Wiltshire Council

Cabinet

13 December 2022

Subject:	**Pathway 2 Bed Procurement**
Cabinet Member:	**Cllr Jane Davies-Cabinet Member for Adult Social Care, SEND, Transition and Inclusion**
Key Decision:	**Key**

Executive Summary

This report sets out the rationale for purchasing new block contracts for the provision of bedded pathway 2 hospital discharge beds. The service will be provided under a new 'hub' model which is currently being piloted in the south of the county.

Patients are discharged from hospital on pathways 0 to 3 (see figure 1). A range of services are commissioned across the pathways to support patients in their onward journey. The Council's Business Plan is clear that the aim is to enable people to remain independent of formal services and to live and age well in their own homes wherever possible. Pathway 2 discharges are focussed on those patients who need a little extra support to return to their usual level of independence. This might be through a period of rehabilitation or simply time to recuperate and address any issues preventing a return home.

Current pathway 2 provision are classed as either Discharge to Assess (D2A) or Intensive Rehabilitation (IR) and experiences several issues:

- Inequitable access to therapy - As the national requirement for discharge moved at pace during the pandemic, D2A and IR beds were sought at various locations across the county. The resulting provision is a piecemeal collection of beds in homes across the county which is not an efficient use of therapy or social care resources, given the travel time between homes and inevitably results in an inequitable service for patients.

- Excessive lengths of stay – from June 2022 to September 2022 the average length of stay in a D2A or IR bed was 56 days. Some stays were over 100 days. These lengths of stay indicate that an individual would have been better suited to another placement, for example a long-term bedded care or end-of-life placement. It also reduces discharge capacity across the system.

- The beds are not meeting patient needs - The change in access criteria because of the Hospital Discharge and Community Support Policy and Operating Model[1] has created a cohort of patients with higher complexity and clinical need that current beds are unable to meet. The analysis of outcomes

[1] Hospital Discharge and Community Support Policy and Operating Model. Hospital discharge and community support guidance - GOV.UK (www.gov.uk) This guidance sets out how NHS bodies (including commissioning bodies, NHS trusts and NHS foundation trusts) and local authorities can plan and deliver hospital discharge and recovery services from acute and community hospital settings that are affordable within existing budgets available to NHS commissioners and local authorities.

(see Table 1 and Appendix A) showed excessive lengths of stay, hospital readmissions and end-of-life cases that indicates a level of complexity that is not usually compatible with intensive, short-term therapy.

- Home closures due to infection outbreaks – whole home closures are a significant risk to patient discharge and flow as it removes beds from the system and requires spot purchases elsewhere.

- Effective use of support services - The current model has become unstainable, with therapists and social care staff having to travel large distances between individual care home beds to deliver therapy and social care support. This does not make the most effective use of these resources.

The number of beds currently available for pathway 2 discharges are managed through block contracts, funded from several sources which has been in addition to recurrent Better Care Funds. This funding will cease on 31st March 2023 (figure 3). When non-recurrent funding stops we will need to manage within the recurrent funding available in the BCF and want to ensure that we have an efficient delivery model to maximise capacity review carried out in August 2021 proposed a new model of delivering the pathway 2 beds which, if successfully delivered, will increase the capacity per bed, make more efficient use of therapy, social care and provider resources and result in increasing independence and a return home for more patients.

A pilot started on 1st September to 'test' the hub model. Initial feedback from staff is positive, as is the Length of stay and outcomes for those patients admitted under the new model.

The nature of patient needs in these beds requires several supporting contracts to be in place (table 7). These cover GP support, social care and therapy input. These are recurrent contracts and we do not recommend any changes to these at this stage though we recognise there may be scope for future efficiencies. The new model of delivery will make the resourcing of the support contracts more effective through the reduction of staff travel time and the right facilities for collaborative working across organisations.

Options for the number of beds to be purchased are based on current average D2A and IR bed costs and other benchmarking evidence, including feedback from providers at the first market engagement event. The beds will be split across up to 3 hubs in the county (one will be in the south). The report recommends a total of 52 beds are purchased though final amounts will depend on bid values.

The reduction in bed provision from 1st April 2023 is a potential risk to hospital discharge flow. While there is reduced bed availability, if the model works well the throughput per bed will be increased and will therefore mitigate this risk to some extent. We are working closely with health and social care colleagues to mitigate the risks posed by a reduction in beds.

Proposal(s)

The report makes the following recommendations:

1.1 That a competition is conducted under the Wiltshire Care Home Alliance to award contracts for the provision of pathway 2 beds in accordance with the indicative timeline in this report, to establish contacts commencing on 1st April 2023.

1.2 To delegate authority to make decisions connected with the procurement and award new contracts and all associated documents to the Director Procurement &

Commissioning, in consultation with the Cabinet member for Adult Social Care, SEND, Transition and Inclusion.

Reason for Proposal(s)

1. The Council's current arrangements for 'discharge to assess' and 'intensive rehabilitation' beds finish on 31st March 2023.
2. The recent pandemic and national changes to hospital discharges has resulted in a model of delivery that is neither the best fit for patients nor financially sustainable.
3. There will continue to be a need for pathway 2 beds, which support residents in gaining their independence following a hospital admission. The ceasing of current contracts provides an opportunity to act on the recent pathway 2 review and create a more efficient, cost-effective and outcomes-based model in Wiltshire.
4. The beds will be funded by an existing Better Care Fund (BCF) budget.

Terence Herbert
Chief Executive

Wiltshire Council

Cabinet

13 December 2022

Subject:	**Pathway 2 Bed Procurement**
Cabinet Member:	**Councillor Jane Davies- Cabinet Member for Adult Social Care, SEND, Transition and Inclusion**
Key Decision:	**Key**

Purpose of Report

This report concerns proposals for the procurement of pathway 2 (PW2) bed capacity on the Wiltshire Care Homes Alliance (WCHA) platform.

