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NHS
Coventry and Warwickshire

Pre-Consultation Business Case (PCBC) for Community Hospital Rehabilitation Bed Provision in South Warwickshire

December 2024

Prepared by:
NHS Coventry and Warwickshire Integrated Care Board (ICB)
South Warwickshire University NHS Foundation Trust (SWFT)

Document control log

Version	Date	Author	Amendment History
0.1	19/09/24	Amy Danahay	Initial draft based on agreed infrastructure and good practice from 'Major Service Reconfiguration' guidance. Chapter headings sent out to key leads (authors) for review and confirmation of role and responsibility. Framework of chapters shared with 'Stand' – external independent organisation supporting the ICB to provide level of assurance required to proceed to public consultation. Versions sent to lead authors to commence work on versions 0.2 upwards.
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Glossary

Term	Definition
ICB	Integrated Care Board: A statutory NHS organisation responsible for planning and commissioning health services for a specific geographical area. The ICB oversees the allocation of resources, strategic planning, and ensuring healthcare services are equitable and effective.
SWFT	South Warwickshire University NHS Foundation Trust: A provider of community and hospital-based healthcare services in South Warwickshire. It manages facilities such as community hospitals and rehabilitation units.
PCBC	Pre-Consultation Business Case: A document that outlines the rationale, proposed changes, and options for significant service reconfigurations in the NHS, serving as a foundation for public and stakeholder consultation.
ICS	Integrated Care System: A partnership of health and care organizations working collaboratively to improve population health, reduce health inequalities, and deliver more coordinated services within a defined region.
NHSE	NHS England: The executive body responsible for the day-to-day operation of the NHS in England, overseeing planning, delivery, and regulation of healthcare services.
D2A	Discharge to Assess: A model of care that enables patients to be discharged from acute hospital settings to their homes or community-based facilities for ongoing assessment and rehabilitation, reducing hospital stay lengths.
PSED	Public Sector Equality Duty: A legal obligation under the Equality Act 2010 requiring public bodies to consider how their decisions and policies impact individuals with protected characteristics, ensuring fairness and inclusivity.
HMT	Her Majesty's Treasury: The UK government's economic and finance ministry responsible for developing and implementing financial and economic policy, including oversight of public expenditure such as NHS funding.
Home First	A national NHS policy emphasizing that patients recover better at home, where possible, rather than in institutional settings. This approach prioritizes discharge from hospital to home with the necessary support services in place.
Rehabilitation Beds	Hospital beds designated for patients who no longer require acute medical care but need continued medical supervision, therapy, and rehabilitation to regain independence before returning home.
NHSE's Bed Test	A framework used by NHS England to assess whether proposed changes to bed numbers in service reconfigurations are justified, ensuring sufficient capacity to meet patient demand.
Equality Act 2010	UK legislation that protects individuals from discrimination, harassment, and victimization based on characteristics like age, gender, race, disability, and religion. It underpins fairness in public services.
Stakeholder Engagement	A process of involving individuals, groups, and organizations that may be affected by or have an interest in a project. It ensures that their feedback, concerns, and insights shape the development and decision-making process.
EBH	Ellen Badger Hospital: A community hospital located in Shipston-on-Stour, South Warwickshire, providing rehabilitation and outpatient services.
CRS	Community Rehabilitation Service: A service designed to support patients discharged from acute hospitals, focusing on therapy and rehabilitation at home to enhance independence.

HOSC	Health Overview and Scrutiny Committee: A local authority body responsible for scrutinizing health and social care services, ensuring accountability and alignment with community needs.
GP	General Practitioner: A primary care doctor who serves as the first point of contact for patients, managing general health concerns and coordinating specialist referrals.
EOL	End of Life: A term referring to care and support provided to individuals nearing the end of their lives, focusing on comfort, dignity, and quality of care.
HEAT	Health Equity Assessment Tool: A framework used in healthcare planning and decision-making to evaluate and address health inequalities. The HEAT Tool guides organisations in assessing the potential equity impacts of policies, programs, and services. It emphasizes understanding how different population groups may be affected by proposed changes, aiming to ensure that initiatives reduce health disparities and improve outcomes for underserved or vulnerable communities. This tool aligns with the principles of the Public Sector Equality Duty (PSED) under the Equality Act 2010.
SWOT	Strengths, Weaknesses, Opportunities, and Threats: A strategic planning tool used to evaluate internal and external factors affecting organisational goals.
MDT	Multidisciplinary Team: A group of healthcare professionals from various specialties who collaborate to provide comprehensive patient care.
CQC	Care Quality Commission: The independent regulator of health and social care services in England, ensuring safety, effectiveness, and quality.
WMCS	West Midlands Care System: Context-specific term likely referring to regional health integration efforts in the West Midlands.
UCR	Urgent Community Response: A service aimed at providing rapid support to individuals in the community to prevent hospital admissions.
JSNA	Joint Strategic Needs Assessment: A process to assess the health and wellbeing needs of a local population, informing strategic planning and commissioning.
SUS	Secondary Uses Service: A data management system used by the NHS for reporting and analysis to support healthcare planning and commissioning.

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Overview of Chapters

As well as the glossary of terms, we have pulled together an overview of each chapter for the reader. This section provides a summary of the chapters to help navigate the document effectively.

No	Chapter Title	Overview
2	Introduction to the South Warwickshire Community Hospital Bed Review and the Pre-Consultation Business Case	This chapter describes the reasons for undertaking the Community Hospital Rehabilitation Bed Review and the role of the Pre-Consultation Business Case.
3	Understanding Coventry and Warwickshire's local health needs	This chapter provides an overview of Coventry and Warwickshire's population, highlighting key demographic and socio-economic trends. It notes that the population is both ageing and diverse, with significant disparities in life expectancy between affluent and deprived areas. The chapter also discusses the future challenges these trends may pose and outlines health and wellbeing priorities for the Integrated Care System (ICS) and the potential impact for requirements around community beds in South Warwickshire.
4	The NHS in Coventry and Warwickshire and the need for change	This chapter describes the current commissioning arrangements for the 1 million people currently living in Coventry and Warwickshire. It outlines the current configuration of provision including GP practices, community and mental health services and acute hospitals, and the interface between services, transport and local authority provision.
5	Understanding the services we are reviewing	This chapter outlines the current situation regarding community hospital services in Coventry and Warwickshire, focusing on South Warwickshire. It highlights the need for further development to ensure equitable access to these services across the geographical footprint for which the Integrated Care Board (ICB) is responsible. The chapter also explains why South Warwickshire was prioritised for review and how this aligns with the wider community strategy and planned rehabilitation services.
6	The National Context	This chapter outlines the national context in which we are undertaking our Community Hospital Rehabilitation Bed Review. It summarises the challenges the NHS is facing at the national level and NHS England's strategy, ambitions and measures. This includes recent government guidance on hospital discharge, community services, and community hospitals which emphasises collaboration between the NHS, local authorities, and other

