Director for CHS (LPT), Sam Leak Director for City ASC, Ruth Lake		
Action Required of CCP	See below		

To approve ☒	For assurance ☐	**To receive and note** ☒	For information ☐
For recommendation or course of action prior to presenting to LLR Exec Team	*To offer assurance for the LLR exec Team that controls and assurances are in place*	*Receive and note implications which may require discussion prior to presenting to LLR Exec Team*	*For note: for intelligence without in-depth discussion prior to presenting to LLR Exec Team*

Purpose of Paper	The purpose of this options appraisal is to seek approval from the LLR Exec Team to mobilise a Pathway 2 service across LLR that provides both D2A assessment 'and' intermediate care for all LLR residents with 24hr care needs requiring discharge from the acute setting, thus: • providing an equitable offer for all • mobilising system P2 IC/D2A capacity that meets demand • improving long-term outcomes for LLR residents • ensuring value for money
Appendices	Yes
Recommendation for CCP	**NOTE** the system data and intelligence provided which informs the long-term options and recommendation. **APPROVE** the options appraisal prior to being presented to the LLR Exec Team.
Report History	In September 2023 a paper was presented by the ICB on behalf of the system, detailing the Pathway 2 bedded settings utilised across LLR at that time. The paper was titled 'Overview of the LLR Intermediate Care Model Proposal for Out of Hospital Bedded Services' and supported the change in provision from the P2 Therapy Led Beds to the P2 High Dependency Beds commissioned from April 24. In early 2024, a system decision was made to recruit a LLR D2A Programme Manager (ICS role: secondment) to continue the demand, capacity, LOS, and outcomes review of all Pathway 2 patient cohorts residing in Pathway 2 bedded settings within LLR, to formulate an options appraisal on behalf of ICTSG to inform the long-term plan for Pathway 2 in LLR from April 25 onwards. The post holder commenced late May 24.

LLR Long-Term Pathway 2 Options Appraisal

1.0 Executive Summary

Whilst navigating national policy and guidance, since early 2023 the Intermediate Care Transformation Steering Group (ICTSG) has been mobilising plans to ensure that Pathway 2 services across LLR provide both Discharge to Assess (D2A) 'and' intermediate care (IC) for all LLR residents with 24hr care needs requiring discharge from the acute setting, to: provide an equitable offer for all, to mobilise system P2 IC/D2A capacity that meets demand, to improve long-term outcomes for LLR residents, and to ensure value for money. Whilst most of the P2 objectives recommended by UEC Improvement Expert Ian Sturgess and Newton Europe have since been achieved by ICTSG, final proposed plans for long-term P2 IC/D2A bedded settings in our system require LLR Exec Team consideration, agreement, and sign-off before mobilisation.

Based upon system P2 data and intel, ICTSG acknowledges that the considerable gap in system P2 IC/D2A bedded capacity to meet the demand of the 24hr residential care needs cohort needs resolving long-term. Additionally, that the system needs to finalise the long-term plans for the system P2 IC/D2A bedded capacity already in place for patients with 24hr bariatric and 24hr high dependency. For this reason, ICTSG recommends that system finance is agreed long-term to fully embed the commissioning arrangements for the P2 Bariatric Therapy Led beds and the P2 High Dependency beds.

In terms of recommending the long-term P2 plan for patients with 24hr residential care needs, this is more complex due to there being three viable options of six, because there is the need for a system led review of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home directly from the acute setting to release P2 IC/D2A capacity for patients with 24hr care needs, and because the final agreed option/s for mobilisation are dependent on system finance.

Finally, acknowledging the increase in acute hospital admission rates each year, seasonal variation, and planning for surge capacity, ICTSG requests that the LLR Exec Team consider the option of mobilising and utilising P2 IC/D2A system beds at 85% occupancy, rather than the current 95-100% occupancy rate; understanding the challenges with increasing the system workforce and the demand on system finance to manage an occupancy rate of 85%.

2.0 Introduction and Context

In March 2020 the focus for hospital discharge changed at pace because of the Covid-19 pandemic. Therefore, following national guidance LLR moved to the 'Discharge to Assess' (D2A) model to embed home first principles and enable assessment of long-term care needs within the community rather than within the acute hospital setting. To enable the approach, the LLR Discharge Hub was mobilised to process Pathways 1, 2, and 3 discharge for all LLR residents requiring new or increased care upon discharge from hospital. Whilst navigating the challenges of the Covid-19 pandemic, all LLR partners worked collaboratively to embed robust Pathway 1-3 function through the LLR Discharge Hub and Integrated Discharge Team (IDT) and used system P1-3 data to inform ongoing transformation and strategic planning for P1-3 discharge.

During recovery from the Covid-19 pandemic in 2023 both nationally and locally, further government guidance was launched recommending that health and social care systems focus on delivering intermediate care services in unison with the D2A model. During 2024 national guidance continued to recommend that Pathway 1 and Pathway 2 intermediate care services are provided by health and social care professionals for up to four weeks/28 days after discharge from hospital to support people's recovery, rehabilitation, and reablement; the aim being to help people regain function, skills, and confidence, maximise independence, and to improve their longer-term outcomes:

- Delivery Plan for the Recovery of Urgent and Emergency Care Services (DHSC, Jan 2023)
- Managing Transfers of Care: High Impact Change Model (LGA, 2023)
- Intermediate Care Framework for Recovery, Rehabilitation, and Reablement following Hospital Discharge (NHSE, Sept 2023)
- A New Community Rehabilitation and Reablement Model (NHSE, Sept 2023)
- Hospital Discharge and Community Support Guidance (DHSC, Jan 24)

In view of the guidance, in March 2023 the Intermediate Care Transformation Steering group (ICTSG) formed and, with the support of Newton Europe (NE) through the Local Government Association, the group commenced a programme of work to review and embed Pathway 1 and 2 intermediate services across LLR. Prior to the review by NE, UEC Improvement Expert Ian Sturgess had also visited LLR and reviewed the approach within our system; the reports from both NE and Ian Sturgess shared that:

- There were ***too many P2 bedded settings*** in use across LLR creating inequity and confusion
- There was an ***inequitable P2 intermediate care*** (IC) offer; intermediate care was provided within some P2 bedded settings, and not others
- 34% of patients discharged to our Pathway 2 bedding settings were ***not residing in the ideal P2 setting to meet their needs***
- 41% of patients discharged to a P2 Residential Care Home bed ***could have returned home with Pathway 1*** but noted the ***lack of Pathway 1 intermediate care capacity*** and reliance on the domiciliary care market
- 35% of delay in discharge planning was driven by ***lack of Pathway 2 intermediate care capacity***
- ***Poor patient outcomes:*** 60% of LLR residents remained in long-term bedded care after the D2A assessment period in the P2 bedded setting, because IC had not been provided

As a result of the findings, the ICTSG mobilised three system led subgroups and developed a comprehensive programme plan for each group: ICT Pathway 1, ICT Pathway 2, and ICT Decision Making. Consequently, from March 2023 to April 24 the following outcomes were achieved to resolve the identified concerns:

- ***Mobilisation of P1 intermediate care services*** delivered by each of our three Local Authorities: City, County, and Rutland. Now in 2024, on average (see appendix 1):
    - 85% of patients are discharged with P1 support
    - 12% to a P2 Residential Care Home bed
    - 3% discharged by P3

- ***IDT decision making with the patient at ward level across all LLR hospitals***, determining the most appropriate discharge plan and pathway (see appendix 1 and 2):
    - enabling P1 discharge, not to P2 bedded settings
    - increasing P1 discharge and reducing Pathway 2 discharge
    - reducing LOS from 'MOFD to actual discharge' by approx. 50%

- ***On average 81% of patients requiring P2 support are now discharged to our P2 Community Hospitals Beds which provide intermediate care*** (with a target of 90% by April 25), and ***a further 4% of patients are discharged to our other system P2 bedded settings which provide intermediate care*** (see appendix 3):
    - Supporting equity and improving patients' long-term outcomes

- *By Oct 24,* ***eliminating P2 discharge from our P2 Community Hospital Beds, as intermediate care and D2A assessment is carried out within that system P2 bedded setting*** (see appendix 4)***:***
    - Improving the patient experience and their long-term outcomes

A further key objective for ICTSG to fully achieve, is to streamline Pathway 2 services within LLR and eliminate the use of P2 bedded settings that do not offer intermediate care, hence the purpose of this options appraisal.

3.0 Current P2 Offer and Position

Through the ICT programme plans led by ICTSG, work was undertaken to ensure system led P2 bedded settings were mobilised and managed through the LLR Discharge Hub, that support both intermediate care and D2A assessment and meet the care needs of our differing P2 cohorts. The below shows the current system P2 IC/D2A bedded settings and P2 cohorts within LLR:

P2 System Bedded Setting: IC provided	P2 Cohort
P2 CoHo Beds at Charnwood Ward in LPT	24hr Nursing Needs
P2 High Dependency Beds in a LLR Care Home	24hr High Dependency Needs
P2 Bariatric Therapy Led Beds in LLR Care Homes	24hr Bariatric Needs
P2 CoHo Beds at Coalville Ward 4 in LPT	24hr Residential Care needs
P2 CoHo Beds across LPT	24hr Medical Step Down (MSD), Palliative Care, and General Rehab

Note: through a separate workstream supported by our system QI Leads, UHL and LPT are collectively reviewing the P2 Stroke Pathway bedded offer in LLR. Therefore, that P2 setting/cohort is excluded from this options appraisal.

Once the LLR D2A Programme Manager commenced in post in late May 24, they collaborated with all system partners and their respective Business Intelligence Teams to collate, review, and analyse Pathway 2 data from all LLR databases. The system P1-3 database aligned to the LLR Discharge Hub, called the S1 Discharge hub Unit, was used alongside all individual partner databases; the P2 data shared from partner databases, mirrored the P2 data shared from our system database:

- System: S1 Discharge Hub Unit
- UHL: NerveCentre and Qlik
- LPT: S1 CoHo Unit
- ASC: LAS (for our Local Authorities)
- MLCSU/ICB: CMS

Through analysis of such P2 data spanning Aug 22 to July 24 (2yr period), a data report was shared across the system confirming our current demand, capacity, LOS (in/out flow), and outcomes for all Pathway 2 bedded settings and P2 patient cohorts. The data report highlights the gap in LLRs provision of P2 beds that support both intermediate care and D2A assessment (see appendix 5), as per the summary below.

P2 Cohort	Ave. Yearly P2 Bed Demand	P2 IC/D2A Beds Insitu	Ave. Yearly P2 Bed Gap	Plans
24hr Nursing Needs	13	13	0	Updated Nov 24 by LPT: capacity now meets demand
24hr High Dependency needs	11	15	+ 4	ICB anticipating full utilisation over winter 25/26
24hr Bariatric Needs	6	2	- 4	ICB increasing bed base by four, By Dec 24
24hr Medical Step Down (MSD), Palliative Care, and General Rehab	204	204	0	Capacity meets demand
24hr Residential Care Needs (City and County LA residents only)	**103**	**15**	**- 88**	**No system agreed plans in place to meet the demand**

Note: the above data is based upon a 100% occupancy rate, with such being the systems' current approach.