PW2 beds are a short-term, time-restricted, goal-based period of care that calls on a mixture of health and social care assessments and interventions to support people to maximise their potential to live as independently as possible by recovering or continuing to improve skills because of those interventions. PW2 beds are required for people who no longer meet the NHS criteria to reside in hospital, but who are not able to return home without further recuperation or assessment in a bedded facility. These beds are not for people who clearly require long term care from hospital, are end-of-life or are likely to be readmitted to hospital. The aim is to enable people to return home.

The value of the PW2 model needs to be assessed against a measure other than just releasing hospital beds. The investment in therapy and enhanced clinical and social care support should demonstrate high levels of customers being able to return home, low readmissions to hospital, and low permanent transfer to placement in care homes

Relevance to the Council's Business Plan

Discharge services support the business plan aim to enable people to remain independent of formal services and to live and age well in their own homes. By reviewing the pathway 2 services in a timely way, the Council can make contracting decisions that deliver best value for money and ensure the right services are in place at the right time.

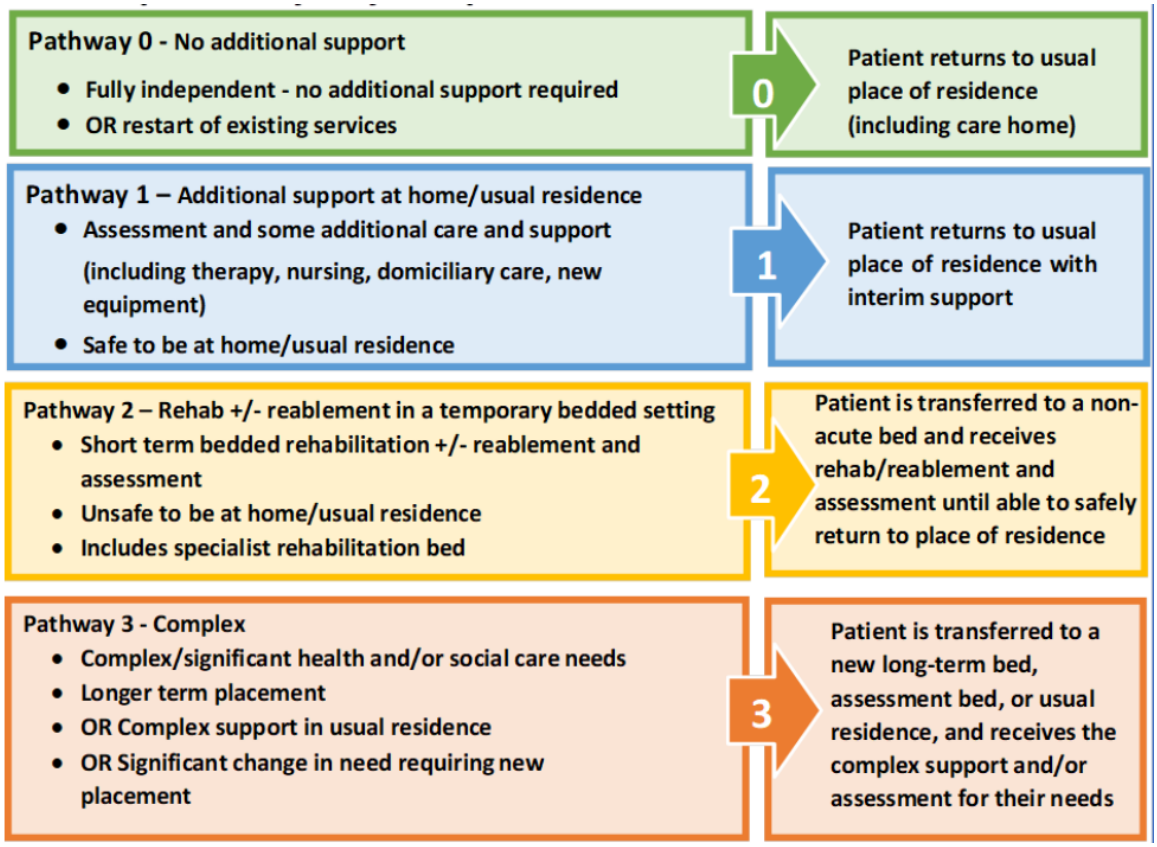
Thriving Economy - Officers have consulted with providers to ensure that these recommendations meet realistic commercial priorities for the local market while still supporting the Council's requirement to deliver best value.

Decisions that are evidence based – These proposals are informed by comprehensive supply and demand modelling, spend and activity analysis and further analysis of best practice in managing demand for care services and shaping care markets sustainably.

Background

When a patient is well enough to leave hospital there are several pathways the discharge follows, depending on the needs of the patient. Figure 1 explains these pathways.

Figure 1: Hospital discharge pathways[2]



This report is concerned with **pathway 2**.

Since March 2020, the Wiltshire health and social care system has been operating within the context of the COVID 19 pandemic and the national DHSC emergency response.

The Hospital Discharge and Community Support Policy and Operating Model released on 7 July 2021 set out the aim to embed the Discharge to Assess (D2A) model actioned during the COVID 19 response. There is an expectation that performance continues to reduce the length of stay for people in acute care, to improve people's outcomes following a period of rehabilitation and recovery and minimise the need for long-term care at the end of a person's rehabilitation.

Pathway 2 (PW2) bed provision for hospital discharge and admission avoidance are part of the service model within the Wiltshire Care Alliance, whose ambition is to ensure that people with health and social care needs are supported to live independently at home and to return there following hospital admission.

The pandemic bought urgency and priority to hospital discharge, but the focus now needs to shift to the value that these services bring to the individuals using them as well as the health and social care system. A review of the pathway 2 provision was carried out in August 2021 and its findings reported to the Governance structures of the CCG (now the Integrated Care Board – ICB) through the Alliance Board, the Locality Commissioning group, and within the BCF plan for 2021-22 which was presented to Health Scrutiny and Health and Wellbeing Boards in December 2021.