		sectors to ensure a smooth transition for patients from hospital to home or community-based settings. The NHS Long Term Plan (published January 2019) is due to be refreshed in the Spring 2025, but the key goals remain focused on improving patient outcomes, increasing efficiency, and addressing health inequalities.
7	Stakeholder Engagement	This chapter describes a summary of Coventry and Warwickshire ICB's approach to stakeholders, how we have involved stakeholders and used their views in the development of proposals for public consultation.
8	Models of Care	This chapter describes the features of the best possible care for people in South Warwickshire across the key clinical pathways relating to community rehabilitation including the role of the community hospital. It describes the models of care proposed; covering how the patient will access the service through to caring for themselves at home, through primary, community and secondary care. The chapter also describes the input that the Clinical Task and Finish Groups and Clinical Care Forum had in developing the descriptions of best possible care. The chapter also includes the outcome of the independent clinical review that took place in October 2024 to assess the appraisal of the clinical proposals
9	Impact Framework	This chapter describes the impact of both the proposed options and how these proposed changes align with the strategic objectives. This framework focuses on key outcomes such as enhancing the quality of life for individuals transitioning from acute care settings to community-based rehabilitation. By evaluating the impact we can ensure that community hospital beds are optimised to support timely, needs based, patient-centered care and long-term recovery outcomes for people that are expected following the implementation of the vision. The evaluation process for selecting the optimal model of care is detailed in Chapter 11: Development of Options.
10	Assurance and Governance	This chapter outlines the extensive internal and external assurance processes the programme has undergone. The clinical proposals have been externally assured, and the programme has successfully met the four tests for reconfiguration set by the Secretary of State, with evidence submitted to NHS England. Additionally, this chapter details the approval process leading up to the final decision by the Coventry and Warwickshire Integrated

		Care Board (ICB), including the review and approval of the pre-consultation business case.
11	Development of options	This chapter outlines the systematic process we used to develop the options for community hospital rehabilitation beds in South Warwickshire. Our approach involved a combination of stakeholder engagement, evidenced reviews, and analysis of existing care pathways. By incorporating both qualitative insights and quantitative data, we identified a range of viable options designed to meet patient needs while optimising resource allocation. This development process was grounded in best practices and aligned with national healthcare priorities to ensure the proposed options are both practical and patient centered.
12	Economic and financial analysis of the options	This chapter presents a comprehensive economic and financial analysis of the proposed options for South Warwickshire's community hospital rehabilitation beds. We evaluate the cost implications and long-term sustainability, considering both direct financial impacts and wider socio-economic benefits. However, given that this case is based on an incumbent service and the proposed change for each option is limited in scope there is a limit to the implications that can be derived.
13	Workforce Modelling	In this chapter, we explore workforce modelling to assess the staffing requirements for implementing the proposed community hospital options. This includes forecasting the necessary skills mix, evaluating existing workforce capacity, and identifying training and recruitment strategies to ensure the effective delivery of services.
14	Demand and capacity modelling	This chapter outlines the demand and capacity modelling approach used to determine the required number of community rehabilitation beds that formed part of the strategic review conducted by SWFT. By analysing patient demographics, referral patterns, and projected service utilisation, we provide evidence-based estimates for capacity needs that align with expected demand.
15	Implementation plans	In this chapter we describe the phased implementation plans for rolling out the selected options. This chapter focuses on the key activities, timelines, and milestones necessary to ensure a smooth transition from current service models to the enhanced community hospital rehabilitation services.

16	Plans for consultation	This chapter outlines the plan for public consultation, includes the context of the consultation, how the consultation will be run and the involvement activities to be carried out to make sure all local residents have an opportunity to share their views.
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Foreword

As leaders of the Coventry and Warwickshire Integrated Care Board (ICB), we are committed to ensuring that the health and wellbeing needs of our population are met through sustainable and effective healthcare services. Our population is growing, ageing, and becoming more diverse, and we must adapt to these changes by developing innovative models of care that deliver the right support in the right place, at the right time.

This Pre-Consultation Business Case outlines our vision for the future of community hospital rehabilitation services in South Warwickshire. It reflects our collective ambition to provide patient-centred care at or closer to home, reducing unnecessary hospital stays, and ensuring smooth transitions from hospital to community-based settings. The review presented here is essential to delivering on our commitment to improve outcomes, address health inequalities, and enhance the experience of patients and families across our Integrated Care System. It is also in line with the shift for the NHS in moving from hospital based care to community, outlined in both the recent Independent investigation of the NHS in England by Lord Darzi and our own Integrated Care Strategy.

In developing this business case, the ICB and South Warwickshire University Foundation Trust (SWFT) have engaged with a wide range of stakeholders, including clinicians, patients, and our communities. Their insights have been invaluable in shaping the options put forward in this document, and we remain committed to further engagement throughout the consultation process.

This Pre-Consultation Business Case marks a significant step towards achieving our shared goal of creating a healthcare system that is responsive to the needs of our local and cross-border populations, ensuring high-quality rehabilitation care is available when it is needed most. We believe this work will enable our system to meet future demands while maintaining the financial and workforce sustainability required for long-term success and ultimately deliver on our vision of helping people to start well, live well and age well, promote independence and put people at the heart of everything we do.

We would like to thank everyone involved in the development of this document, and we look forward to continuing our journey towards a healthier future for Coventry and Warwickshire.

Danielle Oum
Chair
Coventry and Warwickshire Integrated Care Board

Phil Johns
Chief Executive
Coventry and Warwickshire Integrated Care Board

1. Executive Summary

This summarises the key content and messages of the pre-consultation business case.

Background and Purpose

In Coventry and Warwickshire we want people to start well, live well and age well, to promote independence and put people at the heart of everything we do. To do that, we need to offer sustainable high-quality, accessible care which improves the health and wellbeing of our population and, in line with national and local strategies, to shift from hospital-based to community-based care wherever we can. We know patients recover better and more quickly at home, and our approach of home first and the services we have in place to support that means that more people than ever are able to leave our acute hospitals and go straight back to their homes, or usual place of residences.

However there will always be people who need further rehabilitation support as an inpatient before they are able to go home, moving from an acute setting to a community hospital. In South Warwickshire we have 35 rehabilitation beds available to support this cohort of people. Changes in the sites from which these beds have historically been located, and developing needs of our population mean that we now need to look at where those beds are located in the future.

NHS Coventry and Warwickshire Integrated Care Board (ICB), in collaboration with South Warwickshire University NHS Foundation Trust (SWFT), has developed this Pre-Consultation Business Case (PCBC) to ensure that we are delivering the right care at the right time for our patients, building on our home first approach and addressing growing pressures on community rehabilitation services.

This document serves as the foundation for public consultation, presenting two options for optimising the distribution of South Warwickshire's 35 rehabilitation beds to improve patient outcomes and ensure equitable access.

Key Objectives – What do we want to achieve

The reconfiguration of community rehabilitation beds in South Warwickshire aims to address the evolving needs of the population while ensuring long-term sustainability and quality of care.