Currently there are beds hosted by UHL situated on Wd 22 LGH and The Ashton Care Home, that are an extension of the UHL bed base and opened across Aug-Sept 22, due to the number of patients residing in the acute with no reason to reside. However, such beds are utilised internally within UHL only and not via the LLR Discharge Hub, with a hybrid operating model supporting P0-P3 patients. Additionally, a proportion of patients are discharged from those settings, into system P2 beds (see appendices 6 and 7). Therefore, the yearly demand for the P2 patients supported in those beds

is included within the overall P2 bed demand versus capacity data (see appendix 5); with the right P2 option mobilised within LLR, such patients would no longer need to remain residing in UHL once medically optimised for discharge with no reason to reside.

In view of the data and intel provided, it indicates that the main focus for LLR is to agree and mobilise a P2 bedded setting that provides an equitable intermediate care offer for the 24hr residential needs cohort, for City and County LA residents; with Rutland LA already providing a P2 IC/D2A offer for their own LA residents. The aim being to mobilise a long-term P2 service that meets the yearly demand for the 24hr residential care needs cohort and closes the P2 IC/D2A bed gap, whilst also finalising our long-terms plans for the other three cohorts highlighted above.

4.0 Equity and Quality

Enabling LLR residents to stay well, safe, and independent at home for as long as possible has been long standing policy for our health and social care system, locally and nationally. As set out in 'Intermediate Care – Halfway Home' (DoH, 2009), not only should health and social care systems focus on the provision of intermediate care services (IC), but IC services that are equitable and provide quality care. Additionally, both equity and quality remain key themes within recent guidance mentioned earlier in section 2, and within Lords Darzi's report, 'Independent investigation of the NHS in England', shared nationally in Sept 2024. Therefore, on behalf of the system, ICTSG are dedicated to ensuring that the P2 IC/D2A services mobilised long-term within LLR are inclusive, caring, safe, effective, responsive, and well-led.

In view of the above, throughout the P2 options shared within the next section of the paper, there is focus on:

- Managing all P2 IC/D2A bedded settings through the leadership and function of the LLR Discharge Hub
- Reducing the LOS from 'MOFD to actual discharge', thus reducing the impact of potential deconditioning in the acute setting whilst the patients wait for their P2 IC/D2A bed
- Ensuring 'all' LLR residents receive intermediate care in the P2 bedded setting that they are discharged to
- Ongoing collaboration of our health and social care teams to ensure safe/effective care and assessment during the IC/D2A period
- Applying 'home first' principles in the P2 bedded setting, with the focus being to support eventual discharge home where possible
- Enabling P2 IC/D2A support and assessment within the P2 bedded setting, to ensure eventual discharge within 4 weeks/28 days of arrival i.e. discharge home with or without a POC, or to a long-term bed

Additionally, ensuring continued involvement of the patient and their NOK or main carer, during the IC/D2A assessment period, to ensure we remain focussed on the voice of the person (VoP).

Note: the term 'LLR residents' refers to people living within our health and social care system who LLR are responsible for discharging from the acute setting, either because the person resides within a LLR Local Authority, and/or because they are registered with a LLR General Practitioner.

5.0 Pathway 2 Options Explored

As shared earlier within section 3, much work has already occurred through ICTSG to streamline our P2 bedded settings that provide intermediate care and meet the differing needs of our P2 patient cohorts. However, consideration and sign-off by the LLR Exec Team is required to mobilise an equitable long-term P2 IC/D2A offer for the 24hr residential needs cohort, that meets the yearly demand. Therefore, the options below have been evaluated, for consideration:

Potential Options for P2 24hr Residential Needs Cohort
A) Do nothing: ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

As outlined in appendix 8, there are several implications to consider for options A-F, due to: the complexities with caring for patients with 24hr residential care needs (see appendix 9), ensuring timely transfer of care from the acute, providing a safe environment in the community that meets the cohorts needs, and a model that supports both intermediate care and D2A assessment to enable positive long-term outcomes. For this reason, a summary for each option has been provided below relating to demand, quality, equity, safety, and financial impact markers:

Option	Beds Supported for Gap of 88 Beds	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
A	1-88	✗	✗	10 days	✗	✗	✗	✗	✓	✗	High
B	1-88	✗	✗	2 days	✓	✗	✗	✗	✓	?	High
C	1-19	✓	✓	2 days	✓	✓	✓	✗	✓	✓	Moderate
D	1-70	✓	✓	2 days	✓	✓	✓	✗	✓	✓	Moderate
E	1-88	✗	✗	2 days	✓	✓	✗	✗	✓	✓	Moderate
F	1-88	✓	✓	2 days	✓	✓	✓	✗	✓	✓	High

Note: there is a 10 day LOS from 'MOFD to discharge' for patients transferring to privately owned Residential Homes, as the Discharge Hub and IDT are beholden to the care home market for decision making and bed availability. Whereas the LOS is just two days for P2 IC/D2A beds managed by the system, as the decision making and bed allocation process is manged solely by the LLR Discharge Hub and IDT.

Based upon the available data and intel, such suggests that the options meeting the demand, quality, equity, safety, and financial impact markers for the 24hr residential needs cohort, are options C, D and F:

Possible Options for P2 24hr Residential Needs Cohort
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

In terms of the long-term plans for the P2 cohorts below:

- 24hr High Dependency Needs cohort
- 24hr Nursing Needs cohort
- 24hr Bariatric Needs Cohort

as mentioned in section 3, the system mobilised P2 IC/D2A beds to support the intermediate care needs for these cohorts (see appendices 10, 11 and 12), with plans in place to increase the beds to meet the overall demand (see appendix 5). However, such P2 bedded settings require consideration and sign-off by the LLR Exec Team as the long-term solutions. Therefore, the below summaries the demand, quality, equity, safety, and financial impact markers for those system P2 IC/D2A bedded settings:

P2 Cohort/Beds	Total Bed Demand Met	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
P2 TL Bariatric Beds: 24hr bariatric	✓	✗	✗	5 days	✓	✓	✓	✗	✓	✓	No Change
P2 Charnwood Wd: 24hr nursing	✓	✓	✓	2 days	✓	✓	✓	✗	✓	✓	No Change
P2 HD Beds: 24hr high dependency	✓	✗	✗	6 days	✓	✓	✓	✗	✓	✓	No Change

6. Recommendations by ICTSG

<u>24hr Residential Needs Cohort</u>

Based upon the review of all available data and intel by ICTSG, and considering the purpose of this options appraisal and the markers mentioned in sections 4 and 5, the group does not recommend options A, B or E for the 24hr residentials needs cohort:

Options *'not recommended'* for P2 24hr Residential Needs Cohort
A) Do nothing: ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team

Option A would leave the system in status quo with 13% of LLR residents still continuing to wait 10 days in the acute setting whilst MOFD for allocation of a standard P2 D2A RH bed; increasing potential risk of deconditioning, LLR would remain beholden to the care home market for this cohort; impacting on system flow and finance, patients would still not receive an intermediate care offer in the community; resulting in poor patient outcomes and long-term bedded care, and the Discharge Hub and IDT would still not have end to end oversight of the entire hospital discharge to D2A assessment process.

Whilst **Option B** would support patients to return home with an intermediate care offer, this option presents risks for patient safety in the community, challenges around the Human Rights Act (ECHR, 1998) and the Mental Capacity Act and Deprivation of Liberty Safeguards (DCA, 2005), challenges with avoiding hospital admission if the 24h care at home did not meet need as there is not yet a robust step-up model mobilised in LLR to meet demand, long-term patient outcomes are uncertain as this model has not been fully trialled in LLR before, and the Discharge Hub and IDT would not have end to end oversight of the entire hospital discharge to D2A assessment process. Furthermore, it is a high cost model for LLR to operationalise.

In terms of **Option E,** in recent years this model has been trialled within LLR through the block booked arrangements in the P2 Sovereign Unit and P2 Therapy Led bedded settings. During the time the bedded settings were in operation, as

with Option A the system was beholden to Residential Home (RH) management teams for decision making and confirming bed availability with such teams being accountable for the private business arrangements and CQC registration of those care homes. Therefore, most frequently only patients with assistance of one (Ao1) and lower-level care needs would be accepted, not patients with 24hr residential care needs who required assistance of two (Ao2) and higher-level support (see appendix 9 for varying needs of this cohort). Thus, resulting in empty beds in those P2 settings daily, a poor occupancy rate, poor value for money, and City and County ASC instead needing to broker standard P2 D2A RH beds without an intermediate care offer for the 24hr residential care needs patients not accepted. Therefore, the system agreed that those bedded settings were no longer fit for purpose, the beds were decommissioned in April 24, and the patients with Ao1 care needs were instead discharged home with the support of our in-house P1 intermediate care services delivered by our Local Authorities.

Again, based upon the review of all available data and intel by ICTSG, and considering the purpose of this options appraisal and the markers mentioned in sections 4 and 5, the group recommend options C, D and F as viable long-term options for the 24hr residentials needs cohort:

'Recommended' **Options for P2 24hr Residential Needs Cohort**
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource

The rational for ICTSG recommending these options is because not only are the markers mentioned in sections 4 and 5 met, all three options support the systems' ambition to mobilise a Pathway 2 service across LLR that provides both D2A assessment 'and' intermediate care for all LLR residents with 24hr care needs requiring discharge from the acute setting, thus:

- providing an equitable offer for all
- mobilising system P2 IC/D2A capacity that meets demand
- improving long-term outcomes for our residents
- ensuring value for money

In terms of the yearly bed gap of 88 x P2 IC/D2A beds for the 24hr residential care needs cohort, there is potential for the demand to be met by Options C and D combined, Options C and F combined, or Option F alone. However, in view of the systems' financial climate, position, and risks, the option/s to be agreed and mobilised requires steering from the LLR Exec Team as such depends on available system finance.

Additionally, whilst Option D is a viable option, a system led review of LLR Primary Care and Community Health Services is required to confirm if it would be possible for medical-step down patients to be discharged home directly from the acute setting, rather than transferring to P2 Community Hospital beds, to release that P2 IC/D2A bedded capacity for patients with 24hr care needs. For approximately 10 years the current system model has supported the MSD cohort in P2 CoHo beds, but recent data analysis indicates that most MSD patients who transfer to LPT have P0 or P1 social care needs upon discharge from the acute (see appendix 13), and transfer to the P2 CoHo bed for medical intervention and IC rather than having 24hr care needs that require P2 IC/D2A assessment. Therefore, with full scope, analysis, and planning for an alternative P1 system offer for the MSD cohort, there is opportunity to release up to 70 of the 204 beds aligned to the MSD/general rehab cohort in LPT (see appendix 5 and 8), for patients with P2 24hr residential care needs.