The review involved key stakeholders such as GPs, providers and acute providers. They are in support of the recommendations arising from the review. It recommended a move

[2] 1 Hospital Discharge Pathways 0, 1, 2, 3 Graphic - Library (bsuh.nhs.uk)

from the current, piecemeal provision across the county to a ‘hub’ model of delivery. The service will be procured and delivered with an outcome-based approach.

There are several issues with the current provision

Inequitable access to therapy - As the national requirement for discharge moved at pace during the pandemic, D2A and IR beds were sought at various locations across the county. As of October 2022, there were 135 pathway 2 beds across Wiltshire (figure 2), across 10 care homes. These are all block contract beds (see figure 2). New locations were needed to accommodate demand where homes were closed for infection control or other reasons. The resulting provision is a piecemeal collection of beds in homes across the county. This is not an efficient use of therapy, reablement or social care resources, given the travel time between homes and inevitably results in an inequitable service for patients.

Figure 2: Current IR/D2A beds in Wiltshire

Excessive lengths of stay – from 2022 to September 2022 the average length of stay in a D2A or IR bed was 56 days. Some stays were over 100 days. These lengths of stay indicate that an individual would have been better suited to another placement, for example a long-term bedded care or end-of-life placement. It also reduces discharge capacity across the system.

The beds are not meeting patient needs - The change in access criteria because of the Hospital Discharge and Community Support Policy and Operating Model[3] has created a cohort of patients with higher complexity and clinical need. The outcomes of the current D2A and IR beds demonstrates the level of complexity of the patients being admitted. The outcomes recorded against D2A and IR beds were analysed using a NHSE stratification tool[4] (see Appendix A for full detail and table 1 for summary results). The analysis is based on an average of 26 new referrals for D2A/IR beds per week, 104 every 4 weeks. Many of the patient outcomes such as, readmission to hospital, end-of-life or being admitted to a nursing home is an indication that they were not suited to a period of rehabilitation or had more complex needs than could be addressed during a short period of convalescence. It is often the complexity of longer-term health or social care issues that result in excessive lengths of stay and the need therefore for a high number of beds. When those patients deemed unsuitable for a pathway 2 discharge are removed from the figures, it gives an indication of the number of beds required for proposed therapy model. This analysis, in effect removes those patients who would be better suited to specialised end-of-life care, discharge to a long-term care home placement etc.

Table 1 shows that if the correct patients are admitted into a therapy based bed model, the Wiltshire system would require between 53 and 61 beds, depending on the option taken. Included in the stratification tool is a '15% capacity' addition which is recommended to aid system flow. It is unlikely, however, that this will be an affordable option.

Table 1: Outcomes for current beds

PW	Definition	Current outcomes (Oct 21-Mar 22) As % of demand	Beds required	Beds required plus 15% capacity to aid system flow
2a	Medically stable cognitively and physically able to participate in rehabilitation activities Current dependency, rehabilitation or cognition mean not yet able to be managed in community	21%	22 PW2 Hub Model	25
2b	As per 2a plus: Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation[5])	20%	21 PW2 Hub Model	24

[3] Hospital Discharge and Community Support Policy and Operating Model. Hospital discharge and community support guidance - GOV.UK (www.gov.uk) This guidance sets out how NHS bodies (including commissioning bodies, NHS trusts and NHS foundation trusts) and local authorities can plan and deliver hospital discharge and recovery services from acute and community hospital settings that are affordable within existing budgets available to NHS commissioners and local authorities.

[4] Reference to the stratification tool

[5] Refers generally to 'specialised' rehabilitation services (Level 1 and 2). These are high cost / low volume services, which provide for patients with highly complex rehabilitation needs that are beyond the scope of their local and district specialist services. Examples include specialist neuro rehabilitation following serious brain injury. Microsoft Word - Specialised Neurorehabilitation Service Standards 7 30 4 2015-forweb.doc (bsrm.org.uk)

2c	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	16%	18 Nursing beds	21
2d	As per 2a plus; Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation) delirium and complex MH with clinical complexity	10%	10 PW2 Hub Model (Complex)	12
2e	Residing in P2 due to lack of P1 capacity	6%	6 HomeFirst Service	
2f	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	11%	12 PW3	14
-	Hospital readmissions from PW2	20%	21 Community Hospital or clinical optimisation	24
Totals of PW2a, 2b and 2d			53	61

Table 2: Outcomes for current beds

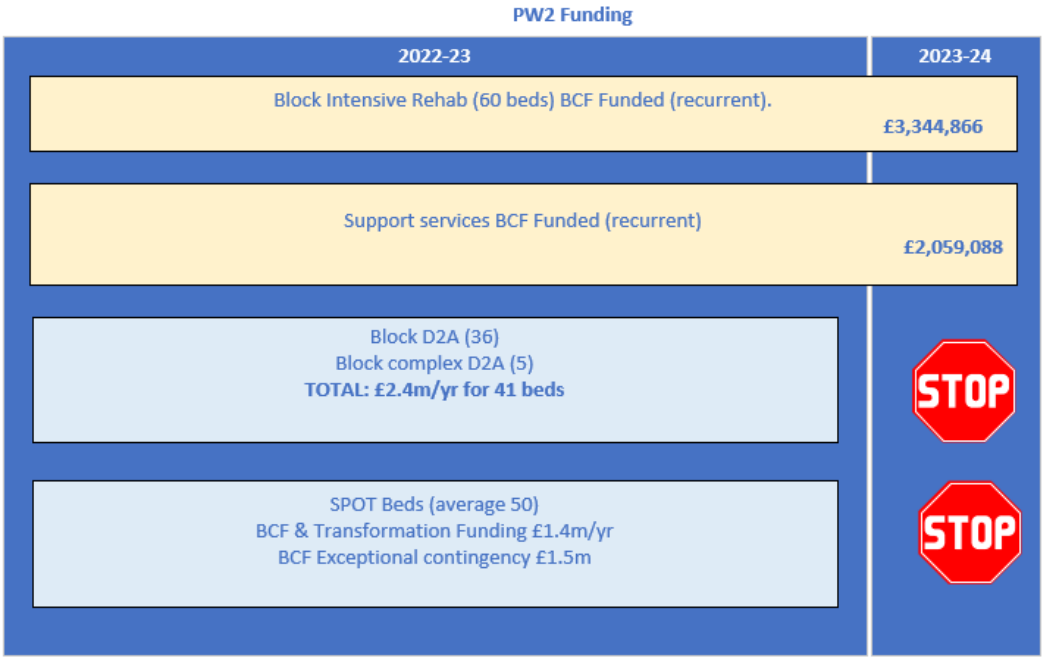
PW2 discharge outcomes	**Average % (Oct 20-Mar 22)**	**Notes**
Hospital readmission	17%	This is likely due to a worsening of an existing condition – whatever the reason, PW2 bed are not appropriate for this level of need.
Nursing home	18%	These customers would have been better suited to PW3 rather than a therapy-based bed
Residential home	14%	
Home independently	10%	This is the aim for most people being admitted to a PW2 therapy-based model
Home with Package of Care	16%	
Home First	12%	For those discharged with Home First it is assumed this could have been an option in the first instance. The bed review showed a high proportion of PW2 customers who, on clinical reassessment, were deemed to have been appropriate for Home First rather than a bedded facility.
End-of-life	13%	On many levels, this is not satisfactory, and alternative bedded provision should be found.

