NHS
North Norfolk
Clinical Commissioning Group

A New and Vibrant Future for Benjamin Court Healthcare Unit -

A Resource for Everyone in

North Norfolk and rural Broadland

Public Consultation and Engagement

June 19th to September 11th 2017

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NHS North Norfolk Clinical Commissioning Group (NN CCG) is a local membership organisation led by family doctors that is responsible for planning and paying for healthcare services. We do not provide healthcare like a GP Practice or hospital. Our role is to make sure the appropriate NHS care is in place for the people of North Norfolk, within the budget we have.

To find out more about NHS North Norfolk CCG go to www.northnorfolkccg.nhs.uk

The personal information you supply as part of your response to this consultation will be shared with a trusted third party. This individual third party will collate and analyse the data into a consultation report. Your feedback will remain anonymous and no personally identifiable information will be used in the consultation report. At the end of the consultation your personal information will be returned to NHS North Norfolk CCG who will securely store them in accordance with Records Management Code of Practice for Health and Social Care 2016.

What is the purpose of this document?

This document is published by NHS North Norfolk Clinical Commissioning Group (NN CCG) in conjunction with the Benjamin Court Steering Group. It offers detail on the proposed vision for the future use of Benjamin Court in Cromer and the development of a new Supported Care Service. It is the basis of the consultation process run by NN CCG to gather the views of local people between June and September 2017.

This document will set out:

- The CCG's overarching vision
- The case for change with supporting evidence
- A number of options considered by the CCG that were developed during extensive conversations with local people and clinicians
- The consultation process and how to have your say
- Opportunities for further public engagement and consultation in the future

What currently happens at Benjamin Court?

Currently Benjamin Court is an 18-bedded intermediate care unit. Intermediate care is defined as *'a range of services provided in the home or designated care setting to promote independence by providing enhanced services from the NHS and social services to prevent unnecessary hospital admissions and offer rehabilitation facilities to enable early discharge from hospital and to prevent premature admission to long term care.'*

The patients at Benjamin Court fall into three broad categories;

1. **Step-down** – patients who have either been within a ward in an acute hospital and are assessed as being medically stable but with on-going nursing needs and/or needing physiotherapy or occupational therapy input.
2. **Rehabilitation for the older person** – This is defined as the process by which patients are given the opportunity to improve physically and medically. This may not restore the patient to their previous physical baseline, but will allow them improved levels of independence. The amount of rehabilitation input for each patient is extremely variable. For some patients this will refer to sitting on the edge of the bed to help build up core stability, for others it will be mobilising around the ward or becoming more confident on the stairs.
3. **Direct GP admissions/step-up** – patients seen by the district nurse or GP and are assessed as having intermediate care needs and are admittedly direct to an intermediate care unit, often as opposed to secondary care.

In addition to the 18 intermediate care beds, there are a range of other outpatient and day care services although these are not intended for change and for this reason, do not fall within the remit of this consultation.

What is our vision for local services?

A new and vibrant future for Benjamin Court

We propose a health and community support hub comprising different types of beds and non-bed based NHS and voluntary sector services. A centre where people are given safe, high quality, person centred care, whatever the focus. This could include:

- ✓ supporting patients and their family and carers to have the most comfortable and dignified end of life care
- ✓ helping people achieve the best quality of life
- ✓ helping people to remain living independently
- ✓ an advice and support hub that brings together the best of our local healthcare and wellbeing organisations under one roof

To continue developing modern and forward-looking health and care in North Norfolk and rural Broadland

Admission into an inpatient bed is sometimes unavoidable and we will ensure that patients get the right care by the right team at the right time - that will never change; people who need to be in a hospital bed requiring care from our skilled nurses will get that bed and that care.

However, the evidence set out below demonstrates that many people who are currently in a community hospital bed could in fact be helped to live safely and independently at home – indeed people tell us they want to be cared for at home whenever possible.

Those who want to be at home, and who have been assessed as safe and medically fit should be at home. These patients will get the right support from the right staff, including NHS Registered Nurses and therapists. The CCG is also working with a project group which includes carers to design support and training to help the informal and family carers maintain their wellbeing and to help them continue in their caring role. Supported care will change the landscape for these patients and will help people remain at home, safe and independent.

Whilst our vision has good practice and patients' needs at the forefront, this is also about the best use of finite NHS resources. We can free up resources to introduce:

- specialist care to Benjamin Court in Cromer that does not exist now, such as palliative care beds so people can be assured of the best care when they need it most,
- specialist assessment beds that help people return home sooner, and
- Intravenous-therapy so people do not have to travel to Norwich.

What do we have now?