<u>24hr Bariatric, 24hr High Dependency, and 24hr Nursing</u>

In terms of patients with 24hr bariatric, high dependency, and nursing needs, as mentioned in section 3 and 5, there are already system P2 IC/D2A bedded settings in place within LLR to meet the needs of these cohorts, with existing plans in

place to meet the overall demand. Additionally, with the support of the LLR Discharge Hub, ongoing PDSA cycles and data analysis takes place within the system to monitor and review performance for those bedded settings, and to support ongoing transformation. However, the P2 High Dependency and P2 Bariatric Therapy Led bedded settings are yet to be agreed as the long-term solutions for these cohorts of patients, therefore ICTSG recommend that finance is agreed long-term to fully embed those commissioning arrangements:

P2 Cohort/Beds	Total Bed Demand Met	DC Hub led End to End inc. data	7 day/Late Admission	Ave. LOS: MOFD to DC	IC Provided	Onsite IDT Approach	24hr Nursing Cover	24hr Medical Cover	VoP Inc. During Assessment	Positive Patient Outcomes	Financial Impact
P2 TL Bariatric Beds: 24hr bariatric	✓	✗	✗	5 days	✓	✓	✓	✗	✓	✓	No Change
P2 Charnwood Wd: 24hr nursing	✓	✓	✓	2 days	✓	✓	✓	✗	✓	✓	No Change
P2 HD Beds: 24hr high dependency	✓	✗	✗	6 days	✓	✓	✓	✗	✓	✓	No Change

Note: the P2 beds on Charnwood Ward in LPT, for the 24hr nursing needs cohort, are already funded substantively.

On a final note, the current system agreement is to utilise P2 IC/D2A system bed at approx. 95-100% occupancy, hence the bed modelling shared within this paper. However, acknowledging the increase in acute hospital admission rates each year, seasonal variation, and planning for surge capacity, ICTSG request that the LLR Exec Team consider the option of instead utilising P2 IC/D2A system beds at 85% occupancy, and increase the suggested bedded capacity by 15% to support that approach; understanding the challenges with increasing the system workforce and the demand on system finance to manage an occupancy rate of 85%.

Appendix 1

The below shows the monthly and yearly percentage of P1-3 discharges from the acute setting, enabled by the LLR Discharge Hub and supported by our three local authorities. The data source is the S1 DC Hub Unit:

	2022					2022 Total	2023												2023 Total	2024									2024 Total	Grand Total
City	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	83%	77%	78%	80%	82%	80%	79%	82%	84%	73%	81%	87%	81%	88%	79%	82%	85%	87%	83%	90%	85%	83%	78%	87%	84%	86%	92%	85%	85%	83%
2	17%	23%	20%	19%	17%	19%	20%	15%	16%	24%	17%	9%	12%	10%	21%	18%	15%	13%	16%	9%	12%	12%	19%	11%	14%	8%	8%	12%	12%	15%
3	0%	0%	2%	1%	1%	1%	1%	2%	0%	2%	2%	4%	7%	2%	0%	0%	1%	1%	2%	1%	3%	5%	3%	3%	2%	5%	0%	3%	3%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	2022					Total	2023												Total	2024									Total	Total
County	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	78%	71%	82%	77%	85%	78%	84%	84%	84%	81%	76%	89%	90%	83%	87%	82%	80%	78%	83%	86%	88%	88%	85%	83%	86%	85%	82%	87%	86%	83%
2	21%	28%	17%	22%	15%	21%	15%	15%	15%	18%	22%	11%	10%	15%	11%	18%	19%	21%	16%	12%	11%	8%	13%	14%	11%	11%	15%	10%	12%	15%
3	0%	1%	1%	1%	1%	1%	1%	1%	1%	0%	1%	0%	0%	2%	1%	0%	1%	1%	1%	1%	1%	4%	2%	3%	2%	5%	3%	3%	3%	2%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

	2022					Total	2023												Total	2024									Total	Total
Rutland	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep		
1	38%	0%	86%	89%	67%	63%	100%	83%	100%	75%	67%	86%	60%	75%	67%	33%	100%	100%	73%	67%	50%	80%	100%	100%	88%	100%	100%	40%	79%	73%
2	63%	100%	14%	11%	33%	37%	0%	17%	0%	25%	33%	14%	20%	25%	33%	67%	0%	0%	24%	33%	50%	20%	0%	0%	13%	0%	0%	60%	21%	26%
3	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	20%	0%	0%	0%	0%	0%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appendix 2

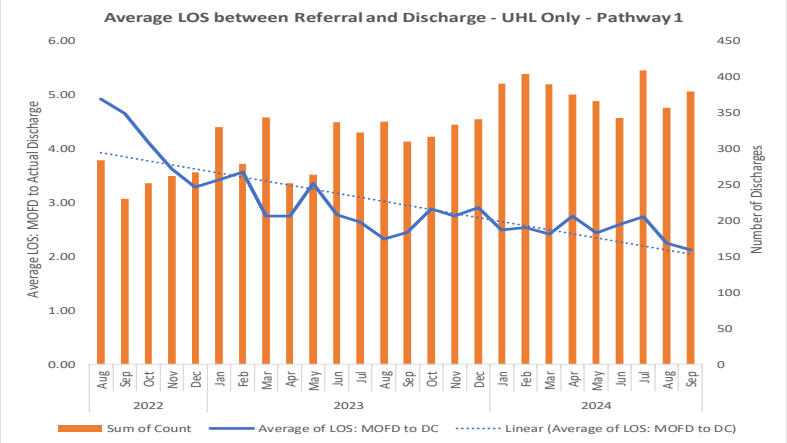
The below shows the monthly and yearly number of P1 and P2 discharges from the acute setting, and the LOS from 'MOFD to actual discharge', enabled by the LLR Discharge Hub and supported by all partners. The data source is the S1 DC Hub Unit.

Note: the LOS from 'MOFD to actual discharge' includes the additional LOS due to incomplete discharge .i.e. the discharge did not occur on the day planned due to a TTO delay

Pathway 1

Pathway	1

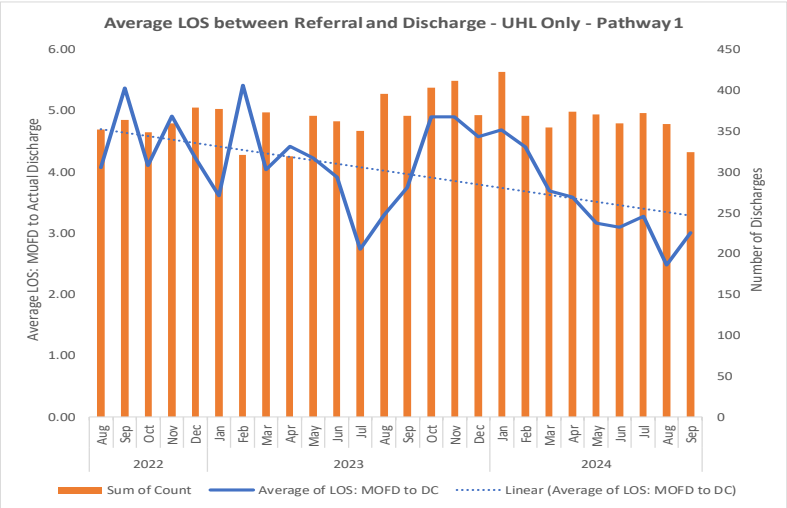
Row Labels	Average of LOS: MOFD to DC	Sum of Count
2022	**4.12**	**1295**
Aug	4.93	284
Sep	4.66	230
Oct	4.13	252
Nov	3.62	262
Dec	3.29	267
2023	**2.87**	**3769**
Jan	3.42	330
Feb	3.57	279
Mar	2.75	344
Apr	2.75	252
May	3.35	264
Jun	2.77	337
Jul	2.64	323
Aug	2.33	338
Sep	2.45	310
Oct	2.88	317
Nov	2.75	334
Dec	2.91	341
2024	**2.48**	**3416**
Jan	2.49	391
Feb	2.53	404
Mar	2.41	390
Apr	2.75	376
May	2.43	366
Jun	2.59	343
Jul	2.74	409
Aug	2.25	357
Sep	2.13	380
Grand Total	**2.90**	**8480**



Pathway 2

Pathway	2

Row Labels	Average of LOS: MOFD to DC	Sum of Count
2022	**4.54**	**1804**
Aug	4.08	352
Sep	5.37	364
Oct	4.10	349
Nov	4.91	360
Dec	4.24	379
2023	**4.15**	**4421**
Jan	3.61	377
Feb	5.42	321
Mar	4.04	373
Apr	4.42	319
May	4.23	369
Jun	3.92	362
Jul	2.73	350
Aug	3.30	396
Sep	3.75	369
Oct	4.90	403
Nov	4.90	412
Dec	4.57	370
2024	**3.52**	**3307**
Jan	4.69	423
Feb	4.41	369
Mar	3.69	355
Apr	3.59	374
May	3.16	371
Jun	3.10	360
Jul	3.27	372
Aug	2.48	359
Sep	3.01	324
Grand Total	**4.01**	**9532**



Appendix 3

The below data shows the total number and percentage of P2 discharges from the acute setting by month and year, by P2 bed type. The data source is the S1 DC Hub Unit.

- Highlighted in green shows the number and percentage of patients discharged to system P2 bedded settings where an equitable intermediate care offer is provided

- Highlighted in red shows the number and percentage of patients with 24h residential care needs, discharged to standard P2 Residential Home beds via City and County ASC where intermediate care is not provided as such beds are not system led or managed

- Highlighted in grey shows the P2 beds no longer in use, and the P2 Temporary Health Conditions (THC) cohort who do not have IC potential until their THC has resolved and therefore have their IC arranged in the community once THC Pathway support has ceased.