The key objectives are:

- **Improving Patient Care and Accessibility:** The proposed changes are designed to enhance patient access to high-quality rehabilitation services across South Warwickshire, with a focus on meeting the needs of both rural and urban populations. This includes:
  - Ensuring that services are available in areas with the highest demand, particularly in central and northern South Warwickshire.
  - Providing equitable access to rehabilitation services, reducing unnecessary travel times where possible.
  - Supporting patient-centered care that prioritises individual needs and promotes better health outcomes.

- **Ensuring Workforce and Financial Sustainability:** Efficient use of workforce and financial resources is crucial in addressing the challenges posed by an ageing population and limited funding. To achieve this, the reconfiguration will:
  - Optimise staff allocation and reduce the need for temporary staffing, improving both quality of care and workforce satisfaction.
  - Align with the recent growth in workforce capacity by focusing resources on fewer sites, which enhances operational efficiency.
  - Address financial constraints by centralising services to reduce overhead costs and ensure the effective use of available resources.

- **Supporting Integrated Care Models:** The reconfiguration aligns with national and local strategies to promote community-based, "Home First" care, enabling patients to recover in familiar settings wherever possible. This focus includes:
  - Reducing the reliance on hospital admissions by emphasising care closer to home.
  - Streamlining patient pathways to improve transition from acute to community-based care and reduce hospital readmissions.
  - Enhancing collaboration across multidisciplinary teams to provide cohesive, community-centered care that prioritises patient independence and long-term wellness.

Scope of Review

The PCBC examines the future configuration of community rehabilitation beds in South Warwickshire to determine the most effective, sustainable, and accessible locations. It covers all 35 commissioned community rehabilitation beds in South Warwickshire, focusing on their permanent geographical location.

Key facts about community rehabilitation beds

- **Number of beds**: The total of 35 beds has been identified as sufficient to meet rehabilitation hospital bed demand across South Warwickshire, based on comprehensive data analysis since 2019, including ward audits and usage studies. This evaluation is also aligned with broader discharge pathway improvements and ongoing transformation across the Warwickshire area.

- **Purpose of These Beds:** The beds provide intermediate, step-down care for patients who no longer need acute hospital treatment but still require medical supervision and rehabilitation. They are not acute beds, which are dedicated to high-intensity care for serious conditions or surgeries.

- **Current Bed Distribution:** Originally, 16 of these beds were located at Ellen Badger Hospital (EBH) in Shipston. Due to construction at EBH, these beds were temporarily moved to a vacant ward at Leamington Rehabilitation Hospital. The remaining 19 beds are located at Nicol Ward, Stratford Hospital.

Rationale for Change

Our ICS is committed to providing high-quality, patient-centered care that adapts to the changing needs of its residents. In recent years, demographic shifts, evolving patient needs, and national policy directions mean we need to examine our community bed provision to ensure resources are optimally allocated for patient recovery and independence.

The need for this reconfiguration is twofold: to meet growing patient demand in South Warwickshire while aligning our community bed provision with the financial and clinical sustainability required by current health policies. This dual focus ensures we optimise resources while upholding high standards of patient care.

Increasingly complex patient needs, demographic shifts, and operational limitations necessitate a reconfiguration of rehabilitation services. The key drivers for change include:

1. Increasing Demand and Complexity: An ageing population with higher rates of chronic conditions requiring ongoing rehabilitation and support demonstrates an ongoing need for bedded rehabilitation for our residents who need it.
2. Healthcare Accessibility: Data shows the highest demand for community beds in central and the northern area South Warwickshire, reinforcing the need for accessible services in these areas.
3. System Alignment with National Goals: In alignment with the NHS Long Term Plan and the Home First approach, South Warwickshire aims to enhance recovery pathways that support patients in home and community settings whenever possible. This reconfiguration will not only improve resource efficiency but also prioritise patient-centred care that enhances independence and well-being. By shifting to a more adaptable community-based model, we address the policy mandate to reduce hospital reliance and improve service accessibility for all residents.
4. Infrastructure Limitations: The retained estate at Ellen Badger which hosted the original 16 beds was not fit for purpose and has needed reconfiguration to address issues such as asbestos in the original building structure. This work means that in is now only possible to host a maximum of 12 beds on the site, meaning that we cannot return to the original configuration of 16 beds at the Ellen Badger site.[1]

Clinical Model for delivering high quality community rehabilitation

To address the drivers for change identified above we have developed a clinical model for community rehabilitation which focuses on delivering high-quality, patient-centered care, emphasising rehabilitation, reablement, and recovery in community settings.

[1] Significant capital constraints and competing priorities across the ICB make it unlikely that funding for a new inpatient facility at Ellen Badger can be secured through a simple capital reprioritisation process. The 'Home First' model and patient demand analysis indicate the highest need in central areas, particularly Leamington, Kenilworth, and Stratford. Constructing would not align with these priority areas and is not feasible under current funding limitations. This is explored in more detail in chapter 4

Key elements and benefits of the model include:

- **Integrated, Patient-Centered Care:** The model prioritises individualised rehabilitation plans, coordinated by multidisciplinary teams (MDTs) comprising nurses, general practitioners, physiotherapists, occupational therapists, and social workers.

  This approach ensures that care is tailored to each patient's unique recovery needs and goals, with ongoing support to enhance patient autonomy and well-being.

- **Home-First and Community-Based Focus:** Aligning with NHS national goals, the model emphasises a "Home First" philosophy, reducing hospital dependency by supporting patients in their home environments whenever safe and feasible.

  This focus is expected to enhance recovery outcomes, reduce readmission rates, and support patients' transition from acute care to community settings.

- **Flexible Bed Use in Response to System Pressures:** Learning from the demands experienced during COVID-19 and the recurring winter pressures, this model integrates flexibility in bed use. During peak times, community rehabilitation beds near acute or emergency services—such as those at Leamington Spa and Stratford—may temporarily support higher-acuity patients to relieve acute hospital pressures.

  This arrangement provides vital support for the wider healthcare system and ensures patient needs are met in times of increased demand, particularly in accessible locations where emergency coverage is readily available.

- **Flexible Care Pathways for Smooth Transitions:** The clinical model integrates clear, structured pathways for transitioning patients from acute care to home-based or bed-based community rehabilitation.

  This structure ensures that patients receive the appropriate level of care at the right time, whether through short-term support at home, step-down intermediate care in community beds, or additional community resources for longer-term recovery needs.

- **Strategic Use of Community Beds:** Community rehabilitation beds provide critical support for patients requiring ongoing medical oversight post-acute care.

  The model optimises the use of these beds by focusing on medically stable patients who benefit from targeted rehabilitation and monitoring, helping to relieve acute care pressures while maintaining effective patient flow across the system.

Through this clinical model we will deliver a cohesive, patient-focused approach to community rehabilitation, ensuring patients in South Warwickshire can recover in the most suitable environment while receiving coordinated, multidisciplinary support.