North Norfolk CCG currently commissions 73 beds across four units in North Norfolk predominantly for a population of approximately 172,000 people:

1. Kelling Hospital near Holt
2. North Walsham Memorial Hospital
3. Benjamin Court Unit (Cromer)
4. Cranmer House (Fakenham)

The units provide intermediate care beds, typically for patients being discharged from secondary care. All are run by Norfolk Community Health and Care NHS Trust (NCH&C).

In comparison to ten other CCGs in England most closely related to the demographics of North Norfolk, we have more intermediate care beds than most. The average of the other CCGs is 60 beds, however in many of these CCGs the beds are used specifically for additional purposes, for example specific palliative care beds or stroke rehabilitation.

Evidence from our neighbouring CCGs has also suggested we do not need so many beds with neither Norwich CCG, South Norfolk CCG nor West Norfolk CCG having as many beds in their area (the number of beds per CCG ranges from 24-45).

Why do things need to change?

One of the greatest challenges facing the health service today is the need to redesign services to meet the increasing needs of patients, improve the quality of care and achieve better value for money. Whilst feedback on the Intermediate Care Beds is broadly positive, they are an expensive resource with a single bed costing on average around £1,700 per week.

A key pillar of the NHS Five Year Forward View[1] is to focus on bolstering care with the community and finding alternatives to bed-based services. Whilst bed-based services will always be the best solution for some patients, it is equally true that for others this may not be the case.

To test this idea the CCG, in partnership with NCH&C, undertook eight clinically-led audits of the intermediate care beds in the four units across North Norfolk.

[1] https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

What did the clinical audits show?

The audits focused on answering the question:

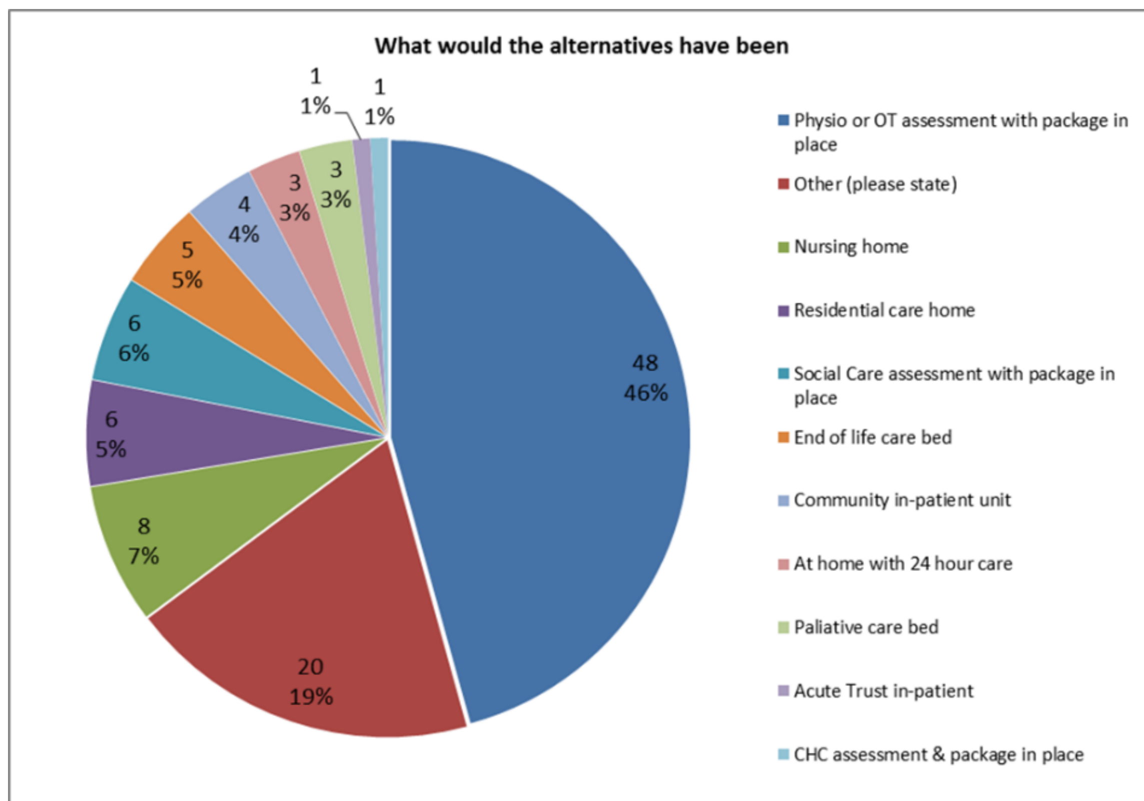
“What needs to be available in the community to enable people to be cared for at home, rather than being admitted to an inpatient unit?”

The Audit looked at

- The demographic of inpatients
- The reasons for the admission
- The referral source and route in to community inpatient units for all patients
- What alternatives are, or could be, available

On the days in question the audits showed that 82% of beds were occupied.