Funding for current beds will end in March 2023 - The current beds are funded by several sources including recurrent and non-recurrent Better Care Funding and BSW winter funding. All funding bar the recurrent BCF funding end on the 31st of March 2023 and associated contracts with the homes providing D2A and IR beds will also cease on

that date. As figure 2 shows, the recurrent funding will remain the same, but we will no longer have access to non-recurrent funding, resulting in **funding available for PW2 beds being significantly lower from the 1st of April 2023.**

The Therapy, Social Care and GP support services are also funded by the Better Care Fund. The social care support is commissioned and managed by Wiltshire Council and the Therapy support is part of Wiltshire Health and Care and commissioned by the Integrated Care Alliance. GP support is provided by agreement with practices though work is under way to bring this under more formal terms.

Figure 3: PW2 Funding



Home closures due to infection outbreaks – whole home closures are a significant risk to patient discharge and flow as it removes beds from the system and requires spot purchases elsewhere. The new model proposes using only venues that can be safely 'zoned' to contain outbreaks so only partial home closures are required, having a significantly smaller impact on service provision and system flow.

Effective use of support services - The current model has become unstainable, with therapists and social care staff having to travel large distances between individual care home beds to deliver therapy and social care support. This does not make the most effective use of these resources. A 'hub' model where all support staff have a base together will support collaborative working and increase efficiency.

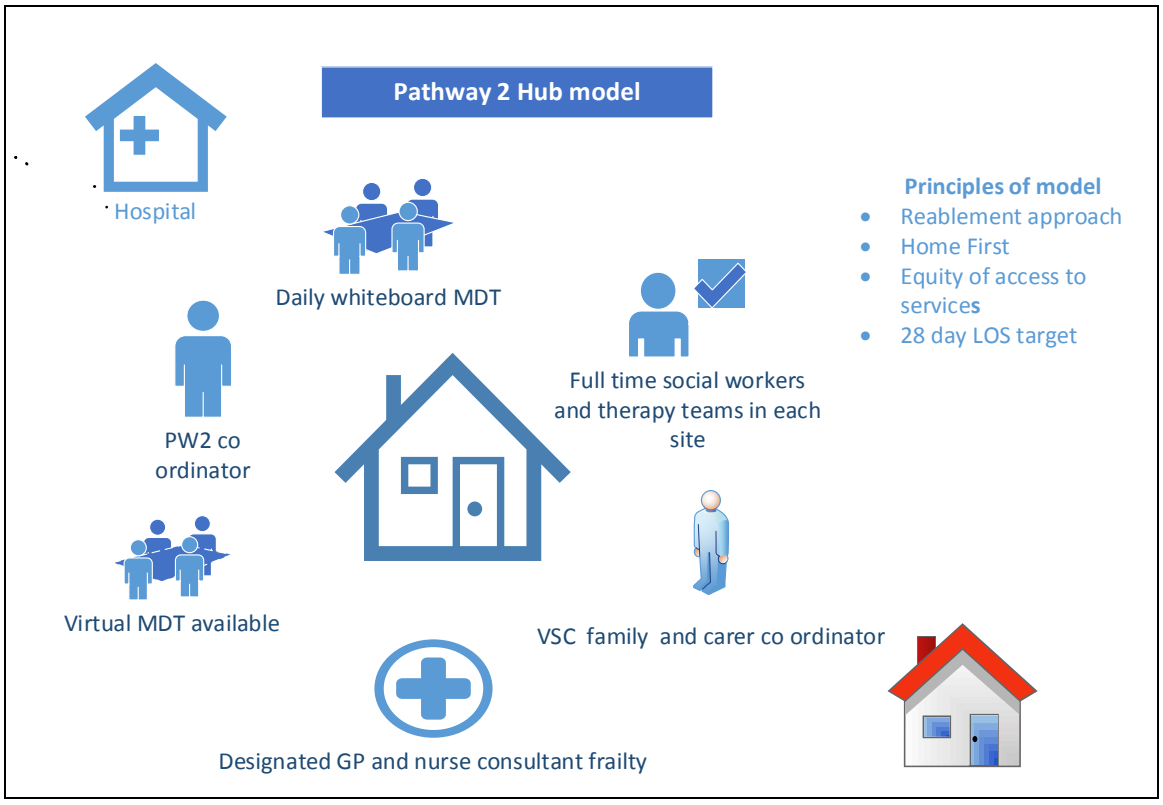
How we propose to tackle the issues.

