NHS
Ipswich and East Suffolk
Clinical Commissioning Group

GP Briefing
Admission Avoidance pilot
Bluebird Lodge Community Hospital

Background

In April 2015 Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) completed a review of community beds utilisation, (in community hospitals and care homes), to compare against benchmarking activity data from 2014. This review was undertaken to inform the system about capacity and potential future community bed needs for Ipswich and East Suffolk.

What is it?

IESCCG are keen to support member GP practices by offering the opportunity to use the beds at Bluebird Lodge Community Hospital differently. Eight of the 28 beds at Bluebird Lodge will be protected solely for the stepping up and stepping across of patients to Bluebird Lodge. This is part of a four-month pilot to support admission avoidance (excluding times of escalation).

The pilot will run from June to September 2015 and begins on Monday 1 June 2015. A brief evaluation will follow to inform the CCG of resilience and future capacity planning for 2015/16.

Benefits to patients

- Access to an appropriate care setting for medically stable patients
- Focus on return to mobility and independent living
- Opportunity to access community-based care
- Reduced admissions to acute hospital
- Increased patient choice

How do I refer?

- Contact Bluebird Lodge Community Hospital on **01473 322149**
- Please see attached flowchart for referral process for your information

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Launch details

- Referrals can be made from Monday 1 June 2015

Contact details

- For any queries regarding the protected beds pilot at Bluebird Lodge please contact the Escalation Managers at Ipswich and East Suffolk Clinical Commissioning Group on:
- escalation@suffolk.nhs.uk
- Telephone number: 01473 770031

Please see overleaf for Referral criteria.

Referral criteria

Definitions for step up and step across care highlighted below:
Step up definition - a pathway for patients who are about to or have tipped into a crisis and who have continuing diagnostic and care needs that cannot be managed in the community setting.

Step across definition – a pathway for patients who are transferred from A&E following diagnostics and assessment and who require bed-based clinical care for a time-limited period before returning to their own home.

Admission Criteria:

Patients will be all of the following:
a) Over 18
b) Medically suitable i.e. not requiring daily intervention from medical staff and seen by a doctor (or a nurse/therapist with discharge competency) within the last 24 hours prior to proposed admission
c) Registered with a Suffolk GP
d) Able to be cared for safely and with dignity within the community hospital environment, taking into account facilities, Health and Safety requirements, Deprivation of Liberty Standards
e) Not presenting an infection control risk to other patients within the community hospital setting
f) Requiring support that is best provided in a community hospital setting rather than an acute hospital
g) Requiring support that is best provided in an in-patient setting rather than their own home

Patients will also have at least one of the following needs:
a) An identified rehabilitation need i.e. clearly defined, time bound goals that are achievable for the patient and the setting, bearing in mind that goals can change during rehabilitation
b) End of life care where complex planning or symptom management is required
c) Active treatment that can be provided in the setting where it is not possible to deliver the treatment in the patient's home

Patients will be considered on their individual needs. Examples of patients who may not be suitable are:
a) Patients with purely social care needs
b) Respite for carers
c) Patients whose needs would be better met in an acute hospital / mental health facility

A nurse led multidisciplinary team will deliver 24 hour continuous support, observation or treatment within an inpatient setting. It aims, through rehabilitation and enablement interventions, to work with individuals to regain sufficient independence to return home. The team will work with patients and their carers to explore alternative discharge arrangements where home is not possible.

On admission, an assessment will inform the expected length of stay for that patient and this will vary based upon the assessed needs. Once goals can be met in another setting discharge will then be made in a timely manner.