	2022					2022 Total	2023												2023 Total	2024									2024 Total
Partner/Pathway	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Bariatric TL Bed		2			1	3		1				1		1	1	1	1	2	8				1	1	2		2		6
City	19	24	21	19	19	102	24	13	16	20	17	10	14	12	23	23	19	16	207	12	18	17	27	13	16	12	8	15	138
County	45	49	32	45	26	197	37	30	40	39	45	26	23	35	24	39	48	52	438	35	29	22	37	38	29	29	41	27	287
LPT: CoHo	243	230	257	248	275	1253	257	231	268	234	261	273	274	299	268	285	307	267	3224	340	291	290	286	296	296	311	292	264	2666
MLCSU: HD	5	16	4	9	16	50	11	10	13	4	8	9	5	7	10	13	12	10	112	12	9	6	8	13	7	11	11	9	86
MLCSU: NH	11	15	14	15	15	70	16	18	9	8	16	19	16	19	20	9			150					3		1			4
Rutland	5	3	1	1	1	11		1		1	1	1	1	1	2	4			12	2	1	1			1			3	8
THC Pathway: City							1	1			1	1	2	2	2	2		2	14	3	3	2	3	4	3	1	1	5	25
THC Pathway: County				1	1	2			1	2	2	2	1	5	1	2	6	3	25	6	2	5	4	3	6	6	4	1	37
TL/Sov Unit Bed	24	25	20	22	25	116	31	16	26	11	18	20	14	15	18	25	19	18	231	13	16	12	8						49
Grand Total	352	364	349	360	379	1804	377	321	373	319	369	362	350	396	369	403	412	370	4421	423	369	355	374	371	360	372	359	324	3307

	2022					2022 Total	2023												2023 Total	2024									2024 Total
Partner/Pathway	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Bariatric TL Bed	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%	0%
City	5%	7%	6%	5%	5%	6%	6%	4%	4%	6%	5%	3%	4%	3%	6%	6%	5%	4%	5%	3%	5%	5%	7%	4%	4%	3%	2%	5%	4%
County	13%	13%	9%	13%	7%	11%	10%	9%	11%	12%	12%	7%	7%	9%	7%	10%	12%	14%	10%	8%	8%	6%	10%	10%	8%	8%	11%	8%	9%
LPT: CoHo	69%	63%	74%	69%	73%	69%	68%	72%	72%	73%	71%	75%	78%	76%	73%	71%	75%	72%	73%	80%	79%	82%	76%	80%	82%	84%	81%	81%	81%
MLCSU: HD	1%	4%	1%	3%	4%	3%	3%	3%	3%	1%	2%	2%	1%	2%	3%	3%	3%	3%	3%	3%	2%	2%	2%	4%	2%	3%	3%	3%	3%
MLCSU: NH	3%	4%	4%	4%	4%	4%	4%	6%	2%	3%	4%	5%	5%	5%	5%	2%	0%	0%	3%	0%	0%	0%	0%	1%	0%	0%	0%	0%	0%
Rutland	1%	1%	0%	0%	0%	1%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%
THC Pathway: City	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	0%	1%	0%	1%	1%	1%	1%	1%	1%	0%	0%	2%	1%
THC Pathway: County	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	1%	1%	0%	1%	0%	0%	1%	1%	1%	1%	1%	1%	1%	1%	2%	2%	1%	0%	1%
TL/Sov Unit Bed	7%	7%	6%	6%	7%	6%	8%	5%	7%	3%	5%	6%	4%	4%	5%	6%	5%	5%	5%	3%	4%	3%	2%	0%	0%	0%	0%	0%	1%
Grand Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Appendix 4

The below shows the month-on-month reduction of P2 discharges from our P2 Community Hospital Bedded setting in LPT, and an increase in P0, P1, and P3 discharge. The data source is the S1 DC Hub Unit.

Date	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend
Pathway 0	41	28	50	66	63	37	55	55	62	79	61	73	74	60	
Pathway 1	146	150	142	142	132	158	141	124	157	156	147	156	152	125	
Pathway 2	34	37	37	41	32	41	39	47	24	26	19	15	6	3	
Pathway 3	4	1	1	1	7	4	12	13	13	8	19	21	31	33	
Total	225	216	230	250	234	240	247	239	256	269	246	265	263	221	

Pathway 0	18%	13%	22%	26%	27%	15%	22%	23%	24%	29%	25%	28%	28%	27%
Pathway 1	65%	69%	62%	57%	56%	66%	57%	52%	61%	58%	60%	59%	58%	57%
Pathway 2	15%	17%	16%	16%	14%	17%	16%	20%	9%	10%	8%	6%	2%	1%
Pathway 3	2%	0%	0%	0%	3%	2%	5%	5%	5%	3%	8%	8%	12%	15%

Note: the only discharges now occurring as P2 from LPT are for patients who have transferred as medical-step down (MSD) and during their stay their needs emerge as 24hr high dependency, or temporary health conditions (THC). Therefore, they are discharged to system P2 High Dependency beds, or via the THC Pathway.

Appendix 5: P2 Demand, Capacity, LOS, and Outcomes Data from Aug 22 to Aug 24, from all LLR system/partner databases (created Aug 24 and updated Oct 24)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Residential Needs (exc. THC Pathway Cohort)	City: Spot RH Bed	212	16			31% home, 61% long term bed, 1% acute readmission, and 7% RIP Ave. LOS in the P2 bed is 32 days (28 in 2024)	Spot purchased. ***Oct 24:*** Framework in place until 30th June 25, but does not meet need ***Intermediate care (IC) not provided*** Ave. LOS from 'MOFD to DC into Bed' is 10 days
	County: Spot RH Bed	427	34			10% home, 42% no/SFunded service (POC/RH), 30% long term bed, and 18% RIP Ave. LOS in the P2 bed is 43 days (24 in 2024)	Spot purchased. ***Oct 24***: Framework in place until 30th June 25, but does not meet need ***Intermediate care (IC) not provided*** Ave. LOS from 'MOFD to DC into Bed' is 10 days
	UHL: The Ashton	82	6				Extra capacity beds until Aug 25 (in a RH)
	UHL: Wd 22 LGH	267	20				Extra capacity beds (onsite at LGH)
	LPT: Coalville Wd 4	170	13	15		24% home, 53% long term bed, 10% acute readmission, and 13% RIP Ave. LOS in the P2 bed is 28 days	Inc. in LPT Community Hospital bed base; opened Jan 24 for this cohort. ***IC provided.*** Ave. LOS from 'MOFD to DC into Bed' is 2 days Ave. bed occupancy is 96%
	UHL: Grace Dieu Wd	52: actual (Jan-March 24)	4				Opened between Jan and March to support winter 23/24 only. ***IC was provided***
LLR Pt OOA: 24hr Residential (exc. THC Pathway Cohort)	County: Spot RH bed	130	10			(as above for County)	As per the above for City and County re: spot purchase for UHL patients
		Total Patient Demand: 1340	**Total Bed Demand:** 103	**Total IC Bed Capacity:** 15	**Total IC Bed Gap:** **- 88**		***There is a 70% (County) v 30% (City) ASC split for the overall gap of 88 beds for this MOFD cohort: County = 62 beds and City = 26 beds***

Note: the ave. yearly patient demand includes total number of actual patient discharges. The yearly bed demand is calculated using a LOS of 28 days in the P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Bariatric Needs (primarily ***social*** care needs)	Bariatric Therapy Led Bed at Aaron Court and Everdale Grange	12	2	2	0	53% home, 24% long term bed, and 23% readmission to acute Ave. LOS in the P2 bed is 58 days	Block booked Bariatric TL Beds are commissioned by the ICB until March 31st 25. ***IC provided.*** Ave. LOS from 'MOFD to DC into Bed' is 5 days
LLR Pt OOA: 24hr Bariatric (primarily ***social*** care needs)	Bariatric Therapy Led Bed at Aaron Court and Everdale Grange	4	(as above)	(as above)		(as above	(as above)
UHL: 24hr Bariatric Needs (primarily ***health*** care needs)	LPT: CoHo Bed	38	4	(none specific)	4	74% home, 9% long term bed, and 17% readmission to acute Ave. LOS in the P2 bed is 30 days ***IC provided.***	There aren't beds within LPT specifically commissioned for bariatric patients. Two beds close in LPT to support one bariatric patient, as staffing and bed capacity allows. Primary care needs for the cohort = 60% social and 40% health Ave. age is 65 yrs (mode is 63 yrs) Ave. LOS from 'MOFD to DC into Bed' is 5 days
		Total Patient Demand: 54	**Total Bed Demand:** 6	**Total IC Bed Capacity:** 2	**Total IC Bed Gap:** **- 4**		***The ICB are aiming to precure four more Bariatric TL beds across winter 24/25, until March 25***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 42 days in the P2 bed for this cohort (9 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr Nursing Needs	LPT: Charnwood Wd	169	13	10	-3	15% home, 42% long term bed (43% NH and 57% RH) 24% readmitted to acute, and 19% RIP Ave. LOS in the P2 bed is 28 days ***IC provided.***	Patients are MOFD upon arrival on the Wd. Inc. in LPT Community Hospital bed base; beds opened Oct 23 long term LOS from 'MOFD to DC into Bed' is 7 days Ave. bed occupancy is 94%
		Total Patient Demand: 169	**Total Bed Demand:** 13	**Total IC Bed Capacity:** 10	**Total IC Bed Gap: - 3**		***LPT are aiming to provide three more beds from winter 24/25 onwards***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 28 days in a P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly P2 Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL: 24hr High Dependency	HD Bed at Everdale Grange	114	9	15		**<u>Shared by ICB in Oct 24:</u>** ***IC provided.*** 74% Long-term bed: 27% CHC, 31% FNC with or without 1:1, 13% Fast Track, 1% S117, and 28% RH. 13% home, 12% readmission, and 1% RIP. Ave LOS in the beds is 32 days (Apr-Sept 24)	Block booked beds commissioned by the ICB until June 25. Spot purchase beds are also brokered if HD patients are declined by Everdale Grange LOS from 'MOFD to DC into bed' is 6 days Occupancy in May to Sept 24 = 80%
LLR Pt OOA: **24hr High Dependency**	HD Bed at Everdale Grange	3	1	(as above)			(as above)
LPT: 24hr High Dependency	HD Bed at Everdale Grange	14	1				
		Total Patient Demand: 131	**Total Bed Demand:** 11	**Total IC Bed Capacity:** 15	**Total IC Bed Gap: + 4**		***The PDSA review by the ICB continues. The available beds will support winter 25/26***

Note: the ave. yearly patient demand includes total number of actual patient discharges, and the number of patients waiting this type of P2 bed each day. The yearly bed demand is calculated using a LOS of 28 days in the P2 bed for this cohort (13 pt per bed, per yr)

P2 Patient Group	P2 Bed Type	Ave. Yearly Patient Demand	Yearly P2 Bed Demand	Current P2 Bed Capacity	P2 Bed Capacity Gap	Outcome for Patients from P2 Bed	Relevant Information
UHL and LLR Pt OOA: **24hr Rehab,** **Medical Step Down (MSD),** **and Palliative Care**	LPT: CoHo Bed Exc. 55 beds: Coalville Wd 4 x 15 Charnwood Wd x 10 Stroke Wds x 30			204	***** The P2 CoHo bed gap relates to Charnwood Wd, bariatric patients, and stroke rehab (as per above and below data/info) *****	85% home and 15% long terms beds/THC pathway Ave. LOS in the P2 bed is 21 days ***IC provided.***	Inc. in LPT Community Hospital bed base of 259 beds LOS from 'MOFD to DC into Bed' is 2 days, which includes the additional LOS due to incomplete transfers (aka delays) Ave. bed occupancy is 93% (acknowledging delayed transfer of patients)
				Total IC Bed Capacity: 204			***34% of all patients who transfer into a P2 CoHo bed are sub-acute with medical step down needs.***

Note: Whilst LLR hosts P2 stroke pathway beds across the system (2 rehab wards in LPT and 1 rehab ward in UHL), such neuro speciality beds are commissioned as per NHSE/NICE guidance, not D2A. Additionally, neuro recovery, rehabilitation, and reablement is already provided within those settings, alongside discharge planning and assessment by the LLR IDT. Therefore, demand and capacity modelling for the stroke rehab cohort is being managed by UHL and LPT collectively, with the support of the respective QI Leads

Appendix 6: Data to relating to UHL at The Ashton from Aug 22 to July 24, from system/UHL databases

Due to ongoing system challenges relating to the total number of medically optimised patients residing in University Hospitals of Leicester (UHL), in Aug 2022 UHL commissioned and mobilised 23 beds within The Ashton Care Home in Hinckley, as an extension of the UHL bed base. The beds were opened to specifically support flow for the Specialist Medicine (SM) CMG.