When looking at how to best meet the needs of the patients, the audit identified that the largest group of inpatients (46%- 48%) would have been able to go home with a Physiotherapy or Occupational Therapy assessment and care package in place if that was an option.



This evidence gave rise to the development and investment in the Supported Care model. This will enable the group of patients mentioned above to be cared for in their own home.

What is Supported Care?

The clinical audits have demonstrated that **additional** care is needed to prevent patients from being admitted to hospital or to be discharged to their own homes rather than an intermediate bed. That is why the CCG is investing around £1.5 million of **additional** resource to achieve this. This represents a significant increase in resources, equating to around 50 extra health, social care and voluntary sector staff in North Norfolk and rural Broadland. The collective name for this additional service is 'Supported Care'.

Supported Care is a new admission avoidance and supported discharge service – this means people only go to hospital if they need to, and get home again quickly if admitted. It is about making adjustments to the way services are organised so that we reach certain patients before they reach crisis point – helping them to stay independent and at home where they want to be. It is being launched on July 31st 2017 as part of an ongoing programme as the CCG develops and tests ideas and applies lessons learned.

The Supported Care service will bring together components from health, social care and the voluntary sector to deliver local joined up care closer to home delivered by a range of different health and care professionals. The service includes:

- Significant reablement care capacity
- Nursing and therapy assessment and oversight
- Informal carer education and coaching
- Community engagement and development

The CCG fully acknowledges that for some patients, an intermediate care bed provides the best solution to their needs. To that end, the intermediate care units in Kelling and North Walsham will continue to operate for rehabilitation, both step down rehabilitation (where patients are discharged from a hospital) and step up care (where patients are referred directly from a GP).

The investment in supported care does however give the health system an opportunity to change the use of the other intermediate care units - Cranmer House and Benjamin Court. In discussion with NCH&C, these units were deemed most suitable for change. Supported Care gives the CCG the opportunity to provide additional services to the community. Discussions are underway to transfer the beds currently commissioned by NN CCG at Cranmer House in Fakenham to NHS West Norfolk CCG who already commission beds there. It is expected that this will happen in August 2017. The Friends of Cranmer House have been involved with this process.

More information on Supported Care can be found in the leaflet "Supported Care in North Norfolk and Rural Broadland" which is available on the NN CCG website or from the CCG (details at the end of this document).

Supported Care – Patient's Journey

Millie is 89 years old. She lives on her own and loves her garden. Recently, whilst going outside she tripped and fell over the step from her kitchen door. Her neighbour heard her calling and phoned for an ambulance that took her to the Norfolk and Norwich hospital.

The team in the Emergency Department found that she had no broken bones but she did have a sprained her wrist and a bruised hip. Millie felt unsteady on her feet and was worried that she might fall again at home. A physiotherapist saw her in the Emergency Department and assessed her ability to walk independently. The physiotherapist felt that she was safe to walk but told Millie that she thought she could use some further physiotherapy to help improve both her confidence and mobility while she recovered from her injuries.

The physiotherapist explained that Millie could go home and the **supported care team** would come and visit her to help her get better and keep mobile whilst she got more confidence in the familiar surroundings of her home.

Millie was delighted that she was able to return to her own home and not have to stay in hospital. This way she could maintain her independence with **supported care** from the specialist healthcare staff she needed.

One week later, although still a little bruised, Millie is back to walking around as she was before she fell.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

What patient and stakeholder engagement has there been so far?

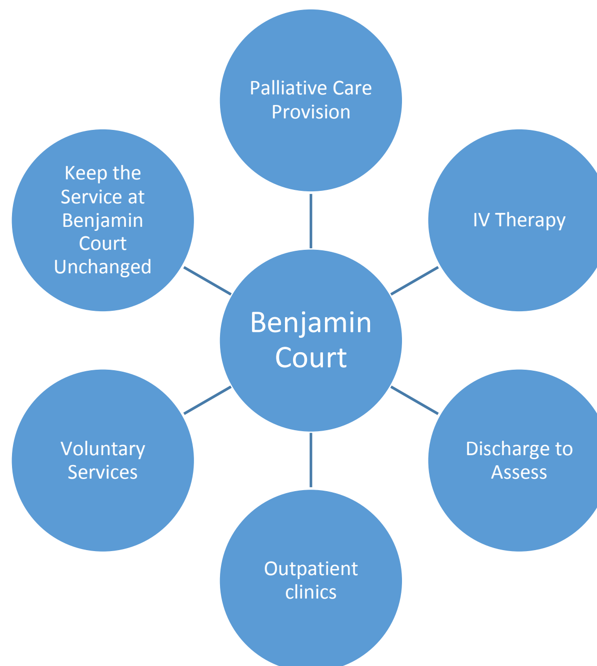
NN CCG has been working with its Community Engagement Panel (CEP), made up of local patient, carer and stakeholder representatives, since April 2016 on the development of Supported Care. A specially focused Project Group was also recruited from the CEP who have been giving more focused feedback on the development of the service. The CCG also hosts regular meetings of representatives from the local Hospital Friends groups to discuss ideas on how to ensure the units remain important local bases for health and care.