Developing the options for how we reconfigure community beds

Putting people at the heart of everything we do is integral to the ICS vision and so stakeholder engagement has been central to the development of our business case, ensuring that proposed options for community rehabilitation services align with the needs and expectations of patients, carers, staff, and the wider community in South Warwickshire. Key engagement activities have included:

- **Comprehensive Community Engagement:** Over several phases, surveys, focus groups, and public meetings have gathered input from a diverse cross-section of the population, including patients and carers with experience of rehabilitation services, community organisations, and groups representing seldom-heard voices.
- **Healthwatch and Scrutiny Committee Involvement:** Close collaboration with Healthwatch Warwickshire and the Health Overview and Scrutiny Committee ensured that public concerns and insights informed the options development process, and added independent perspectives to validate the engagement approach.
- **Feedback on Priorities and Concerns:** Key themes from stakeholder feedback included accessibility of services, especially in rural areas, the importance of maintaining quality and continuity of care, and the need for a model that aligns with the shift towards home-based, community-focused rehabilitation.

This work has informed our thinking throughout, leading to the development of options that reflect both local priorities and system needs.

In addition to the work with our stakeholders, the development of options for the future of community rehabilitation beds has also been grounded in comprehensive data analysis and workforce capacity considerations.

Building on the community engagement work we considered a range of options for the 35 community rehabilitation beds in South Warwickshire, narrowed down from a long list to a short-list that was presented to the ICB in 2023. Subsequently, a further revalidation of the options further refined the short list leaving only the options which were considered viable to deliver.

Key aspects of the options development process include:

- **Data and Evidence-Based Process:** Analysis included a review of patient demographics, utilisation rates, and travel accessibility data, ensuring each option aligns with patient needs, system efficiency, and resource availability.
- **Workforce and Financial Sustainability:** Each option was evaluated for its impact on staffing, operational costs, and financial viability to ensure that they were deliverable.
- **Alignment with Strategic Priorities:** Both options were evaluated to ensure that they align with the ICB's strategic goals of reducing reliance on hospital-based care through community-based, flexible service models, allowing for high-quality, accessible, and sustainable patient care.

Together, the stakeholder engagement process and options development framework have led to two viable options that are both data-driven and reflective of community needs, supporting an informed public consultation process and a sustainable path forward for community rehabilitation services in South Warwickshire.

Options for Community Rehabilitation Beds

The review identifies two viable options for restructuring the 35 community rehabilitation beds:

1. **Option A – Three sites**: Distribute the 35 beds across Ellen Badger Hospital, Leamington Spa Hospital, and Stratford Hospital and continue to improve our care at home provision. This option includes services at Ellen Badger Hospital, enhancing local access for residents of Shipston-on-Stour.
2. **Option B – Two sites**: Provide all 35 beds at two sites, Leamington Spa Hospital and Stratford Hospital, and continue to improve our care at home provision, aligning with demand concentrated in central and the northern area of South Warwickshire and improving operational efficiency.

As is detailed above, both options were informed by data, stakeholder engagement, and consideration of factors such as accessibility, operational viability, and workforce and financial sustainability.

Implications and Impact

The proposed reconfiguration of community rehabilitation beds will influence several key dimensions of healthcare in South Warwickshire, especially patient access, system efficiency, and workforce and financial sustainability and we have considered the implications and impact of each option against a range of aspects.

Patient Access and Health Equity

- **Option A**: While this model enhances local access for patients in the Shipston area, it may reduce accessibility for the larger portion of patients who reside in central South and the north of South Warwickshire, where demand is highest. This approach could lead to longer travel times for those visiting or supporting more centrally located patients, who form a significant portion of service users.
- **Option B**: Centralising beds at two sites (Leamington Spa and Stratford) prioritises accessibility in high-demand central areas, ensuring that the majority of patients can access services more easily, though it may increase travel times for those in Shipston and other rural areas in the southernmost part of Warwickshire.

System Efficiency and Hospital Capacity

- **Option A**: By spreading services across three locations, this option could increase logistical complexity, making it harder to streamline patient flow from acute to community care settings.
- **Option B**: Consolidating beds at two central sites allows for more efficient patient transfers and optimised resource use, reducing strain on acute hospital beds by ensuring smoother, coordinated discharges to rehabilitation services.

Workforce and Financial Sustainability

- **Option A**: Staffing multiple sites may dilute workforce resources, creating challenges in maintaining consistent care levels and increasing operational costs.
- **Option B**: Focusing resources at two locations allows more efficient staffing and resource use, reducing operating costs and enhancing workforce retention and satisfaction.

Community and Stakeholder Impact

- **Option A**: Responds to community interest in retaining services at Ellen Badger Hospital but may limit accessibility for the majority of service users in central South Warwickshire..
- **Option B**: Although centralising beds may limit local options in southernmost rural areas, it aligns with system-wide goals of improving accessibility for the majority population in high-demand central areas. Stakeholders focused on operational sustainability may view this as a more balanced option.

Patient Outcomes and Experience

- **Option A**: While enhancing access for rural patients in the southernmost part of South Warwickshire, this option might impact overall service efficiency and could lead to variations in care quality if resources are stretched thin.
- **Option B**: Enhanced resource focus at two sites supports a more cohesive care model, potentially improving patient outcomes through concentrated, consistent care.

Conclusion

The proposed reconfiguration seeks to achieve an optimal balance between access, sustainability, and quality of care for community rehabilitation services in South Warwickshire. Each option presents distinct advantages:

- **Option A** aims to enhance rural accessibility, particularly benefiting residents in the Shipston area by maintaining rehabilitation beds across three locations.

- **Option B**, on the other hand, prioritises operational efficiency, central accessibility, and resource concentration to better meet the demand across South Warwickshire.

A significant level of engagement has informed the development and refinement of these options for the 35 community rehabilitation beds. Based on alignment with system-wide priorities—workforce management, financial sustainability, and responsiveness to changing healthcare needs—the ICB favours

Option B. This option promotes flexible and efficient bed use, particularly during periods of high demand, and aligns with the Integrated Care System's (ICS) commitment to sustainable, patient-centered, and community-based healthcare.

Both options reflect the ICS's dedication to meeting long-term population health needs while adapting to an evolving healthcare landscape. The formal public consultation will proceed with both options to assess the impact of rurality on patient access and to gather the views of the South Warwickshire community. This input will ensure the ICB Board makes a fully informed decision regarding the optimal geographical location of the 35 community rehabilitation beds.

Next Steps

The PCBC lays the groundwork for public consultation, during which further feedback will be collected from residents, local authorities, and healthcare partners to aid subsequent decision-making. Once the final decision is made by the ICB Board, the chosen reconfiguration option will then proceed to implementation, with ongoing evaluation to measure the impact on patient outcomes, equity, and service sustainability.

2. Introduction to the South Warwickshire Community Hospital Bed Review and the Pre-Consultation Business Case

This chapter describes the reasons for undertaking the Community Hospital Rehabilitation Bed Review and the role of the Pre Consultation Business Case.