In preparation for mobilising the beds, UHL worked collaboratively with the LLR Discharge Hub to ensure the right cohort of patients were internally transferred to The Ashton, whilst they waited their discharge plan. Initially the aim was for the beds to be utilised for City and County LA residents waiting P2 D2A Residential Home beds via the Discharge Hub, but due to challenges with the estate and contract for The Ashton, the approach adapted to internal transfer of P0-3 patients from SM CMG. The challenges included: terms of CQC registration, availability of equipment, laundering and infection prevention, catering and infection prevention, and medical cover.

Up until May 2024, all patients of the P2 24hr residential care needs cohort who transferred to The Ashton received intermediate care by the UHL workforce based there, but did not receive D2A assessment by ASC. However, as part of our LLR intermediate care (IC) journey and recognising the provision of IC within that setting, from May 13th 2024 the IDT were mobilised to support D2A assessment alongside the IC offer at The Ashton. Therefore, from that date onwards patients with P2 24hr residential care needs who transferred to The Ashton no longer had a P2 D2A RH bed brokered but remained in that setting to complete their P2 IC/D2A period, and were discharged via P0, P1 or P3 only.

The below data collated by UHL using NerveCentre, indicates 417 x P2 patients transferred to The Ashton between Aug 22 and July 24 (2 year period), and shows the pathway the patient was discharged by. The data highlighted in green shows that 142 x patient's needs converted from P2 to P0 and P1.

Note: the S1 DC Hub Unit does not capture data regarding the internal transfers and P0 discharges as such is managed by UHL internally.

Discharge from The Ashton for P2 D2A Cohort

Count of Discharge Date	2022						2023													2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	Jun	Jul	2024 Total	Grand Total
P0			3	1	4	**8**	3	1	1	5	3	2	6	7	4	5	2	2	**41**	2			1			**3**	**52**
P1	1		7	1	2	**11**	6	4	9	2	5	9	5	6	2	1	10	4	**63**	8	3	2		2	1	**16**	**90**
P2		11	9	12	13	**45**	16	16	7	27	19	14	15	15	13	20	17	22	**201**	16	4	2	5		1	**28**	274
P3																									1	**1**	1
Grand Total	**1**	**11**	**19**	**14**	**19**	**64**	**25**	**21**	**17**	**34**	**27**	**25**	**26**	**28**	**19**	**26**	**29**	**28**	**305**	**26**	**7**	**4**	**6**	**2**	**3**	**48**	**417**

The below data collated from the S1 DC Hub Unit highlights all P1-3 discharges progressed by the LLR Discharge Hub from The Ashton between Aug 22 and July 24 (2 year period). The data highlighted in green indicates that 22 x patients were discharged by P3 via City and County from the date the P2 IC/D2A approach commenced at The Ashton.

Note: all P2 D2A RH bed discharges from The Ashton via City and County are included within the overall P2 D2A RH discharge data for all UHL patients via ASC between Aug 22 and July 24.

Count of Discharge Date	Co																												
	2022					2022 Total	2023												2023 Total	2024							2024 Total	Grand Total
Row Labels	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul		
Pathway 1	9	28	24	25	20	106	33	20	30	13	21	42	36	31	18	21	20	16	301	28	25	22	28	33	21	25	182	589
City	1	7	10	7	11	36	9	2	8	3	10	17	17	12	3	5	5	5	96	9	6	6	14	8	5	14	62	194
County	8	21	12	16	8	65	23	18	22	10	10	22	17	17	14	15	15	11	194	17	19	16	14	24	16	9	115	374
MLCSU: EOL			1			1						1							1					1			1	3
Rutland			1	2		3						1	1	1					3	1							1	7
THC Pathway: City					1	1	1					1	1	1		1			5							2	2	8
THC Pathway: County											1				1				2	1							1	3
Pathway 2	11	26	12	24	20	93	19	19	24	23	19	23	19	18	18	31	20	24	257	23	12	16	20	12	4	5	92	442
City	2	3	4	8	7	24	6	4	8	5	5	4	3	4	6	5	5	5	60	2	4	6	6	3	1	1	23	107
County	7	19	8	10	6	50	6	12	12	13	9	9	11	9	7	20	12	16	136	15	4	5	11	2	2		39	225
LPT: CoHo				2	4	6	3	3	2	2	1	4			3	3	2	2	25	3	3	1	2	5	1	1	16	47
MLCSU: HD	1	1			1	3							1						1					1		1	2	6
MLCSU: NH		1		1		2	2		2	2	2	3	3	3	2	1			20									22
Rutland		2		1	1	4								1					1				1				1	6
THC Pathway: City							1					1	1						3	1	1	1		1			4	7
THC Pathway: County				1	1	2					2	1		1		2	1	1	8	2		2	1			2	7	17
TL/Sov Unit Bed	1			1		2	1			1		1							3									5
Pathway 3		1	1	2		4		1	2	1	3	4	2	4	4		1	1	23	1	1	2	4	5	5	14	32	59
City											1	2	2	2					7		1		2		1	7	11	18
County			1	2		3		1	2	1	1	1		1			1	1	9			2	1	5	4	5	17	29
MLCSU: EOL		1				1					1	1		1	2				5	1			1			1	3	9
MLCSU: NH															2				2							1	1	3
Grand Total	20	55	37	51	40	203	52	40	56	37	43	69	57	53	40	52	41	41	581	52	38	40	52	50	30	44	306	1090

Summary

Based upon the available system data across a two year period, it indicates that 164 patients (ave. 82 a year) were supported by UHL at The Ashton, who would have otherwise required a P2 D2A RH bed via ASC. Such will be included within the overall demand/capacity modelling for long term P2 plans within LL

Appendix 7: Data to relating to Wd 22 LGH in UHL from Sept 22 to July 24, from system/UHL databases

Due to ongoing system challenges relating to the total number of medically optimised patients residing in University Hospitals of Leicester (UHL), in Sept 2022 UHL opened 16 beds on Wd 22 LGH to support flow for the Specialist Medicine (SM) CMG. Over time the bed base increased to 20 beds.

The 20 beds on Wd 22 LGH are managed by UHL internally for patients residing in SM CMG only. An internal referral process takes place whereby patients with P2 care needs showing rehabilitation potential are identified, and a request for internal transfer is made. Note: the Discharge Hub is not involved with this process.

UHL Therapists are aligned to the ward to support the rehabilitation approach and have a 5 day LOS to work with. In view of the need for flow and the 5 day LOS approach, 33% of patients who transfer to Wd 22 LGH are referred into the Discharge Hub for a system P2 IC/D2A bed predominantly within our community hospitals.

As per the data below, from the S1 DC Hub Unit, of 435 x P1-3 discharges from Wd 22 LGH between Sept 22 and July 24, 145 x patients were discharged to P2 IC/D2A system beds, and of which 108 x transferred to LPT for their IC/D2A journey. Also, 289 x patients' care needs converted from P2 to P1.

Count of Discharg Co	2022				2022 Total	2023												2023 Total	2024							2024 Total	Grand Total
Row Labels	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec		Jan	Feb	Mar	Apr	May	Jun	Jul		
1	**12**	**8**	**8**	**7**	**35**	**4**	**9**	**12**	**5**	**7**	**8**	**6**	**5**	**18**	**14**	**15**	**15**	**118**	**18**	**20**	**21**	**19**	**18**	**17**	**23**	**136**	**289**
N/A	12	8	8	7	35	4	9	12	5	7	8	6	5	18	14	15	15	118	18	20	21	19	18	17	23	136	289
2	**4**	**1**	**5**	**3**	**13**	**9**	**3**	**6**	**2**	**5**	**3**	**6**	**10**	**3**	**8**	**5**	**13**	**73**	**11**	**9**	**7**	**7**	**5**	**10**	**10**	**59**	**145**
COHO		1	4	2	7	5	1	3	1	4	3	3	8	2	6	4	12	52	8	9	7	7	4	6	8	49	108
HD	1				1							1	1					2	1							1	4
RH	1		1	1	3		1	1	1	1		2		1	2	1	1	11	1				1	4	2	8	22
TL/SOV	2				2	4	1	2					1					8	1							1	11
3																									**1**	**1**	**1**
NH																									1	1	1
Grand Total	**16**	**9**	**13**	**10**	**48**	**13**	**12**	**18**	**7**	**12**	**11**	**12**	**15**	**21**	**22**	**20**	**28**	**191**	**29**	**29**	**28**	**26**	**23**	**27**	**34**	**196**	**435**

Pathway	%	Comments
1	66	
2	33	28% went to P2 IC/D2A (CoHo and TL beds)
3	0	

In terms on P0 discharges from Wd 22 LGH, such data is not captured by the LLR Discharge Hub, therefore UHL provided the below data using NerveCentre. The data shows that of the patients who transferred between Jan 24 and July 24 to Wd 22 LGH with P2 care needs, 80 x patients' care needs converted from P2 to P0 (ave. 11 patients a month):

Count of Month of Discharge	Co							
Row Labels	Jan	Feb	Mar	Apr	May	Jun	Jul	Grand Total
0	8	13	10	10	12	15	12	80
Grand Total	8	13	10	10	12	15	12	80

Using extrapolation, the above data trend suggests that a further 165 patients were discharged via P0 from Wd 22 between Set 22 and Dec 23, instead of transferring from UHL to a P2 bed within the community.