The review further identified areas where efficiencies could be made both to pathway 2 admissions and across other discharge pathways to enable a reduction in the overall number of pathway 2 beds. We propose to deliver these beds through a new 'hub' model (see figure 4). It is considered the best option to address the issues of the current provision while remaining within the funding available.

The proposed organisational model is to establish specialist hubs – adaptable, equitable and able to deliver a short term, rapid, high-quality level of assessment and rehabilitation if required. A hub model provides economies of scale – enabling GPs, Social Care and therapy staff to concentrate support in one place.

Each PW2 hub unit will either be in the centre, south and north of the County, but will not number more than 3 units. These hubs will deliver a discharge to assess bed model and have the capability to assess and then deliver complex care and rehabilitation. The units will have a requirement to be able to separate into pods or separate areas for infection control purposes, reducing the risk and impact of whole home closures due to infection outbreaks.

Figure 4: Proposed new hub model



System Improvements

Table 3 below sets out the key performance indicators for the hub beds If the KPI for length of stay is consistently met then the turnover rate per bed increases from a turnover the current 7 to 13 patients per bed, per year. This means a higher capacity per beds. This can only be achieved by admitting the right patients.

Table 3: Key Performance Indicators for proposed model

KPI	Definition	Reporting Period	Tracked & Reported By	Minimum Standard %
Respond to referrals within 2 hrs	The Supplier will be sent the assessment (via secure email). The Supplier must respond to the referral within 2hrs hour of receipt – informing the Brokerage team of: Acceptance to admit Request for further information or Declining to admit the person, reason why not admitting will need to be given	Monthly	Supplier	85
percentage of people accepted following the completion of an assessment	Total number of referrals received, broken down by the number accepted on the information provided on the trusted assessment and the number of face-to-face assessments that were required, with reasons why.	Monthly	Supplier	80%
Number of Care home discharges at, or under 28 days	The number of customers discharged from the facility at, or under 28 days	Monthly	Tracked and recorded on administrative whiteboard	85%
The number of customers returning to their usual place of residence	Usual place of residence will include own home, care home (if previously a resident).	Monthly	Social Worker records	Improvement on baseline (30%)
The number of customers with improved customer directed goals	Customers to agree personal goals.	Monthly	Therapists and supplier	No current baseline 50%
The number of customers satisfied with		Annual and Monthly	Healthwatch (annually) and	85%

KPI	Definition	Reporting Period	Tracked & Reported By	Minimum Standard %
the pathway and care			Provider (monthly)	

We will need to provide the right support to those care homes providing the pathway 2 beds. There is existing contractual commitment from therapy and social care providers to support these beds (see funding figure) and medical support will be available via contracted GP support.

Revised eligibility criteria for the beds and clear exit pathways when patients reach a maximum of 28 days stay will be in place at the start of the contract.

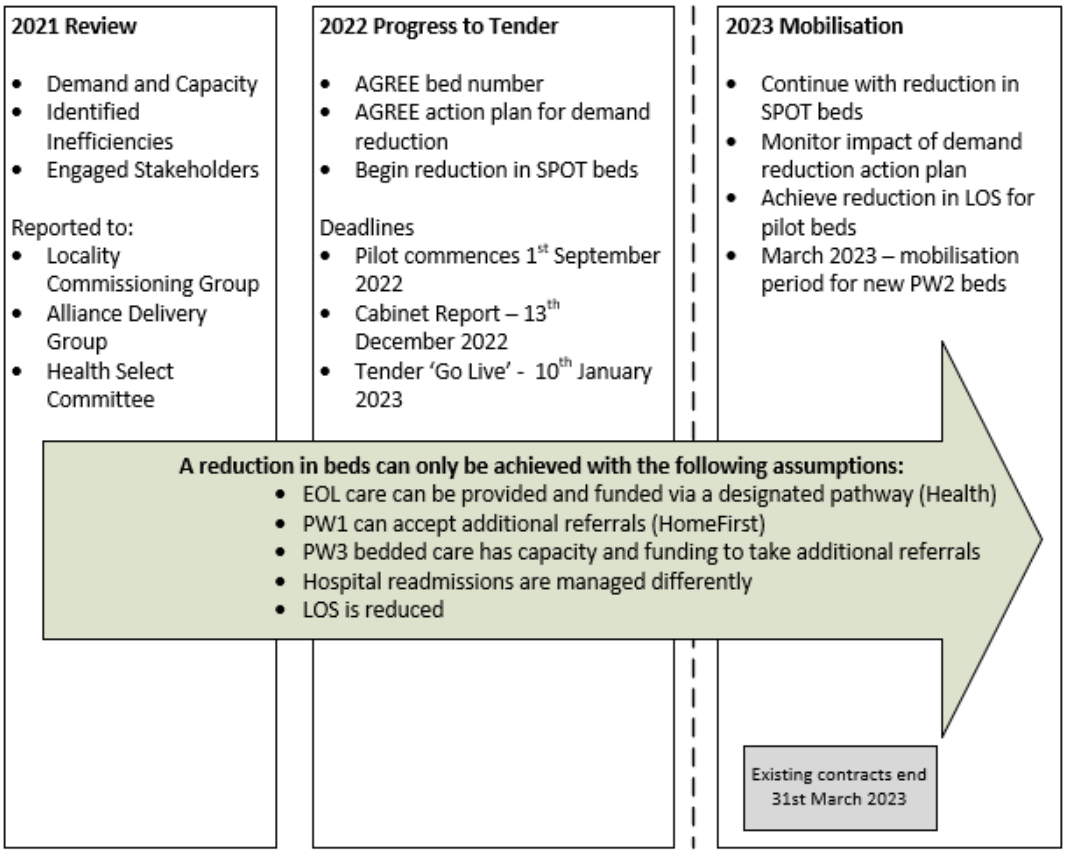
Providers will be supported in service provision as set out in table 4.