2.1 Introduction

This Pre-Consultation Business Case (PCBC) is part of our commitment to transforming healthcare in South Warwickshire to better meet the needs of our ageing population while aligning with both regional and national strategic priorities. The proposed changes in community bed rehabilitation are grounded in three key strategies:

1. NHS Long Term Plan: In line with the NHS Long Term Plan, this PCBC supports the goal of increasing out-of-hospital care and reducing reliance on inpatient settings by enabling patients to receive care closer to home. This shift promotes patient independence and enhances quality of life while also managing demand on hospital services.

2. Coventry and Warwickshire Integrated Care Strategy: The local Integrated Care Strategy emphasises collaboration across health and social care sectors to create seamless, person-centered care pathways. This PCBC aligns with this strategy by focusing on enhancing community-based rehabilitation services, ensuring continuity of care across different settings, and making services more accessible and responsive to local health needs.

3. 'Home First' Model: Our approach is consistent with the 'Home First' model, which prioritises home-based and community support over hospital stays whenever clinically appropriate. This model aims to improve patient outcomes by supporting recovery at home, reducing unnecessary hospital admissions, and optimising the use of inpatient resources for those with the most acute needs.

Through these strategic alignments, this PCBC is not merely a reconfiguration of beds but supports the wider transformation in how and where patients receive care. By integrating community resources, investing in home-based care, and aligning with overarching health and care goals, we are preparing South Warwickshire's healthcare system to meet future demands sustainably and effectively.

Together, these strategies represent our commitment to creating a sustainable healthcare model that adapts to evolving demands and focuses on long-term community resilience. This PCBC thus lays the foundation for a transformation in how care is delivered in South Warwickshire, making healthcare more accessible, sustainable, and aligned with national and local priorities.

2.2 Who We Are

Coventry and Warwickshire 'Integrated Care System' (ICS) represents all of the organisations which support local people with their health and care needs, from the NHS and Local Authorities to community groups and the voluntary sector. Working together we want to help everyone lead healthier and happier lives, be part of a strong community and benefit from effective and sustainable health and care services where and when they need them most.

Across Coventry and Warwickshire, we provide health, care and wellbeing services and support to over one million people.

NHS Coventry and Warwickshire Integrated Care Board (ICB) was established in July 2022. The Integrated Care Board has responsibility for the NHS budget for the whole population of Coventry and Warwickshire and leads the planning and commissioning of services, working closely with partners across the Integrated Care System. The ICB has a key strategic role to play in planning the future direction of the health and care system. It leads health and care integration by bringing together all those involved in the planning and delivery of health and care services to take a collaborative approach and maximise our combined impact. Critically, by delivering effective commissioning at the right level across the health and care system, the ICB will create an environment in which the health and care system is focused on outcomes, collaborative arrangements are able to flourish, and the benefits of integrated care can be realised.

2.3 Our Vision

As an Integrated Care System, we have agreed a common vision (figure 1) as well as the principles of how partners will work together. This is underpinned by the Health and Wellbeing Concordat for Coventry and Warwickshire.

This Concordat was agreed by our two Health and Wellbeing Boards[2] and sets out our goal to enable people across Coventry and Warwickshire to pursue happy, healthy lives and put people and communities at the heart of everything we do.

Figure 1 ICS Vision and Priorities

[2] A Health and Wellbeing Board is a partnership between local authorities, the NHS, and other stakeholders. It aims to improve the health and wellbeing of the local population, reduce health inequalities, and promote integrated working between health and social care services.

Our vision is more than just an aspiration: it is the driver for real change across Coventry and Warwickshire.

2.4 The need for a Community Bed Review

South Warwickshire's ageing population has increased demand for urgent and unplanned medical care, resulting in a higher need for inpatient support. In response, we have significantly invested in support packages that promote earlier discharge and independent living at home. These initiatives have helped to decrease reliance on bed-based rehabilitation, allowing inpatient rehabilitation beds to be reserved for those with the most intensive needs. As patients age, their length of stay in overnight facilities tends to increase, but community-based rehabilitation programmes are providing effective alternatives, helping to ensure that bed-based care is available for those who require it most.

Locally, and in line with national policies, we are committed to implementing a 'Home First' approach, reducing reliance on bed-based care and prioritising recovery at home whenever possible. Our integrated health and care strategy focuses on supporting people to remain at home, promoting independence and improving outcomes. However there will always be people who need further rehabilitation support as an inpatient before they are able to go home, moving from an acute setting to a community hospital. Community hospital rehabilitation beds form are designed to support patients who no longer need acute hospital care but still require rehabilitation before returning home or moving to longer-term care.

The financial challenges facing the NHS are well-documented and, as is demonstrated in section 2.3 a key aim for all ICSs nationally is to enhance productivity and value for money. Therefore the need for this review was twofold: to ensure that we meet growing patient demand in South Warwickshire while aligning our community bed provision with the financial and clinical sustainability required by current health policies. This dual focus ensures we optimise resources while upholding high standards of patient care.

SWFTs comprehensive strategic review of bed provision was undertaken between 2021-2023 and aimed to determine whether current bed capacity met patient demand, aligned with national health and care strategies, and optimised resources to ensure services were both clinically appropriate and affordable.

2.5 How the review was carried out

The Strategic Review of community hospital rehabilitation beds in South Warwickshire (2021-2023) (Appendix 1 Strategic Review of community hospital rehabilitation beds in South Warwickshire (2021-2023)) was conducted with a focus on aligning services to current and future health needs, optimising resources, and improving patient outcomes. Led by South Warwickshire University NHS Foundation Trust (SWFT), the review encompassed the 35 ICB commissioned community inpatient beds located at Ellen Badger Hospital in Shipston on Stour and the Nicol Unit at Stratford Hospital, supporting approximately 430 admissions annually.

Key steps in the review process included:

- **Data Collection and Analysis**: SWFT analysed patient flows, service utilisation, population health needs, and workforce capacity to ensure the review was data-driven. Population health intelligence was used to assess current and future demands, particularly focusing on high-need groups.
- **Stakeholder Engagement**: Throughout the review, SWFT engaged with patients, families, staff, local authorities, and community partners. Healthwatch Warwickshire and the Health Overview

Scrutiny Committee provided critical feedback, ensuring the patient and community voice shaped the options developed (Chapter 7 Stakeholder Engagement and Chapter 11 Developing the Options).

- **Independent Expertise**: To ensure a robust and best-practice approach, SWFT engaged independent providers to support clinical scrutiny, offer expert guidance, and ensure alignment with statutory and legal duties.
- **Evaluation of Current Service Provision**: SWFT evaluated the current service provision in terms of bed utilisation, clinical outcomes, and patient experiences to determine whether existing services were meeting patient needs efficiently.
- **Options Development and Appraisal**: A range of options for future service delivery was developed based on the insights gathered. Each option was thoroughly evaluated against key criteria, including its impact on patient outcomes, operational efficiency, and financial sustainability. In line with the four tests for service change, the options were also assessed for their alignment with patient choice, the level of public engagement, the strength of the clinical evidence base, and the support from commissioners. Additionally, the relevance of the fifth test—considering any reduction in bed numbers—was carefully reviewed to ensure that the proposed changes maintain appropriate capacity while meeting patient needs.