Summary

Based upon the available system data over a two year period, it indicates that 534 x patients (ave. 267 a year) were supported on Wd 22 LGH, who would have otherwise required a P2 IC/D2A system bed. Such will be included within the overall demand/capacity modelling for long term P2 plans within LLR

Appendix 8: Options for Long-Term P2 Planning: for '24hr Residential Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Current Yearly Financial Impact
A) Do nothing: **ASC continue to spot purchase Residential Care Home (RH) beds within the LLR Care Home Market without a system intermediate care (IC) offer, with or without standard LPT Community Therapy input via SPA**	- Through effective IDT face to face reviews of patients at ward level, and ASC panel review, there is assurance that the patients who transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - There is a plethora of privately run Residential Homes (RH) with residential care beds across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - Ave. 10 day wait for a P2 D2A RH bed via ASC (MOFD to actual discharge), increasing risk of deconditioning in hospital ***- Intermediate care (IC) is not provided in the RH beds, only D2A assessment, which results in poor long-term outcomes for our patients*** - Dependent on ward level referral to LPTs SPA, some patients receive standard Community Therapy input and others don't - Nationally 80% of patients who are discharged from hospital to RH beds without an intermediate care offer, never return to their own home and remain in long-term residential care; locally this is approx. 60% - Saturation of LLR Care Home beds - Self-funders having to use their life's savings to fund long-term RH beds, when they may have returned home with IC - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The gap of 88 x system IC/D2A beds for this cohort would remain*** - Ave. 10 day wait for a P2 D2A RH bed via ASC (MOFD to actual discharge), impacting upon system flow - The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT - RHs often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - There are many RHs for ASC to cover, to provide effective case management and D2A assessment - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - All County LA patients must be discussed at County ASC internal Fair Outcomes Panel prior to RH brokerage	- None: the quality concerns and risks relate to the RH's being privately run businesses, who: Do not provide IC Are spread across LLR Decide who/when to accept Rarely support weekend or bank hol admissions Prefer accepting long-term residents, not short-term Not 100% compliant with completing RH Tracker Rely on GP cover No system database for IC/D2A outcomes in RHs - Fair Outcomes Panel for County LA patients continues	These beds are financed through the system 'risk share' agreement until 31st March 25 **Cost Pre-Discharge from Acute Hospital** The proxy daily bed cost in the acute is £700. Therefore, the ave. yearly cost for LLR patients waiting 10 days in the acute for discharge to a spot purchased P2 D2A RH, is: £7000 per patient (per 10 days) X ave. yearly patient demand for UHL (1040 pt) = **£7,280, 000** **Cost During D2A Assessment Period** There are varying costs for RHs bed per week, but the ave. cost for both City and County, is: £875 bed/wk and £3500 bed/28days Based upon patient demand and a 28 day LOS in a RH bed, the ave. yearly cost for 'all LLR' residents requiring discharge to a RH bed via City (30%) and County (70%), is: City ave. = £1,232,000 (352 pt) County ave. = £2,863,000 (818 pt) Combined ave. = **£4,095,000** **Cost After D2A Assessment Period** On ave. 60% of LLR residents remain in long-term RH beds after D2A ax, and the ave. yearly cost to LLR, is: 466 pt a year x £44,200 ave. bed cost a yr (ave. £850 a wk) = £20,597,200 (exc. the approx. 43% self-funders in County) 271 pt a year x £46,072 ave. bed cost a year (ave. £886 a wk) = £12,485,512 (exc. the approx. 23% self-funders in City) Combined ave. cost = **£33,082,712** Note: approx. 10% more compared to D2A ax outcomes for pt discharged from Coalville Wd 4 **Total Ave. Yearly Cost to LLR** Prior to discharge: £7,280,000 During D2A ax: £4,095,000 After D2A ax: £33,082,712 **Total = £44,457,712**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
B) Procure 2 x 24hr carers in the patients' home, providing IC with the support of Community Therapy **Note:** the current system offer for P1 via ASC is a maximum of four calls a day with up to two carers (QDSx2), not 24hr carers	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who transfer do have 24hr residential care needs (not P1). However, this decision is based upon the current system/ASC offer of a maximum of four calls a day with up to 2 carers (not 24hr carers) - If 24hr care is precured, the IDT will continue to complete face to face reviews of patients to confirm level of need for discharge -Increase in P1 discharges, and vast decrease in P2 discharges	- ***The system IC/D2A bed gap could be met (with or without other option included)*** - The current ave. LOS for P1 discharges is 2 days, from 'MOFD to actual discharge'. However, depending on the offer available, the LOS may differ - Patients are supported in their own home ***- Both intermediate care 'and' D2A assessment would provided by health and social care partners in the patients home*** - Avoids saturation of LLR Care Home market beds - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- Data for eventual outcomes for this option does not exist within the system as it is not a historically commissioned service. Therefore, it is unclear what the impact could be for our residents - GP cover only. Risk of re-admission to the acute - ASC must align workers to all patients homes across LLR - Community Therapy must support all patients in their own homes across LLR; increased demand which will result in increased need for Therapists - There not being spare bedrooms for the carers to sleep in, so costlier waking night provision is required - Challenges with complying with Human Rights Act, and MCA Act and Deprivation of Liberty Safeguards, with 1:1 24hr care being restrictive - Challenges with brokering emergency step-up care in a RH to avoid hospital admission, should the patient not manage at home - Potential to destabilise LLR domiciliary care market - Managing expectation of patient and family when needing to reduce the POC, with 24hr care at home not a long-term offer via ASC - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	Unable to mitigate the below due to: - predicting patient outcomes to evidence the patient benefits of this option - the need for MCA/DoLs due to legislation and law - waking nights must be brokered if a spare bedroom is not available - if the 24hr care does not meet need as planned, re-admission is likely as an emergency step-up bedded solution that meets overall demand is not yet planned or mobilised in LLR However, see possible mitigations below: -re-alignment of ASC workers - Monitor re-admission data - Community Therapy recruitment - IDT to work closely with patient and NOK to manage expectations re: reducing POC during the IC/D2A assessment - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **High additional yearly cost to LLR, as the additional Community Therapy offer and 24hr carers would need be to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
C) Mobilise Grace Dieu Ward in LPT long term, with an onsite intermediate care offer	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - ***Grace Dieu Ward*** is based in Loughborough Community Hospital and ***provides 19 x P2 IC/D2A beds.*** The site hosts four wards in total, offering peer support - The LPT MDT, Discharge Hub and IDT are familiar with providing a P2 IC/D2A offer within LPT's bedded settings; with success of patients returning home with P0 and P1 support - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort on Coalville Wd 4, with success of patients returning home; the approach would be mirrored on Grace Dieu Ward - During winter 23/24 Grace Dieu Ward was hosted by UHL and supported by the Discharge Hub and IDT to provide a P2 IC/D2A offer for the 24hr residential needs cohort; with success of patients returning home - Transfers across 7 days, and no cut off time - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- 24hr Nursing cover, Medical cover during working hours, and DHU cover during out of hours, to support patients' health needs and to avoid re-admission to the acute - ***Both intermediate care 'and' D2A assessment would be provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 CoHo bed is 2 days compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Successful outcomes for patients receiving P2 IC/D2A support across LPT: approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - Data for discharge into and out of Grace Dieu Wd can be captured using the S1 DC Hub Unit and the S1 CoHo Unit - 'Reason to Reside' and 'Discharge by Pathway' shared with NHSE - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The total of 19*** **x beds** would not meet the overall gap of 88 beds for this cohort, and ***leaves a gap of 69 x system IC/D2A beds for this cohort, so a further option would need to be mobilised*** - The ward is currently used as a decant ward for LPT, to support essential estates works i.e. as an established ward closes for works essential, it occupies Grace Dieu. Therefore, LPT would not have a decant ward if Grace Dieu opened long-term - The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place - Recruitment of additional Therapists to support this cohorts' needs	- Additional option to be chosen, signed-off, and mobilised to meet overall bed gap - LPT will need to close Community Hospital beds as vital estates works take place - Further engagement and training has been supported across LPTs Community Hospital teams (completed Oct 24), to embed both IC and D2A assessment within the 28 day LOS. - ASC will align workers to Grace Dieu Wd to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS. - the LPT MDT, alongside the IDT, will ensure patients are supported out of bed and dressed in their day clothes, they will promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate - Recruitment of Therapists	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **Moderate additional yearly cost to LLR, as the 19 beds do not form the total number of long-term funded beds within LPT**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
D) Limit or cease the number of sub-acute patients who transfer to LPT from UHL into a medical step-down bed (MSD), and instead re-model the beds to provide an onsite intermediate care offer for the 24hr residential needs cohort who are MOFD **Note:** the model would mirror that provided on Coalville Ward 4	- 34% of P2 CoHo beds are utilised for the MSD cohort - Data indicates that most MSD patients have P1 social care and health intervention needs that could instead be managed by Primary Care and Community Health Services and a POC at home, and therefore not need to transfer to a system P2 bed - Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - The LPT MDT, Discharge Hub and IDT are familiar with providing a P2 IC/D2A offer within LPT's bedded settings; with success of patients returning home with P0 and P1 support - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort on Coalville Wd 4, with success of patients returning home; the approach would be mirrored across LPTs wards - Transfers across 7 days, and no cut off time - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer - Opportunity to flex beds for the 24hr nursing cohort, should there be occasions where the demand outweighs capacity on Charnwood Ward	- ***This option would provide up to 70 x system P2 IC/D2A beds*** - 24hr Nursing cover, Medical cover during working hours, and DHU cover during out of hours, to support patients' health needs and to avoid re-admission to the acute - ***Both intermediate care 'and' D2A assessment would be provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 CoHo bed is 2 days compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Successful outcomes for patients receiving P2 IC/D2A support across LPT: approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - Data for discharge into and out of LPT can be captured using the S1 DC Hub Unit and the S1 CoHo Unit - 'Reason to Reside' and 'Discharge by Pathway' shared with NHSE - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- ***The total of 70* x beds** would not meet the overall gap of 88 beds for this cohort, and ***leaves a gap of 18 x system IC/D2A beds for this cohort, so a further option would need to be mobilised*** - If the health intervention need is too high for Primary Care and Community Health Services to manage, medical step-down (MSD) patients may need to remain in the acute until health intervention complete, and instead be considered 'not MOFD' with 'a reason to reside' - The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place - Potential need to recruitment additional Therapists to support this cohorts' needs - Potential to destabilise LLR Care Home Market	- At this time, it is not possible to mitigate against the potential increased LOS in UHL should patients need to receive their remaining health intervention in the acute and not at home, as it is not yet known if Primary Care and Community Health Services have the capacity to meet the demand, or can respond within 24-48hr to support the P1 discharge - The 24hr residential needs cohort will no longer wait 10 days in UHL for a system P2 bed, but instead 2 days from 'MOFD to discharge', thus creating acute/system flow i.e. 8 less bed days for 1040 patients in UHL each year, resulting in a saving of 8,320 bed days per year. - Additionally, because most MSD patients have P1 needs not P2, they will be discharged with a POC via ASC within 2 days from being MOFD; this LOS being no different to the wait for a P2 bed in LPT for MSD, therefore not impacting on acute/system flow - Further engagement and training has been supported across all Community Hospital teams in LPT (completed Oct 24), to embed both IC and D2A assessment within the 28 day LOS. - ASC will align workers across all Community Hospital wards to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS (as they would no longer need to D2A assess patients in RH's) - the LPT MDT, alongside the IDT, will ensure patients are supported out of bed and dressed in their day clothes, they will promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate - Recruitment of Therapists	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **whilst there would be no additional cost to LLR for changing the operating model for the P2 beds hosted by LPT for the MSD cohort, there is anticipated moderate cost to the system to enable Primary Care and Community Health Services to instead provide the MSD cohort with their remaining health intervention at home (rather than within our P2 CoHo Beds or within UHL), which would need to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
E) Procure 'RH beds and staffing' within existing privately run Residential Care Homes in LLR, and provide intermediate care with onsite support from ASC, Community Therapy and Community Care Home Training Team	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - There is a plethora of privately run Residential Homes (RH) with residential care beds across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - The system has experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort - The system has prior experience of this option/model, when the system P2 Sovereign Unit and P2 Therapy Led Beds were in place - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- ***The system IC/D2A bed gap could be met (with or without another option included)*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a P2 Sov Unit or P2 TL Bed was 2 days when in place, compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Based upon our IDT approach in our current P2 IC/D2A beds, there could be successful outcomes for our patients: across LPT approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - No nursing oversight for patients with complex care needs - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards to enable discharge planning - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - Potential to destabilise LLR Care Home Market	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment, compared to spot purchasing P2 D2A RH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **Moderate additional cost to LLR, as the additional Community Therapy offer would need be to be funded long-term**