The CCG set up a specific steering group to discuss the use of Benjamin Court going forward. The steering group comprises of representatives from NCH&C, Norfolk & Norwich University Hospital (NNUH), clinicians working in the unit, GPs in Cromer and elsewhere in North Norfolk, Norfolk County Council, Cromer Town Council, Hospital Friends and members of Patient Participation Groups (PPGs) linked to local GP surgeries.

The steering group has met on four occasions. The first meeting was to provide some background to the work that was taking place and hear feedback. The second meeting was to explore some potential options for Benjamin Court going forward with the third meeting then being a discussion on the wider engagement which would take place. The fourth meeting took place on the 12th June 2017 allowing the CCG to put forward the more detailed options for the future use of the unit and finalise the details of the wider public engagement.

What are the options for the possible future of Benjamin Court Hospital?

This diagram summarises the options that have been explored. More detailed information for each option is given below.



Option 1 Keep the Service at Benjamin Court Unchanged

Summary of proposal

This option would mean that Benjamin Court continues to provide 18 beds for predominantly step down rehabilitation care. Whilst the service is well received from patients and there are no concerns over the quality of care being provided to patients, this would not address the fact that intermediate care is not the best solution for a number of patients. The CCG does not believe ‘standing still’ in this way is a good or viable option, especially in the context of the evidence from the audit mentioned above and far-reaching proposals outlined below.

On the days audited, occupancy in Benjamin Court beds ran between 83%-94%. Overall the 4 units accounting for the 79 intermediate care beds (including 6 commissioned by West Norfolk CCG at Cranmer House) run at approximately 91% occupancy. Supported care should enable, across all 4 units, 46%-48% of patients to go home.

The reduction in patient numbers would therefore make 'standing still' economically unviable at a time when precious NHS resources are under considerable pressure.

Advantages

- **No change** – There would be no disruption to the services at Benjamin Court and uncertainty for staff.

Disadvantages

- **Capacity in the wrong place** - The predicted occupancy at Benjamin Court will fall as more patients receive intermediate care at home, and this is not the best use for an expensive commodity.
- **Maintaining Skills** - Without a defined patient group, the available beds will still be used but will not be protected for specific pathways. This adds an element of clinical risk as the specialities will be varied and the nursing staff may not have the correct skills to care for the patients but more importantly patients may not be treated according to their specific needs.
- **Static service** - It would not be a service that was designed to meet the evolving needs of the community.
- **Recruitment** – finding staff to work in intermediate care in the North of Norfolk is difficult.
- **Not meeting other patient's needs** – should the beds remain in use for the current group of patients, it would prevent other patients from being able to access services locally, e.g. palliative care.
- **Value for money** – the beds at Benjamin Court cost around £1,700 per week. With other possibilities available for the use of the unit, questions would be raised around the value for money of continuing to run the current service.

Option 2 Palliative Care Provision

Summary of proposal

Palliative care aims to ensure the best possible quality of life for individuals at end of life or with advanced illness and their families. Patients with advanced disease, whatever their diagnosis, deserve the best care that can be provided and evidence shows that for each medical speciality, having dedicated wards or units to care for patients, offers the most consistent high quality of care. Our proposal of providing a

number of palliative care beds at Benjamin Court would enable multi-disciplinary teams that include consultants in palliative medicine, nurse specialists, and General Practitioners to assess, plan and deliver care that is specific to the needs of that patient and their relatives. For many patients it would mean avoiding admission to an acute hospital further from home if symptoms worsened and also offer support in a purpose-made environment for those who do not want to be (or cannot be) at home.

Evidence from palliative care staff who work in Norfolk shows that throughout the county there is a need for 49 in-patient palliative care beds. Currently there are only 18 at Priscilla Bacon Lodge (PBL) in Norwich. The care at home service has shown us there is a demand for extra provision - specifically an inpatient bed service.

There is a growing need for palliative care both in home settings and in community hospital settings, as the population ages. Proportionately people aged 85 or over receive less specialist palliative care than other age groups and importantly people with non-cancer diagnoses not only receive less specialist care, they also receive less generalist care than people with cancer (although they receive more social care).

Within the cohort of palliative care and end of life patients, there is a wide variation of age, even within North Norfolk. Young people who it was previously presumed would prefer to die at home have in fact identified that a hospice like setting, closer to home would offer more comfort and alleviate some of the fear around end of life. Montel et al (2009)[2] examined the factors that influence the choice of place of death in teenagers and young adults with cancer. Ninety percent of the families said they did not have a choice of the place of death, but would nevertheless have chosen the hospital where the death did in fact take place had they had a choice.