This comprehensive approach ensured that the proposed changes within the review were both evidence-based and aligned with the needs of the South Warwickshire population.

2.6 Purpose and scope of the Pre-Consultation Business Case

The Pre-Consultation Business Case (PCBC) builds on the Community Bed Review and serves as a comprehensive, evidence-based document designed to support the process for the reconfiguration of community hospital rehabilitation beds managed by South Warwickshire University NHS Foundation Trust (SWFT).

It further builds on the national policies put in place since the review was undertaken. The *Darzi Report* (September 2024) supports this need for change, emphasising the shift towards community-based care and enhanced rehabilitation services. The review also highlighted the importance of improving patient flow and integrating health and social care services and our PCBC follows these principles, ensuring that rehabilitation beds are used effectively to support patient recovery while freeing up acute hospital capacity for more critical cases.

This direction is reinforced by the updated *Hospital Discharge Guidance* (January 2024), which advocates for home-based, strengths-based care as the first-line approach. Furthermore, the *Darzi Report* (September 2024) strongly supports our strategy, emphasising the shift towards community-based care and the need for enhanced rehabilitation services that integrate health and social care.

With these developments in mind, the PCBC outlines the rationale for reconfiguring community bed provision in response to current challenges, including patient needs and operational inefficiencies. It provides evidence showing how the proposed changes will improve patient outcomes, enhance service sustainability, and align with national health and care strategies. It sets out the future clinical model for

community hospital rehabilitation beds, focusing on a patient-centered, integrated approach that emphasises home-first care and reduces unnecessary hospital admissions. It also details the development and appraisal of various service options, evaluating their impact on staffing, finance, and patient access.

Stakeholder engagement has played a vital role throughout this process, ensuring that feedback from patients, families, and local organisations has informed the planning. The PCBC prepares the groundwork for public consultation and supports meaningful discussions with local authorities and the Adult Social Care and Health Overview and Scrutiny Committee (HOSC). It also includes comprehensive impact assessments to evaluate the implications of the proposed changes for vulnerable populations and the broader health system. Finally, the PCBC confirms that the proposed service changes comply with NHS England's service change tests, ensuring clinical and financial sustainability while addressing local and national priorities.

2.7 Principles underpinning the programmes approach

Our approach is based on the following key principles:

- Patient-Centered Care: Our approach is grounded in patient-centered care, prioritising safe and accessible services that align with patient preferences. This focus is supported by extensive community feedback gathered in consultations, which emphasised the importance of flexible, home-based care options, particularly for those requiring rehabilitation support.
- Equity of Access: We are committed to reducing health inequalities and ensuring that services are accessible to all communities, particularly those in rural or deprived areas. In line with the Equality Act (2010) and the Public Sector Equality Duty (PSED), we will actively consider how these changes affect people with protected characteristics, ensuring that no group is disproportionately impacted by the proposed service modifications. Our approach aims to promote fairness and inclusivity, addressing the diverse needs of our population.
- Sustainability: Our focus is on delivering services that are operationally and financially sustainable, ensuring resources are used efficiently and effectively. This aligns with the NHS 'Triple Aim' duty, which seeks to improve the health of the population, enhance the quality of care, and ensure the efficient use of NHS resources.
- Integrated Care: We will collaborate with all health and social care providers to create seamless care pathways that promote recovery and prevent unnecessary hospital admissions.

2.8 Key things to understand throughout the PCBC

Chapter 5 provides an overview of the services under review.

Key points to consider are:

- **35 community beds** are under review as part of this process.
- The PCBC focuses on evaluating the most suitable permanent geographical location for these beds in South Warwickshire.
- These 35 beds provide **intermediate care**, serving as a step-down option for patients who no longer require acute hospital care but still need medical supervision and rehabilitation. They are not acute beds which focus on immediate, high-intensity care for serious conditions or surgeries.

- Originally, **16 of the 35 beds** were located at Ellen Badger Hospital (EBH) in Shipston. However, due to ongoing construction work at EBH, these beds were temporarily relocated to a vacant ward at Leamington Rehabilitation Hospital.
- The remaining 19 beds are currently located at the Nicol Ward, Stratford Hospital.

In alignment with national guidelines, any significant or substantial service changes may necessitate a public consultation. The proposed adjustments to the community hospital rehabilitation bed provision are classified as a major service reconfiguration, primarily due to the changes in geographical location. Additionally, the reconfiguration may be perceived as significant by some stakeholders based on the reclassification of certain buildings and their future designation within the healthcare system.

However, it is important to emphasise that while the reconfiguration is classified as major, the scale of these changes is not as extensive as some other major reconfigurations. The focus is on redistributing beds and enhancing our care-at-home services, with no reduction in the total number of community beds. These adjustments aim to optimise service delivery without fundamentally altering the overall healthcare model in South Warwickshire.

The PCBC is the next step, outlining the proposed changes, stakeholder engagement, and the implications for future service provision.

3. Understanding Coventry and Warwickshire's local health needs

This chapter provides an overview of Coventry and Warwickshire's population, highlighting key demographic and socio-economic trends. It notes that the population is both ageing and diverse, with significant disparities in life expectancy between affluent and deprived areas. The chapter also discusses the future challenges these trends may pose and outlines health and wellbeing priorities for the Integrated Care System (ICS) and the potential impact for requirements around community beds in South Warwickshire.

3.1 Overview of Coventry and Warwickshire

Coventry and Warwickshire have a growing and diverse population of around 1.15 million people. The area includes two Local Authorities (Coventry City Council and Warwickshire County Council) and five Districts and Boroughs. It is served by three acute hospitals, two community service providers, one mental health Trust, 19 Primary Care Networks, and 119 General Practices. Additionally, there is a vibrant third sector and a variety of community organisations and independent providers, reflecting the area's diverse communities.

3.2 Profile of Coventry and Warwickshire's Population

Over the past two years, the GP registered population in Coventry and Warwickshire has grown by an average of 2.7% annually, a trend expected to continue. This growth is primarily driven by an influx of working-age individuals, alongside a general ageing of the population. (Appendix 2 ICB Population Data)

Key differences between Coventry and Warwickshire include:

- Median Age: Coventry's median age is 37, while Warwickshire's is 43.
- Elderly Population: In Coventry, 12.9% are over 64 (3.7% over 80), compared to Warwickshire's 20.7% over 64 (6.1% over 80).
- Core20 LSOAs: 14.7% of the total population lives in these areas, with 26.1% in Coventry and 6.5% in Warwickshire.
- Ethnic minorities Population: Coventry has a 39.3% ethnic minorities population, whereas Warwickshire has 11.9%.