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
F) Procure 'the building, beds and staffing' within a previously run private Residential Care Home in LLR, and provide intermediate care with onsite support by Nurses, Community Therapy, and ASC. The system will also need to run and maintain the estate, with the respective staffing resource	- Through effective IDT face to face review of patients at ward level, and ASC panel review, there is assurance that the patients who would transfer do have 24hr residential care needs (not P1); varying from A01 to A02 - Empty and available care home settings available to purchase - The DC Hub and IDT have direct control of in and out flow, as the beds are system owned and managed (not beholden to Care Home market/managers): 7 days - The system can apply for CQC registration - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - The system has prior experience with providing a P2 IC/D2A offer for the 24hr residential needs cohort, within a system run bedded setting - Transfers across 7 days, and no cut off time - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required - County LA residents would not need to be discussed at County ASC internal Fair Outcomes Panel prior to transfer	- ***The system IC/D2A bed gap could be met (with or without other option included)*** - The DC Hub and IDT would have direct control of in and out flow, as the beds would be system owned - 24hr nursing oversight ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into a system P2 bed is 2 days, compared to 10 days for a RH bed, including the additional LOS due to incomplete transfer i.e. transport or TTO delay - Based upon our IDT approach in our current P2 IC/D2A beds, there could be successful outcomes for our patients: across LPT approx. 85% return home, and 15% require long-term bedded care. Compared to approx. 60% requiring long-term bedded care from a P2 D2A RH in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- Sustaining the workforce for acute services within UHL, the workforce for Community Hospital/services within LPT, whilst also sustaining the workforce required for the Care Homes purchased - GP cover only. Risk of re-admission to the acute and GP's do not register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - Potential to destabilise LLR Care Home Market - Cost of maintaining the estate (see finance section re: running cost per bed)	- Recruitment of required workforce - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment, compared to spot purchasing P2 D2A RH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **High additional yearly cost to LLR, as the additional estate and workforce would need to be funded long-term**

Appendix 9

The below is the patient criteria for the 15 x beds on Coalville Ward 4 in LPT, our system P2 IC/D2A bedded setting which operates to support the 24hr residential care needs cohort within LLR:

Coalville Ward 4 Patient Criteria

- The patient is a County or City Local Authority resident within LLR
  Note: not a Rutland LA resident
- Is an inpatient within hospital, who is medically optimised for discharge, and no longer meets the criteria to reside
- Upon discharge is unable to return home with health and social care or family support in the community i.e. currently unable to manage at home with a P1 care package and community health services
- Has 24h 'residential care' needs and requires a period of recovery, reablement and rehabilitation (intermediate care)
- Aim is for discharge home, after intermediate care and D2A assessment period to determine longer term care needs

24hr Residential Care Needs include:

- May or may not have cognitive impairment (acute and/or chronic)
- May or may not be confused (acute and/or chronic)
- Care needs can range from all care in bed with A02, to A01 with care needs as the patient is relatively able with ADL's but their cognitive impairment is the limiting factor to safety at home without 24hr supervision
- May or may not need support with hydration and nutrition
- May or may not be incontinent (urine and/or faeces)
- Mobility may range from Ao2 with hoist, to Ao1 with frame or supervision
- Wandering with or without purpose. There may be a risk of absconding
- May display altered behaviours: shouting, distress, crying, verbal aggression
- IP may include: MRSA, CRO, and covid etc

Note: if the patient's altered behaviours relate to physical aggression and 1:1 support is in place for such, the patient should be reviewed for the High Dependency Cohort and should 'not' transfer to Coalville Wd 4

Exclusion – patients who meet the following criteria:

- Rutland LA residents
- Patients for P1 discharge
- 24hr Nursing Needs Cohort
- 24hr High Dependency Cohort
- Temporary Health Conditions Cohort (aka NWB)
- CHC Fast Track discharge from the acute (EoL)
- Acquired Brain Injury Pathway

Location of P2 D2A/IC bed: Coalville Community Hospital, Coalville Wd 4, LPT

- All LLR patients who meet the criteria can transfer to Coalville Ward 4; including LLR patients in OOA Trusts who reside in a LLR Local Authority and registered with an LLR or OOA GP

Appendix 10: Options for Long-Term P2 Planning: for '24hr High Dependency Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Finance
Continue to contract and commission High Dependency Beds in a Dual Registered Care Home, *with onsite Community Therapy*, as the IC/D2A offer for the 24hr high dependency needs cohort **Note:** the alternative being to return to discharging patients to P2 Care Home beds without an IC offer, with the support of MLCSU	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr high dependency care needs (not P1) - There is a plethora of privately run Dual Registered Carel Homes (CH) across LLR - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - 1:1 provided onsite, as required - The system has experience with providing a P2 IC/D2A offer/model for the 24hr high dependency needs within Everdale Grange CH - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- ***The system IC/D2A demand can be met*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - 24hr nursing oversight as needed **Note:** compared to spot purchasing separate RH and NH beds without IC - GP cover ***- Both intermediate care 'and' D2A assessment would provided by the MDT and IDT*** - The ave. 'LOS from MOFD to actual discharge' into this bed type is 6 days, including the additional LOS due to incomplete transfer i.e. transport or TTO delay **Note:** compared to approx. 6wks (42 days) when brokering spot purchased P2 RH/NH beds without IC - Based upon our IDT approach in our current P2 IC/D2A beds, the outcomes for our patients are: 74% long-term bed, 13% home, 12% readmission, and 1% RIP **Note:** historic data for HD cohort specifically is not available - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the CH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - ASC must align workers to all the Care Homes precured, in addition to all Community Hospital wards, and UHL wards supporting P3 decision making, to enact D2A assessment - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - There will be fewer Care Homes for ASC to cover for D2A assessment **Note:** compared to spot purchasing P2 D2A RH and NH beds across LLR without IC support - System to agree and mobilise a system database for these beds, or continue to use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR as the beds are already financed by until 30th June 25, but agreement and sign-off is required for long-term funding**

Appendix 11: Options for Long-Term P2 Planning: for '24hr Nursing Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
Continue to commission Charnwood Wd in LPT as the IC/D2A offer for the 24hr nursing needs cohort **Note**: the alternative being to return to discharging patients to P2 D2A NH beds without an IC offer, with the support of MLCSU	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr nursing needs (not P1) - There is just one site for the IDT to work within for this cohort **Note:** not several NHs across LLR - The patients are supported and progressed by the LPT workforce and the LLR IDT, with a focus on both IC and D2A assessment - Overall case management is not required by MLCSU as an additional funded service **Note:** patients only receive D2A assessment in P2 D2A NH beds, not IC - Since Oct 23 when Charnwood Wd was mobilised for 24hr nursing cohort, the system has provided the P2 IC/D2A offer through this bed base/model with success **Note:** better patient outcomes compared to the P2 D2A NH bed approach - Data for discharge into and out of Grace Dieu Wd can be captured using the S1 DC Hub Unit and the S1 CoHo Unit **Note:** no system database in place for patients supported in P2 D2A NH beds	- ***The system IC/D2A bed gap can be met if three additional beds are mobilised in LPT*** - The DC Hub and IDT has direct control of in and out flow, as the beds are managed by system **Note:** we are not beholden to the care home market ***- Intermediate care 'and' D2A assessment are provided by the MDT and IDT*** - 24hr nursing oversight, Medical cover during day, and DHU out of hours - The ave. 'LOS from MOFD to actual discharge' into these P2 beds is 7 days, including the additional LOS due to incomplete transfer i.e. transport or TTO delay **Note:** compared to 11 days for a P2 D2A NH bed - Based upon our IDT approach in the P2 IC/D2A beds, there are successful outcomes for our patients: approx. 15% return home, and 42% require long-term bedded care. **Note:** compared to approx. 60 % requiring long-term bedded care from a P2 D2A NH bed in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The MDT and IDT must maintain a LOS of 28 days or less, to support system flow - The P2 IC/D2A offer is provided within a hospital environment, where hospital activities must still take place	- ASC have aligned workers to Charnwood Wd to ensure the D2A assessment is completed alongside the IC period within LPT, within the 28 day LOS. - The LPT MDT, alongside the IDT, ensure patients are supported out of bed and dressed in their day clothes, they promote the use of communal spaces and meaningful activities, and limit clinical intervention where possible/appropriate	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR, as the beds are already funded within LPT long-term**

Appendix 12: Options for Long-Term P2 Planning: for '24hr Bariatric Needs Cohort'

Please cross-reference the P2 Demand, Capacity, LOS, and Outcomes data (Aug 22 to July 24) when reviewing the below.