When it comes to numbers of community palliative care beds and provision to manage patients symptoms in their own home, there is wide variation both across the county, and among our other 10 comparative CCGs. Creating pathways for palliative patients would potentially increase the number of patients who could benefit by being referred to the service.

Advantages

- **Satisfy unmet demand** - There is a high demand for this service from the data given to us by our palliative care colleagues which is not currently being met in the most effective way – placing palliative care beds within the community would achieve this.
- **Local resource** - Benjamin Court would continue to serve the whole community and provide a local service for these patients.
- **More services available** - The unit would potentially form part of the palliative care directorate meaning that admissions into a palliative care bed at Benjamin

[2] Montel, S. Laurence, V. Copel, L. Paquement, H. and Flahault C. (2009) Place of Death of Adolescents and Young Adults With Cancer: First Study in a French Population, Palliative and Supportive Care, 7, pp. 27-35.

Court would be managed by Pricilla Bacon Lodge (PBL). A co-ordinator at PBL would triage each referral, refer to a palliative care consultant where appropriate and admit patients directly from the community, enabling patients to avoid an admission into NNUH. Patients already within the NNUH that required ‘fast tracking’ home could also be stepped down into these beds, getting them at least one step closer to their preferred place of death.

- **Clinical improvement** - Pain and symptom control is one area that is central to palliative care and would be one of the core aims of the Enhanced Palliative Care beds at Benjamin Court (although palliative care is also a much wider concept). There is some evidence on differences in pain control depending on the setting. In a recent National Survey of Bereaved People in England, pain was reported as being relieved ‘completely, all of the time’ in a non-acute inpatient setting almost twice as often as in an acute inpatient bed and three times more likely than when patients were at home.
- **Better for patients** - Having a dedicated unit for Palliative care would mean that care would be targeted specifically at each patient, physically and emotionally. The patient would have access to specialist services that could treat and control not only pain but other symptoms synonymous with palliative patients. Additional this would include emotional and psychological support for patients and their relatives, creating a service around a patient and their specific needs. The ward at Benjamin Court lends itself to privacy and dignity for patients and their families by having individual rooms to care for patients during what can be a very difficult time.
- **Releases beds in secondary care** – providing palliative care beds within the community prevents patients from being admitted to secondary care, thus releasing beds for those patients who are acutely unwell.
- **Better for staff** - By having a specific patient group, nursing staff will be able to develop more focused skills needed for this more complex patient group. They will identify pathways for patients being discharged to a variety of settings. This would include discharging patients home which would have a positive impact on patients who wish to die in their usual place of residence and could allow, in the future, patients to be admitted to the unit directly ensuring the best patient journey. Many nurses say they find most rewarding. For patients at the end of their life, there is one chance as health care professionals to get it right, and achieve their priorities of care. Focusing the care provided at Benjamin Court would mean that nurses’ confidence and competence in both enhanced Palliative care and end of life care would further develop.

Disadvantages

- **Time needed for service to fully develop** - There will be a transitional period where workforce skills may need enhanced development. For this reason the service will need to develop slowly in step changes before being ‘fully functional.’

Palliative Care - Patient's Journey

Grace is 37 years old. She is married and has two children aged 6 and 8. Grace has a particularly aggressive form of breast cancer. She finished her second round of chemotherapy last week and has been suffering with nausea and vomiting since then. She has lost weight, become increasingly frail and fatigued and feels that she is no longer coping at home.

The care at home team have seen Grace this morning and feel that she now needs her symptoms controlled. They have spoken to the triage co-ordinator at Priscilla Bacon Lodge and a **palliative bed** close to her home in Cromer will be available later that afternoon. When Grace arrives with her husband to Benjamin Court later that day, she is met by the registered nurse who will be looking after her and is shown to her side room. The nurse takes a full set of observations, inserts a cannula so Grace can have **intravenous (IV) therapy** and takes a blood sample. The palliative care consultant comes to assess her. Grace's bloods show that she is dehydrated and this has had an effect on her kidney function. The consultant prescribes some IV fluids which should help her kidneys as well as some IV anti-sickness medication. She talks her through the benefits of a range of nutritional support and to start with they both agree to attempt small amounts of her new diet, as long as the anti-sickness medication works well.

Eight days later, Grace is taking anti-sickness tablets and her blood tests show her kidney function has improved. She is managing to eat several small meals each day with occasional snacks and feels a lot stronger. The care in Benjamin Court has enabled Grace to return home to her husband and children, with the support of the care at home team. She is given an outpatients appointment at Benjamin Court to see her palliative care consultant in two weeks' time to ensure her symptoms remain under control.