Table 4: Support for proposed model

1. GP Support	We will use existing support services to ensure medical support to the beds
2. Therapy Support	Qualified occupational therapists and physiotherapists will be available as part of the 'hub' team so access to this support is equitable across all the beds, including the more complex dementia and delirium cases.
3. Social Care support	Social workers will be part of the 'hub' teams and therefore able to be more reactive in terms of timely assessments etc.
4. Training to support a cultural shift toward reablement	Training for care home staff on the ethos and approach to reablement and increasing independence will be provided to support the service.
5. Revised eligibility criteria	To ensure only those with rehabilitation or reablement potential are admitted to the beds.
6. Reducing Length of Stay	Length of stay in Wiltshire across all D2A and IR pathways are on average more than twice the national standard of 28 days. In some instances, there are stays in D2A and IR of over 180 days. This has the biggest impact on current capacity. Delays in discharge from these beds will be addressed through the pathway 1 review. A hub model will also result in the right expertise, such as social care on site to enable timely assessment of individuals. Any reduction in length of stay, even on an incremental basis, to allow the system to calibrate and increase resources where needed, will be transformative.
7. Access to a consultant geriatrician and a virtual MDT	Support of a weekly virtual MDT and consultant geriatrician will support providers in making decisions on residents' care and ensure appropriate support of individuals.

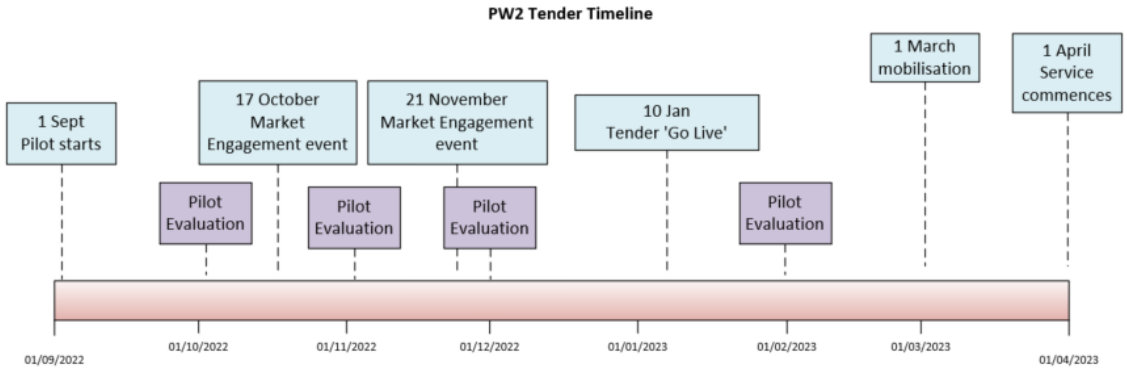
The move to a 'Hub' model and a reduction in the overall number of beds is dependent on the success of various improvement projects across the system. The planned system improvements span all pathways and are led by colleagues across health and social care and are funded in different ways. Their success is essential to managing the demand in pathway 2 (figure 5).

Figure 5: Pathway 2 implementation



Indicative Timeline
The indicative timeline is as follows:

Figure 6: PW2 Tender Timeline 1



The PW2 Pilot

The Locality Commissioning Group requested that the proposed model was tested prior to tender. A pilot model was created in partnership with Little Manor Care Home via an exemption from their existing IR contract. Commissioning worked in collaboration with the provider, social care, therapy teams, the patient flow hub and brokerage colleagues

to create a pilot that will run from 1st September 2022 – 31st March 2023. The pilot has the following aims:

- To understand what needs to be in place to successfully deliver the 28-day LOS ambition.
- To test how to identify those patients that will benefit most from a therapy-based model.
- To 'test' ways of collaborative working.
- To understand how we effect a cultural shift in the provision of therapy to improve independence and increase the number of people returning to their own homes.

The pilot is monitored daily, with performance information gathered weekly.

Outcomes

At the time of writing the PW2 pilot has been in running for a period of 12 weeks and the long-term outcomes are therefore unavailable. However, there have been some positive outcomes to date centred around the number of discharges that have taken place and the length of stay within the pilot.

- Since the pilot began there have been 44 discharges, an average of 14 a month, compared to an average of 7 per month prior to the start of the pilot. These discharges include patients who were admitted into the home prior to the pilot commencing on 1st September 2022.
- Prior to the pilot, admissions to the beds averaged 4 per month. During the pilot this has averaged 10 per month.
- The average length of stay for patients admitted during the pilot is 28 days. Some patients have exceeded the 28-day target. Of 15 patients to exceed the 28-day length of stay, only 2 is due to the patient requiring further rehabilitation. The other patients are held up by issues such as awaiting a package of care, home adaptations, or onward placements.
- The pilot is having a positive impact on those patients already resident in the home prior to the pilot starting. Many of these already have excessive lengths of stay. Of these 'legacy' patients discharged 60% returned home compared to 32% in other IR and D2A beds combined.

Service-user and staff feedback has been positive

Patients were very complimentary of the service they received, that they were aware of their rehabilitation goals and most were very motivated and intent on recovering as soon as possible to get home. All appreciated the amount of rehabilitation they were receiving.

Staff were clear that being able to work closely across teams (social care, therapy and care home) had a positive impact on care. More staff have input to the goal setting, providing a more holistic picture of the patient. This was cited as an improvement on the usual way or working. Being on site gave professionals the ability to see patients both frequently and easily so questions and issues could be addressed face to face rather than through time-consuming emails. Several care home staff commented on how the different way of working resulted in a quicker turnover of patients. While this could be a challenge in terms of familiarising themselves with patients and the additional paperwork, they cited they appreciated working with patients who were able to make a recovery and be discharged home. This was very satisfying for staff.

The pilot is influencing discussions about the number of beds required and the impact of the admission criteria. The pilot will continue past the tender timeline and will continue to shape the future service operating procedure.