As people age across Coventry and Warwickshire, they experience greater health issues and morbidity, with the most common conditions being:

- Childhood: Asthma is the most prevalent long-term condition.
- Ages 18-54: Depression is the most common, followed by Asthma.
- Age 55 and older: Hypertension is the most prevalent, followed by Osteoarthritis.

The prevalence of long-term conditions (LTCs) varies by age, ethnicity, and deprivation level. In children and young adults. Ethnic minorities ethnic groups show lower morbidity, partly due to lower recorded levels of depression.

However, after age 60, the prevalence of LTCs such as cardiovascular disease (CVD), diabetes, and hypertension becomes higher in ethnic minorities populations across Coventry and Warwickshire North where these populations are found.

3.3 Overview of Population of South Warwickshire

In the context of community bed provision at South Warwickshire University Foundation NHS Trust these beds are used primarily for the population of South Warwickshire, and primarily by people aged over 64.

In September 2024 there were 351,381 registered GP patients living in South Warwickshire, from the total 1.15 million patients across Coventry and Warwickshire as a whole.

Of this 28.1% of the population of South Warwickshire is aged over 64, with 6.5% of these aged over 80. South Warwickshire overall is an affluent area, with only 2% of the total population residing in the Core20 areas (20% of areas most deprived nationally).

South Warwickshire's aging population has increased demand for urgent and unplanned medical care, resulting in a higher need for inpatient support. In response, we have significantly invested in support packages that promote earlier discharge and independent living at home. These initiatives have helped to decrease reliance on bed-based rehabilitation, allowing inpatient rehabilitation beds to be reserved for those with the most intensive needs. As patients age, their length of stay in overnight facilities tends to increase, but community-based rehabilitation programmes are providing effective alternatives, helping to ensure that bed-based care is available for those who require it most.

Summary of Population

- Population Growth: In 2021, 21% of Warwickshire’s population were aged 65 and above. This is projected to increase to 24% by 2033.
- Distribution by Area: The proportion of older adults varies by district, with 25% in Stratford-on-Avon and 18% in Rugby. Stratford-on-Avon is expected to see the largest increase in its 65+ population.
- Age Breakdown: Most older adults are aged 65-74 (51%; 63,500 people), while 13% are aged 85 and above (16,400 people). Higher growth rates are projected for the older age groups.
- Gender Distribution: Among older adults, 54% are female, increasing to 62% for those aged 85 and over.
- Ethnic Diversity: The older population is less diverse, with 93% identifying as white British compared to 82% of the overall population. However, ethnic diversity is expected to increase in the future.
- Health Expectancy Gap: Older adults are likely to spend many of their later years in poor health, with a gap of 19.3 years for females and 17.6 years for males between healthy life expectancy and overall life expectancy.

- Main Causes of Death: Cancer, dementia, and heart disease are the leading causes of death among people aged 65 and above, highlighting areas for prevention and early intervention.
- Contributors to Poor Health: For those aged 70 and above, back pain, hearing loss, and diabetes are significant contributors to poor health. These conditions, though not always immediately considered, also present opportunities for prevention and support.
- Mobility Challenges: Nationally, 10-20% of older people have difficulty with daily tasks related to mobility. Muscle mass and strength decline from age 40, with up to 50% loss by age 80. Women are more likely to need help with daily tasks than men, and the need for support increases with age.
- Diabetes: About one in seven adults over 65 have diabetes (around 19,100 people). The highest rate is in men aged 80-89, with 19% having type 2 diabetes. The percentage of adults aged 60+ receiving all nine recommended care processes for diabetes decreases with age, from 29% in those aged 60-69 to 13% in those over 90.
- Frailty: The prevalence of frailty increases with age, from 6.5% in those aged 60-69 to 65% in those aged 90 and above. In England, 12% of the 65+ population lives with moderate frailty, but only 2.4% of the 65+ population in Warwickshire are registered with a GP with moderate frailty.
- Falls: One in three people over 65 and half of those over 80 experiences at least one fall per year. While not all falls require medical treatment, 1 in 20 older people in the community experience a fracture or need hospitalization after a fall. The rate of hip fractures and falls-related admissions rises with age and is higher for women.

3.4 Our Transformation Aspirations

Across Coventry and Warwickshire, the number of moderate to high frailty risk people is projected to increase by approximately 2,500 over the next decade rising to over 15,000 people. The precise breakdown of these projections is not known in clinical detail. As more severe frailty patients are known to require on average 3 hospital visits in their final years according to previous data it was recognised that a different approach was required.

South Warwickshire has been at the forefront within the region and nationally developing proactive approaches to service delivery for older people living with frailty. Two main principles have been applied, each based on clinical evidence and patient preference.

1. Reduced focus on inpatient bed accommodation

National programmes rely on clinical evidence to promote this approach e.g. EndPJParalysis campaign. Clinical examples include the observation that older adults can lose 10 % of their muscle power within a week; unfortunately, it can take a frail older adult all their power to stand up so such a loss of strength can leave them incapable of independent mobility.

The use of Community Hospital beds has diminished in number and change in function over recent years. Much of the research at home and abroad has seen the acute function of such beds increase, and often the traditional lower acuity community hospital beds have reduced or disappeared. Focusing rehabilitation on complex need patients on fewer sites also strengthens skill and workforce resilience.

2. Home First Philosophy

This approach recognises that people prefer and generally benefit from treatment and recovery in their own home. Specific pathway initiatives have already been effective and may be more so in future for example CRS rehabilitation at home, a national frontrunner programme. Virtual wards programme where we lead the region. Some others are in an early phase of development eg hospice @ home, discharge to assess @ home.

While it is difficult to offer convincing projections detailing the future capacity of these models they are likely to be more flexible and scalable than fixed inpatient beds; and they appear to provide as good or higher quality and safety of care.

3.4.1 Predicting our future demand and capacity summary

Further information on the demand and capacity modelling approach used to determine the required number of community rehabilitation beds can be found in Chapter 14.

Predicting the future requires assumptions about population growth, and assumptions about how the morbidity of patients is impacted through adoption of alternative ways of supporting patients in the community such as care closer to home, community rehabilitation, virtual wards and better management of long-term conditions.

Health needs change over time, and the use of capacity also changes as technological opportunities allow services to be delivered closer to home.

In the past few years two immediate service changes that have a direct impact on options for treatment have been:

- the development of Virtual Wards treating patients at home at the end of their hospital stay and
- the implementation of the Community Recovery Service (CRS) which offers non acute community-based rehabilitation to all patients discharged from hospital on a discharge Pathway 1- discharge home with additional Support.

This together with the development of same day emergency care which treats patients when they present at hospital on the same day reducing the requirement for the patient to be admitted into hospital, as well as community service developments to improve the management of long-term conditions has mitigated growth in the demand for bed-based rehabilitation.