At the appointment, she is examined by the palliative care consultant and has her bloods taken. Grace says that she feels stronger physically, but she is struggling emotionally both with her prognosis and with how she can explain to her daughters what is going to happen. She is visibly distressed and explains that her husband is unable to discuss with her the practical implications of her deterioration. The consultant realises Grace has never accessed any psychological support due to the rapid detection and treatment of her disease. She is offered a referral to the psychological services within palliative care and also made aware of the volunteer counselling and drop in services offered in the **cancer support centre** at Benjamin Court. That evening, Grace discusses the counselling services at Benjamin Court with her husband and they agree to attend an appointment together.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

Option 3 Discharge to Assess (D2A) – Assessing care needs for frail patients in the community

Summary of proposal

This service enables medically fit patients to be given both the environment and therapies they need to get them to their best before an assessment of their longer term on-going care needs is made. These patients can be frail but with the potential to improve in strength and confidence. Assessing people when they have reached their optimum recovery means that they can plan the most appropriate care for their future needs.

Sometimes patients will be waiting for assessments for Continuing Healthcare (CHC) the name given to a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need".

Discharge to Assess (D2A) service enables patients to be discharged earlier from acute inpatient wards by co-ordinating care in alternative settings.

Important features of D2A include the trusted assessment between health and social care, in-house re-ablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process

D2A beds at Benjamin Court would support a timely discharge from hospital and would also support care closer to home whilst re-enablement takes place. By having some D2A beds at Benjamin Court, it would help maintain patients' independence where possible and reduce the requirements for long-term care packages. Work that was done before the D2A service started showed that approximately 4-6 patients per month would be appropriate for this pathway.

Many of the patients already on a D2A pathway are in nursing homes as this is where the beds were initially commissioned. This means they have far less access to therapy services and nursing staff, and therefore many patients are spending longer in a nursing home than they should.

Advantages

- **Better for patients** - By having D2A at Benjamin Court rather than in nursing homes, patients can have access to daily therapy support and there would be a greater focus on getting them to 'their best' prior to the assessment. This could not only speed up the time from admission to assessment but also increase the number of patients that are able to go back to their own home. Patients in the D2A beds at Benjamin Court would have more staffing cover than they currently receive in nursing homes.

- **Local primary care support** – There would be easy access to GP services on site.
- **Opportunities for staff** – Professional development opportunities for staff to progress into the re-ablement role.
- **Pleasant environment** – Benjamin Court has a pleasant environment with a large site and café for relatives to take patients out and explore to help with their rehabilitation.
- **Better chance of meeting patient's needs** – D2A beds provide a better chance of ultimately meeting the needs of a patient by assessing them in an environment best placed to assess their needs.

Disadvantages

- **Vulnerable group of patients** - Consideration would need to be given to whether the layout of the ward is suitable for complex needs.
- **Complex pathway** – D2A can be a complicated pathway and relies on the appropriate patients being targeted.

Discharge to Assess - Patient's Journey

James lives alone, but nearly four months ago he fell and broke his hip. He has been in hospital ever since. Before his fall, James was independent around his house; he could walk to the local shop to buy a few bits and pieces but his son, Anthony, and daughter in law, Sue, did James' main food shop for him. Sue also visited most days and helped him clean the house and maintain his garden.

James also suffers from COPD and whilst recovering in hospital during his four-month stay, he developed a chest infection. As a result and combined with the hip injury he has lost a lot of muscle tone meaning he cannot even stay balanced whilst sitting on the edge of a bed let alone walk independently.

On a ward round, James was told by his consultant that he was medically fit and that the team at the Norfolk and Norwich University Hospital were looking for the best way to discharge him. James told the consultant that he lived alone and whilst he wanted to go home, he didn't think that he could cope right now. The nurse in charge was also on the ward round and agreed with James. She said he could be assessed for a specific discharge where the focus would be on trying to improve his mobility, ideally to as good as it was before he came into hospital. From that point he would then be assessed for any additional care. Later that afternoon, he was assessed by one of the nurses and eligible for a **Discharge to Assess** bed at Benjamin Court.

Whilst James was in Benjamin Court, he was seen by a physiotherapist and a plan for his reablement was developed. Each day, the reablement nurse would go through his exercises and four weeks later was able to stand independently and walk a couple of steps. His hip movement remained constricted but it was continuing to improve. Anthony and Sue would visit most days and made the most of the facilities at Benjamin Court, taking him for tea in the café and exploring the grounds when the

weather allowed. After seeing the occupational therapist a week later, he was taken back to his home, where he demonstrated that he could safely stand and walk from his lounge into his kitchen and make a cup of tea. After discussions with James, Anthony and Sue, it was decided that James could go home with additional support he needs. Five months after James' fall, he was finally able to go back to his home.