Two Market Engagement events have been held, with a good level of interest from providers across the County. The events were held on the 17th October and the 21st November. An average of 20 providers attended both sessions and we have been able to share detail about how the service works in more operational detail. This helped providers to give more detailed feedback on ability to deliver and likelihood of tendering.

Main Considerations for the Council

Options

The table below shows the options considered for the procurement of the PW2 beds. Option 1 includes the costs for maintaining the current bed base. If PW2 beds are required as a speedy discharge from hospital whatever the cost, then current outcomes must be seen as within remit, acceptable and an appropriate number of beds commissioned. While it has already been acknowledged that the 2023-24 funds available are some way off affording this option, it demonstrates the costs involved if we do not attempt a different delivery model.

Options 2, 2a and 2a(i) are variations to the hub model and option 3 would require no change to service delivery except a push for a length of stay of 28 days or less.

Table 5: Options

Option	Bed No	
1. 'Do Nothing' - cater for the highest number of beds used.	150	• Highest cost option • Difficult to manage LOS • Difficult to manage flow • Unsustainable for Social Care and therapy input • Variance to national model
2. Base bed numbers on outcomes of the stratification with 15% flow but breakdown as 10 complex and 51 standard. Operating at 28 days LOS 85% of the time. Assumes support contracts cannot be amended.	61	• Excluded activity needs to be met elsewhere • Easier to deliver LOS defined bed population • Easier to manage discharge and flow
2a. Base bed numbers on the stratification results without the 15% flow broken down as 10 complex and 42 standard. Operating at 28 days LOS 85% of the time. Assumes support contracts cannot be amended	52	• Lower cost option • Lower Excluded activity needs to be met elsewhere • Easier to deliver LOS defined bed population • Easier to manage discharge and flow cost option
2a(i) As per option 2a. **Assumes reduced associated support contract costs.**	52	• Lowest cost option • Excluded activity needs to be met elsewhere • Easier to deliver LOS defined bed population • Easier to manage discharge and flow
3. Based on reducing LOS to 28days to increase capacity on current demand. No stratification	120	• Higher cost • Difficult to manage LOS • Difficult to manage flow

		• Unsustainable for SW and therapy input • Variance to national model

Costs

When factoring the support contract costs the following shows the total costs for the beds. The table references the support contracts as shown in the funding table. The contracts were set up to support 60 beds, so if less beds are purchased there may be scope for efficiencies within these contracts. This will be managed by the respective lead commissioners in health and social care.

Table 6: Costs

Option	Bed No.	Bed cost (£1246 std, £1412 cx)[1]	Support costs	Total Cost	Total Budget available	Shortfall/ Surplus
1	150	£9,718,800	£5,209,153	£14,927,953	£5,444,319	£-9,483,634
2	61	£4,038,840	£2,118,389	£6,157,229	£5,444,319	£-712,910
2a	52	£3,455,712	£2,118,389	£5,574,101	£5,444,319	£-129,782
2a(i)	52	£3,455,712	£1,805,840	£5,261,552	£5,444,319	£182,767
3	120	£7,800,000	£4,167,322	£11,967,322	£5,444,319	£-6,523,003

1. The bed cost used is an average of current costs for standard and complex beds across Discharge to Assess and Intensive Rehabilitation beds. Actual prices could be higher or lower following the tender. The prices used do, however, correlate with responses from the market engagement event and other benchmarking exercises.

Option 2a(i) is the preferred option. The reduction in support contracts shown is that already achieved with the GP support contracts. While option 2 would give the system some flex in terms of the additional 15% capacity, given feedback from the market we don't believe the beds can be purchased within the funding available. So, although the table is showing a surplus, we are not anticipating a surplus. Dependent on the tenders received, 52 beds is the maximum we expect to achieve but this will reduce to remain within the financial envelope.

Support Contracts

Table 7 and figure 3 reference the support contracts. Any changes to these contracts will be managed by the lead commissioners. It is unlikely that contract costs can be reduced in the immediate term but is something that the BCF team will review will health and social care colleagues. A more detailed breakdown of the support contracts is shown in table 7.

Table 7: Support Contracts

Contract	Budget (2023-24) Recurrent	Purpose
Social Care	£591,696	To provide dedicated social care support to patients to expedite onward discharge
Therapy	£962,082	To provide dedicated therapy support for patient rehabilitation
GP Cover[1]	£545,655	To ensure care homes are supported with dedicated GP support for patients on this pathway.
Total	**£2,099,433**	

Pricing and value for money

The price/quality split will be 60% price, 40% quality.

It is proposed that the Council uses price bandings. The banding for the standard PW2 beds is between £1480 and £1550, per bed, per week. The tenderer who submits the lowest price within that band will be awarded 100% of the available marks. Prices that are greater than that will receive a percentage of the available score until they reach the maximum price. Anything submitted that is greater than the maximum price will have their submission rejected deeming it non-compliant.

We propose to purchase beds in up to 3 hubs. These hubs must be based around where the highest demand is. This is currently the south and north/west of the county. Final locations will depend on bids, but it is vital to service delivery that providers are based in locations that match demand.

Procurement

The current contracts for D2A/IR beds come to an end on 31st March 2023. It is possible that current providers will bid for the new contracts. There is a risk that providers feel the tender is biased toward the pilot provider and we are following procurement team advice regarding the tender.
The procurement will be published to members of the Wiltshire Care Home Alliance (WCHA) and any member will be able to bid. Market engagement events will also be held which will encourage providers not already on the alliance to join.

Complex Care
We propose to purchase 10 block 'complex' beds as part of the total number of beds These beds will be designed to meet the very complex needs of people suffering from delirium. It ensures the right environment is available to keep this cohort of patients safe while providing access to therapy and reablement in a temporary setting.

Overview and Scrutiny Engagement

The PW 2 review was included within the BCF plan 2021/22 presented to the Health Select and Health & Wellbeing Board. It is also referenced in the 2022/23 BCF plan (Section 8, page 14) which is due for sign off at the Health and Wellbeing Board in December 2022. A briefing will also be provided for the Health Select Committee.