Option	Benefits	Quality and Equity	Risks	Mitigations	Proposed Yearly Financial Impact
Continue to contract and commission Bariatric Therapy Led Beds in Residential Homes as the IC/D2A offer for the 24hr bariatric needs cohort **Note:** the alternative being to return to discharging patients to P2 CoHo beds in LPT, resulting in two bed spaces per patient	- Through effective IDT face to face reviews of patients at ward level, there is assurance that the patients who transfer do have 24hr bariatric care needs (not P1) - Just two care homes for the IDT to visit and work within **Note:** not several care home and the Community Hospitals - Bed base supports patients with either health or social care needs (RH and NH beds) - Care home environment, with day rooms, shared dining, activities, and outdoor spaces - Already CQC registered - Already staffed to provide and support all activities of daily living, and social care needs - The system has experience with providing the P2 IC/D2A offer through this bedbase/model **Note:** Avoids the need to utilise 2 x bed spaces in LPT for each patient - Daily reporting of IC/D2A 'Reason to Reside' or 'Discharge by Pathway' to NHSE not required	- ***The system IC/D2A bed gap could be met*** ***(with or without other option included)*** - The DC Hub and IDT do not have direct control of in and out flow, as the beds are privately owned and managed - 24hr nursing oversight, as required - GP cover ***- Intermediate care 'and' D2A assessment are provided by the MDT and IDT*** **Note:** in P2 D2A RH beds they don't - The ave. 'LOS from MOFD to actual discharge' into these P2 beds is 5 days, including additional LOS due to delayed discharge i.e. TTO **Note**: compared to 10 days for a RH bed, or 5 days to a P2 CoHo bed - Based upon our IDT approach in the P2 IC/D2A beds, there are successful outcomes for our patients: approx. 65% return home, and 16% require long-term bedded care. **Note:** compared to approx. 60% requiring long-term bedded care from a P2 D2A RH bed in LLR - VoP supported through patient, NOK and carer engagement by MDT and IDT during IC/D2A assessment period	- The RH Management Team have the final say about accepting patients, not the Discharge Hub/IDT, impacting on LOS from 'MOFD to actual discharge' - RH Managers often won't accept new patients at weekends, or beyond the afternoon - GP cover only. Risk of re-admission to the acute by the RH when a patient requires support with their health needs. Also, GP's don't register new patients at weekends and bank holidays - Challenges with providing real-time occupancy, LOS, and D2A assessment data to enable PDSA reviews	- During the procurement/ contracts phase, to request that the beds are managed by the DC Hub and IDT, and the RH Management Team are informed about the transfer rather than be the final decision maker - During the procurement/ contracts phase, to request a 7 day approach to transfers so that beds can be utilised by the DC Hub and IDT during weekends and bank holidays - To fully utilise the beds by Friday, prior to the weekend - System to agree and mobilise a system database for these beds, or set-up and use excel	Rating **Red =** high additional cost **Amber =** moderate additional cost **Green =** no additional cost Score: **No additional cost to LLR, as the beds are already financed through the ICB's Discharge grant until 31st March 25, but agreement and sign-off is required for long-term funding**

Appendix 13 Data re: patients with medical-step down needs who transferred from UHL into P2 Community Hospital beds, using the S1 DC Hub Unit and S1 CoHo Unit

Review of UHL to LPT Transfers for P2 CoHo Medical Step-down Cohort (MSD)

For patients who transferred to LPT from UHL for P2 CoHo medical step-down beds (MSD) between June to Sept 24, a review took place of the RDS' submitted into the Discharge Hub identifying the patients' health and social care needs. Additionally, an internal review by LPT also took place of the patients' onward care, medical intervention, and discharge plans whilst residing in LPT; which indicated that for some patients, their MSD needs were above what had been described on the referral form.

The below shows the themes for the medical-step down support required for the patients, and the possible alternative plan for discharge from UHL (rather than to a P2 bed), based upon the patients' social care need upon arrival in LPT, should Primary Care and Community Health Services be able to provide the medical-step down intervention outside of the hospital setting. However, there is need for a system led review to take place of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home from the acute instead of to system P2 beds:

Theme for Medical Step Down	Count
Blood test and monitoring	1
Breathlessness	1
Cellulitis. Pain management	1
Constipation. Pain management	2
Constipation: laxatives	2
CXR in 6-8wks	1
Hydration and nutrition	1
Hypokalaemia. Pain management	1
Hypotension. Pain management.	1
IV antibiotics. Pain Management.	3
IV Antibiotics. Pain management.	1
IV antibiotics. Pain management. Constipation and laxatives. Wound clip	1
IV antibiotics. Pain management. Constipation and laxatives. Wound clip	1
IV antibiotics. Wound clip removal in 2	2
IV Meds. Pain management. Wound clip	1
IVAB. Pain management	1
IVI. Oxygen ween. Hydration	1
Monitor CBGs	1
NIV care support/rehab	1
Oral Antibiotics	1
Oral antibiotics. Hypotension. Medication	1
Oral antibiotics. Pain management	2
Oxygen ween	3
Pain management	15
Pain management. Constipation.	1
Pain management. Constipation:	1
Pain management. Hydration	1
Pain management. Wound clip removal	3
Pain managment	1
Resolving delirium but orientated	2
Treatment for AKI. Pain management	2
Treatment for high CBG. Pain	1
Treatment for UTI. Pain management.	1
VAC and wound management	1
Grand Total	**60**

Potential Alternative Plan to P2 Discharge From	Count	%
None: Acute Care Required	8	13
P0	1	2
P0 and Community Support	1	2
P1 and Community Support	35	58
P1 and Community Support after O2 ween	2	3
P1 and Community Support with OPAT	5	8
P1 and Community Support. VAC insitu	1	2
P1 via THC Pathway	1	2
P2 Appropriate as 24hr social care needs	5	8
P2 via THC Pathway	1	2
Grand Total	**60**	**100%**

Of the patients reviewed, the below shows the reason/pathway for the onward discharge from LPT after the patients had received their medical-step down intervention and rehab in the Community Hospital setting; such correlates with the potential alternative plan for discharge directly from UHL (rather than to a P2 bed) should Primary Care and Community Health Services be able to provide the medical-step down intervention outside of the hospital setting:

	Count	%
P0	8	13
P1	38	63
P1 THC	1	2
P2 THC RH	1	2
P3 RH	4	6
Re-admitted to UHL within 1 day	2	3
Re-admitted to UHL within 2 day	3	5
Re-admitted to UHL within 13 days	1	2
Re-admitted to UHL within 26 days	1	2
Re-admitted to UHL within 7 days	1	2
Grand Total	60	100%

Note: the average LOS for MSD patients supported in LPT for both their medical-step down and rehab is 20 days

In terms of the current ave. LOS from MOFD to actual discharge from UHL to a P2 CoHo bed, please see below:

Average of LOS: MOFD to DC	Column Labels																											
	2022						2023																		2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	May	Jun	2024 Total	Grand Total
LPT	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2
2	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2
Grand Total	2	2	2	2	3	2	2	3	2	2	2	2	1	1	2	3	3	3	2	4	3	2	2	2	2	3	2

Whilst this is not an exhaustive review of all patients who transferred from UHL to LPT into a P2 CoHo/MSD bed during June to Sept 24, and the data doesn't cover many months or even years, it does indicate that P2 beds are being utilised for patients with P0 and P1 social care needs, as our P2 Community Hospital bedded setting is currently modelled to support the medical-step down cohort. Therefore, there is the potential for such beds to be re-modelled to support the P2 24hr residential needs cohort instead, and the MSD instead be discharged home from the acute with a Pathway 1 package of care at home, with support from Primary Care and Community Health Services.

Whilst this is not an exhaustive review of all patients who transferred from UHL to LPT into a P2 CoHo/MSD bed during June to Sept 24, and the data doesn't cover many months or even years, it does indicate that P2 beds are being utilised for patients with P0 and P1 social care needs, as our P2 Community Hospital bedded setting is currently modelled to support the medical-step down cohort. Therefore, there is the potential for such beds to be re-modelled to support the P2 24hr residential needs cohort instead, and the MSD instead be discharged home from the acute with a Pathway 1 package of care at home, with support from Primary Care and Community Health Services.

As previously mentioned, the ave. LOS from 'MOFD to actual discharge' for discharge to a P2 CoHo bed is 2 days, whereas the LOS from 'MOFD to actual discharge' for the 24hr residential needs cohort waiting for discharge to a standard P2 D2A Rh bed is 10 days. Therefore, there is potential for saving many beds days in the acute each year.

Average of LOS: MOFD to DC	Column Labels																											
	2022						2023																		2024							
Row Labels	Aug	Sep	Oct	Nov	Dec	2022 Total	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2023 Total	Jan	Feb	Mar	Apr	May	Jun	2024 Total	Grand Total
City	7	6	6	5	4	6	4	5	4	6	5	5	5	4	5	3	3	3	4	3	3	3	5	4	4	4	4
1	6	4	4	4	4	4	4	3	3	3	4	4	4	3	2	2	2	3	3	2	2	2	3	3	3	3	3
2	10	12	11	10	8	10	7	14	12	15	11	14	11	11	14	9	10	8	11	10	8	8	10	8	7	9	10
3			8	46	24	22	7	5		16	11	19	16	4			19	5	13	5	16	10	11	17	18	13	13
County	6	8	6	6	4	6	4	5	4	4	4	3	3	4	4	6	5	5	4	4	4	3	4	4	4	4	4
1	5	5	4	4	3	4	3	4	3	3	2	2	2	2	3	4	3	3	3	3	3	3	3	2	3	3	3
2	11	15	12	13	12	13	8	11	8	9	10	7	8	11	11	15	13	10	10	10	10	8	9	8	12	10	11
3	4	10	21	19	3	14	6	30	14	48	15	11	28	19	27	3	7	28	19	7	11	14	18	16	14	14	15
Grand Total	6	7	6	6	4	6	4	5	4	5	5	4	4	4	4	5	4	4	4	3	4	3	4	4	4	4	4

Based on available LOS and demand data, the potential bed days saved for UHL by ceasing transfer of the medical-step down cohort and instead using the beds for MOFD with 24hr residential care needs, is below:

- Ave. yearly demand of the 24hr residential needs cohort in UHL is: 1040 x patients
- The ave. time waiting in UHL for a P2 D2A RH bed for the above cohort, from 'MOFD to actual discharge', is 10 days
- The ave. time waiting for a P2 CoHo bed for a MOFD patient in UHL, from 'MOFD to actual discharge', is 2 days
-

Therefore, acknowledging the data/intel above, the below bed savings could be made across one year:

- 1040 x patients waiting 10 days whilst MOFD is 10,400 bed days a year
- 1040 x patients waiting 2 days whilst MOFD is 2,080 bed days a year
- 10 day cohort – 2 days cohort = *8,320 bed days saved a year*

Summary

- Data indicates that, based upon current system agreed bed modelling for our Community Hospitals, P2 CoHo beds are being utilised for the medical-step down cohort with P1 social care needs. Note: the ongoing medical intervention is what drives the need for step-down into the P2 bed, to create and support system flow
- There is potential for the system P2 CoHo beds being utilised for patients with P1 care needs, to instead be used for patients with P2 24hr residential care needs; supporting the reduction in the system P2 IC/D2A bed gap for this cohort
- However, there is need for a system led review to take place of LLR Primary Care and Community Health Services to confirm if it would be possible for medical-step down patients to be discharged home from the acute instead of to system P2 beds, to release P2 IC/D2A capacity for patients with 24hr residential care needs