This is a fictitious example of a real life scenario designed to demonstrate the type of patient who could utilise the service.

Option 4 Intravenous Therapy at Benjamin Court

Summary of proposal

Intravenous (IV) therapy is when medicines or fluids are administered directly into a vein. Having IV services that can operate in the community, in people's homes or in community units, can be of significant benefit to both patients and the NHS. Throughout the UK there are a range of intravenous drugs that are administered outside of the acute hospital, these medications include (but are not limited to) blood and other blood products, antibiotics, iron, medication that slows down or prevents bone damage and antibodies that treat a wide variety of illnesses. They can prevent hospital admissions, facilitate early discharge, improve patient safety by reducing the risk of infection and improve choice by enabling patients to stay in their homes.

It requires a lots of different teams of health and care staff to work together and needs good communication between acute and community settings. Starting with a small service around palliative care, IV Therapy could over time expand to offer the range of therapies listed above that are not currently available in a community setting. The CCG is also working in partnership with the NNUH to ensure the best use of local facilities such as Cromer Hospital in the development of future IV services.

Advantages

- **Closer to home** - Patients needing a range of IV therapies can receive them closer to home. Receiving this therapy may go on to have an impact on the patients pathway and reduce the need for a hospital admission.
- **Life-changing service** - Patients who have long term IV therapy needs will travel less, and spend less time in treatment. This could reduce the impact the long term IV therapy has on their life and improve their quality of life.
- **High demand** - Based on the growth of community IV therapy services in the last few years, there is no doubt that this area of healthcare provision will continue to expand.
- **Avoid regular readmission –** clinicians have told us that IV therapy within Benjamin Court could prevent patients in Intermediate Care Bed from being readmitted to secondary care.

- **Impact on large group of patients –** IV therapy can be administrated reasonably quickly meaning a large number of patients can utilise a single bed per day and provide a greater impact for the North Norfolk population than the beds in their current guise could.

Disadvantages

- **Significant training and investment needed** - To ensure it is managed safely and effectively, there needs to be appropriate training and support. This will cost money to not only train staff but to backfill for this training gap.

Option 5 Voluntary Services

Summary of proposal

Big C is a Cancer charity based throughout Norfolk and Waveney giving local residents access to information and support in their local areas. The Big C have indicated they would like to offer a drop-in support and information centre within Benjamin Court. They have a number of centres throughout the region which provide valuable information and support for patients and their loved ones on all aspects of cancer and its impact on their lives. They would like to increase their presence in north Norfolk.

The Big C already has four support centres as well as online support for people who cannot make it into one of the centres. The Big C knows that there is demand for their services to further expand in this geographical area. The CCG would see this as an opportunity for other voluntary and community services to further complement this aspect of Benjamin Court as a hub for wider health and community support.

Advantages

- **Awareness** – Big C will help to raise awareness of the facility as it will be featured in their marketing and communications as well as people being signposted to their services within Benjamin Court.
- **Improved Patient Care –** Big C adds value to statutory provision for all those affected by cancer by offering five areas of care: information, advice (e.g. welfare advice), complementary therapies, talking therapies and access to exercise.
- **Support for Carers –** Big C services are inclusive of carers providing support and information for the family and friends of the person diagnosed with cancer.
- **More volunteer opportunities** – Having a presence at Benjamin Court may help the Big C attract additional volunteers to the service from the local area.
- **Opportunity to develop a community support hub** – Big C have extensive experience of working with other NHS and voluntary and community sector

providers. They have also delivered some services on behalf of the NHS so that they can be accessed by all (cancer and non-cancer patients) at the same centre. Having the Big C show an interest in working at Benjamin Court adds an opportunity to develop a wide-ranging community support hub, something that serves the whole community and might encourage other charitable organisations to follow suit.

- **Supporting Self-Management –** Big C's services help empower patients and carers in successful self-management for many areas of their care. This gives them more independence and is also in line with national and local priorities for care.

Note

- **Accommodation and resources** - Details about the space and configuration required have yet to be finalised. Consideration would need to be given about how a wider community hub can be funded, accommodated and managed.

Option 6 Outpatient Services

Summary of proposal

There are a variety of opportunities for developing additional community services at Benjamin Court such as outpatient clinics, many of which would currently involve going to an acute hospital. Many of these outpatient services are oversubscribed and the number of patients going into NNUH means waiting times are longer. Outpatient services could include:

Gynaecology clinic – to support women's and reproductive health.

Dermatology clinic – to support people manage conditions relating to skin.

ENT (Ear, Nose and Throat) clinic – to support people with conditions relating to the Ear, Nose and Throat.

Antenatal hubs – to support pregnant women and their families.

Palliative care clinic – to support people living with long term conditions with areas such as medicines and pain management.

Advantages

- **Investment in staff** - By developing a new service, additional skills would be needed by staff and that would lead to training and professional development opportunities.
- **Closer to home** - More access to services closer to home.