Equalities Impact of the Proposal

An initial EQIA risk assessment was undertaken to support the implementation of the WCHA which concluded that the potential impact on service users did not meet the requirement for a full Equalities Impact Assessment (EQIA).

These proposals support equitable access for any individual who has assessed needs and will be provided free to all those that need the service. Contract opportunities and service specifications for the service will require providers to demonstrate social value.

WCHA members must demonstrate that they have policies and procedures in place that are compliant with Equality Act 2010.

Service specifications under the Wiltshire Care Home Alliance state that providers must demonstrate use of local resources, take account of customer's religion and culture, value diversity and promote equality and inclusivity.

Public Health Implications

The new model will result in an increase in people receiving therapy-based support. The model will free up resources and enable the beds to benefit more people. There will be more suitable arrangements made for those that the stratification analysis showed could be better managed elsewhere (eg, end-of-life).

The tender will encourage applications from homes that are able to 'zone' their bedded provision. This helps to mitigate the risks posed to hospital discharges when homes are closed for infection control reasons. It will help to maintain the capacity needed to ensure people are discharged from hospital in a timely manner.

Staffing terms and conditions and working practices will not change but there will be wellbeing benefits to staff in terms of reduced travel time and closer collaborative working with colleagues. It is hoped that this will also bring benefits in terms of recruitment and retention across all organisations involved.

Environmental and Climate Change Considerations

The tender evaluation criteria and contract terms & conditions include provision on environmental and climate change impact to ensure this is appropriately considered.

By ensuring a range of good quality local provision in the county, residents are enabled to remain living in Wiltshire. Travel and associated fuel costs and usage for families are reduced along with related fuel emissions.

The hub model being adopted will decrease support staff travel time, further reducing associated fuel cost and related fuel emissions.

Associated Risks

Table 8: Associated Risks

Risk	Impact	Mitigation
Wider system efficiencies are not realised in a timely manner and are not in place to support the reduced number of beds.	System flow is negatively impacted by the reduction in beds and people are delayed in being discharged from hospital and other settings. Length of stay in the beds remains higher than 28 days, further negatively impacting system flow.	Working closely with health and social care colleagues to track and ensure impacts from workstreams are embedded by March 2023.
Home closures for IPC reasons	The 'Hub' model increases the impact as more beds are involved at the home.	The specification is written to ensure the service is provided from a venue suitable for 'zoning' to reduce the number of beds closed at any time due to IPC needs.

There is a risk of appeal if providers feel the tender is unfairly biased toward the pilot provider.	May delay the start of the new service	We are working closely with procurement colleagues as we develop the tender and are following their advice to mitigate this risk .

Financial Implications

The costs for the PW2 beds are met from the Better Care Fund (BCF) so there is not a direct impact Wiltshire Council budgets for this bed provision. However, the BCF has its own budgetary constraints and as such any pressure must be met from reductions in other areas of the BCF which could impact on Council services.

There is a risk that there could be financial implications on adult social care budgets as the new model is not suitable for those with long-term bedded care needs. It is therefore likely that this cohort of patients will be discharged to PW3 provision without first spending time in a PW2 bed. However this is how the pathways should be working and as long as assessments are done in a timely manner this should mitigate any increased length of stay in a PW3 bed and therefore any financial impact.

Legal Implications

Any procurement must be undertaken in accordance with the Public Contracts Regulations 2015 and the Constitution.

The recommended proposal is that the procurement will be undertaken under the Wiltshire Care Home Alliance. This means the tender will need to be undertaken in accordance with the terms and conditions of the Wiltshire Care Home Alliance Agreement. All members of the Wiltshire Care Home Alliance will have an opportunity to bid for this contract.

Legal advice has been sought on this project and will continue to be until contract award.

Workforce Implications

These proposals relate to a continuation of current activity which is delivered through external providers. There is no direct impact on the Council's own workforce.

The implications for therapy and social care support staff have been considered and both services have been involved in the co-production and delivery of the pilot. There will not be any significant change to working practices for staff in terms of locations or working hours.

Recommendations

Cabinet is recommended to: approve the purchasing of new block contracts for the provision of bedded pathway 2 hospital discharge beds.

Helen Jones (Director - Procurement & Commissioning)

Report Author: Helen Mullinger Commissioning Manager BCF

Date of report December 2022

Background Papers
Pathway 2 Review. August 2021

Appendix A – PW2 Outcomes Stratification Tool

	PW2a	PW2b	PW2c	PW2d	PW2e	PW2f	Readmissions
Definition	Medically stable, cognitively and physically able to participate in rehabilitation activities. Current dependency, rehabilitation or cognition mean not yet able to be managed in community	Medically stable, able to participate in comprehensive rehabilitation program. Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation)	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation) delirium and complex MH with clinical complexity	Residing in P2 due to lack of P1 capacity	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	Hospital readmissions from PW2
Workforce requirements	Nursing, SW, AHP	Nursing, SW, AHP	Nursing, SW	Complex specialist nursing, SW, AHP	Nursing, SW, AHP	Nursing, SW	
Current average outcomes PW2 June 22-September 22[6]	21% of demand	20% of demand	16% of demand	10% of demand very delayed	6% of demand	11% of demand	20% of demand
Bed equivalent required and numbers against 4 weekly av demand of 104	PW2 hub 22 beds	PW2 hub 21	End of life nursing beds 18 beds	Complex beds PW2 hub 10 beds	Home First 6 beds (equivalent)	PW3 beds 12 beds	Community hospital or clinical optimisation 21 beds
Plus 15% bed capacity to enable flow	22 + 3 Total 25 beds	21 + 3 Total 24 beds	18 + 3 Total 21	10 + 2 Total 12		12 + 2 Total 14 beds	21 + 3 Total 24 beds

[6] Data from April and May 2022 was skewed by Omicron (covid) cases and was therefore omitted from the outcomes data.