- **Complement Palliative Care** - the palliative care directorate see an outpatient clinic a natural extension of having inpatient beds.
- **Releases capacity in secondary care** – secondary care is under significant demand pressures and these outpatient clinics would release capacity for other patients in Norwich.

Disadvantages

- **Accommodation** - Appropriate space to house the consultation rooms and to offer an efficient functioning reception area to organise appointments. Also, enough space for a patient waiting area.
- **Information Technology (IT)** - There may be questions over how the IT systems for patient appointments within the acute trusts would work outside their hospitals.

Observation Beds for Ambulance Conveyances

The option to include observation beds at Benjamin Court as an alternative to taking people who have dialled 999 to A&E was considered but discounted as a viable alternative by the steering group. Patients would have been triaged to access an assessment from a GP, Emergency Nurse or Paramedic Practitioner where appropriate instead of being admitted to an acute hospital.

Whilst this option would have provided a service closer to home, and potentially helped ease pressure at A&E departments, there were concerns about both patient safety and the number of patients who would be suitable for this service.

The CCG will however continue to investigate ideas that help prevent patients being taken to A&E unnecessarily, and that help ease pressure on ambulances in North Norfolk.

Benjamin Court Steering Group's Preferred Option

Many of the options above present excellent opportunities for the future of Benjamin Court and for the people of North Norfolk and rural Broadland; bringing new services to the community, helping more people to live well at home for as long as possible and putting finite NHS resources to better and more productive use.

Having considered the advantages and disadvantages of each of these options and fully explored them with relevant stakeholders, the stakeholders who made up the

Benjamin Court Steering Group believe the most credible options for Benjamin Court to be:

- Up to 8 Palliative Care Beds
- 2 IV Therapy Beds/Chairs
- 6 Discharge to Assess Beds
- Additional voluntary/third sector provision
- Additional outpatient clinics

The steering group is clear that it wants to keep Benjamin Court as a vibrant and focal point of the community and proposes an increase to the services it provides, whilst equally recognising the change needed to allow this to happen. The additional services being provided at Benjamin Court would require a similar number of nurses and health care assistants to that currently being provided and the CCG is therefore expecting minimal changes to staff numbers. Additional medical resource in the form of palliative care consultants and GP resource is being discussed. Additionally, these options would bring new opportunities for further training and development for doctors, nurses and support services.

The steering group understands and respects that there is a reluctance for change and that this is a valued and much-loved local resource. But it remains the view of the group that doing nothing is not a viable option. The preferred option presented above is better for people living in North Norfolk and rural Broadland, and delivers much more for Cromer and the surrounding area to more people.

Feeding Back and Next Steps

So what do you think?

We would like you take part in our consultation which is running between **June 19th and September 11th 2017**. We would like to know:

- ❖ How would these proposed changes impact you?
- ❖ What else should the CCG consider in making this decision?

How do I have my say?

Online: www.northnorfolkccg.nhs.uk/benjamincourtconsultation

Email: nnccg.contactus@nhs.net Please label your message with “Benjamin Court Consultation”

It would really help us if you could send your feedback by email or from our website but if you are not able to do so please use our freepost address overleaf.

Post: NHS North Norfolk CCG
FREEPOST RTKA-RUCU-BLHU
1 Mill Close
Aylsham
Norfolk
NR11 6LZ

Governing Body meeting in public:
September 26th 2017 ACT Centre, Aylsham NR11 6YA
Meeting papers will be available and meeting times confirmed one week in advance on the CCG website:
www.northnorfolkccg.nhs.uk/news-events/governing-body-meetings

Drop-in event: A drop-in event is planned for Cromer during the public consultation and engagement and will be advertised across North Norfolk and rural Broadland in the local media. Details will also be available on the CCG website.

Next steps

1. Period of public consultation and engagement **June 19th – September 11th 2017**
2. Consultation and engagement report compiled **September 11th – 18th 2017**
3. Benjamin Court Steering Group meeting to receive the consultation and engagement report in the **week starting September 11th**
4. Governing Body meeting in public **September 26th 2017**

Want to get involved going forward?

If feeding back on this document has given you a taste for getting involved in local healthcare commissioning why not consider one of the following options?

The Benjamin Court Steering Group will meet after the public consultation and engagement finishes to receive the results of the report. The consultation may raise awareness about the Friends of Cromer Hospital and Benjamin Court, and provide opportunities for recruiting more volunteers.

So why not?

Join your local Hospital Friends group at Cromer, Kelling, North Walsham or Cranmer House?

Join the North Norfolk CCG Community Engagement Panel (CEP) – more details from NHS North Norfolk CCG.

Join your GP Practice's Patient Participation Group (PPG) – more details from your local surgery.