The graph below shows the overall reported bed position for South Warwickshire University Foundation NHS Trust since April 2021, together with the core capacity of the community rehabilitation beds, the number of virtual ward beds managed by SWFT, and the growth in community-based rehabilitation services for patients discharged from hospital.

Table 1 SWFT reported bed position since April 2021

	SWUFT total Beds Daily Sitrep			Community Rehab beds included within total SWUFT beds Core beds	Community Alternatives	
	Core	Escalation	Total		Available Vitual Wards - Hosp @ Home	Recovery Service (CRS) patients full year
Apr-21	352	28	380	35	0	0
Apr-22	385	25	410	35	70	0
Apr-23	379	22	401	35	78	2,786
Apr-24	367	51	418	35	115	3,084*
Dec-24	396	15	411	35	115	

CRS Started in April 2023
* Estimated Full Year Outturn
Pre CRS community rehab was approx 1,500 per year

The general and acute bed base of SWFT changes on a daily basis as the service flex to meet peaks and dips in demand especially for emergency care but generally SWFT has operated with around 410-420 beds in place across the year in the last three years.

SWFT has consistently maintained the capacity for community rehabilitation beds at 35, as set out in this consultation document. However, with beds located at Campion and Nicol wards, there is flexibility to increase wider general capacity of the hospital as the two wards together allow for the provision of 50 beds, with 35 being rehabilitation and an additional 15 general beds.

Patients being discharged early back home as part of the virtual ward development was not available prior to Covid, and currently 115 patients a day can be managed at home supported by SWFT. Being in their own home helps to prevent patients decompensating and reduces the need for rehabilitation post discharge below that of people who remain in acute based hospital beds.

The Community Recovery Service (CRS) was started in April 2023 and provides community based rehabilitation as well as other support services for patients being discharged home, this increased the number of patients in receipt of community rehabilitation significantly, from a level pre CRS of around 1,500 Warwickshire patients a year, to now over 3,000 Warwickshire patients a year. This both reduces the increase in demand for community bedded rehabilitation services directly, but also reduces the likelihood of a patient being readmitted post discharge home, so mitigates demand for emergency care as well.

3.4.2 Known factors driving demand

We know that the GP Registered population for Coventry and Warwickshire has been increasing at up to 2.7% year on year. Therefore, over a 5-year period we could expect the population overall to have grown by up to 13.5%.

Within this the growth of patients aged over 64 who primarily are users of the community rehabilitation beds may be expected to grow by around 13.2%, the growth being slightly lower as a lot of the current population growth is driven by migration into new housing being built across Warwickshire.

A 13.2% unmitigated growth in the demand for community rehabilitation beds would be to increase the provision of the current 35 beds, to a requirement potentially of 40 beds over a 5-year period.

This is well within the capacity of the existing wards to flex their capacity.

The Integrated Care Board (ICB) funds a baseline of 35 community rehabilitation beds across South Warwickshire: 19 beds at Nicol Ward, Stratford Hospital and 16 beds that were originally at Ellen Badger Hospital (EBH) but are temporarily relocated to Campion Ward, Leamington Spa. These 35 beds meet the usual community rehabilitation demand.

However, during times of increased patient need, SWFT has the flexibility to temporarily increase capacity. When demand surges, Campion can expand beyond the 16 relocated beds to accommodate additional patients (between 25-29), and Nicol can expand to accommodating an additional 2 beds, further ensuring continuity of care without requiring permanent funding for these extra beds.

This setup allows the system to balance regular, funded bed capacity with the ability to scale up temporarily during high-demand periods, making efficient use of resources while still meeting patient needs. Looking to the future, we are also exploring options such as remote technology to further enhance flexibility in patient care.

However, this being said because of changes to how services have developed the use of same day emergency care (SDEC) pathways, CRS, Virtual Wards, Community Integrator projects demand for patients being admitted overnight in hospital for emergency care are actually lower overall currently than they were pre-covid. Overnight admissions lasting more than 1 day are 2% lower in the current year than they were in 2019-20 pre-covid.

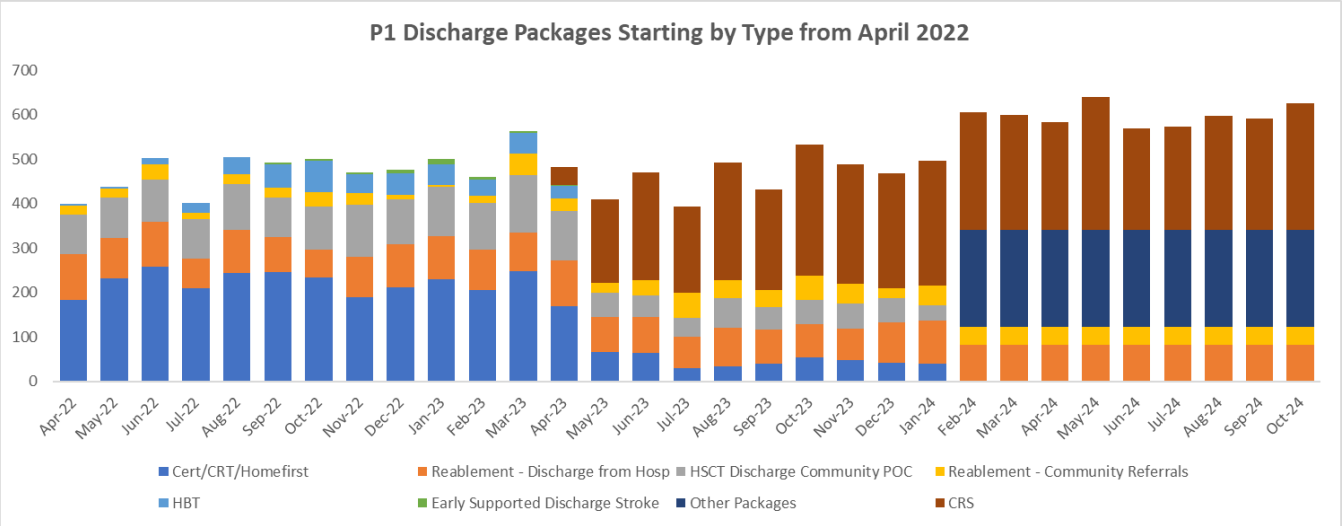
In the last 5 years we have not seen the same increase in demand for overnight emergency care that the growth in population would have suggested. This shows that the community-based alternatives have had an overall impact on managing demand, and it is likely the growth in demand in the next 5 years would continue to be less than the growth projected for the overall population growth.

It is very likely that the requirement for community bedded rehabilitation will therefore be below the previous mentioned unmitigated demand figure of 40 beds and that the 35 beds within this consultation will be the required level of beds in this period.

However, as already mentioned the current provision allow for flexing the capacity well beyond the 35 beds within the consultation if found necessary, without the need for additional capital funding if this were Option B. Option A can also deal with any additional growth, but the growth wouldn’t be at the Ellen Badger site, it would remain with the escalation beds available on Campion and Nicol.

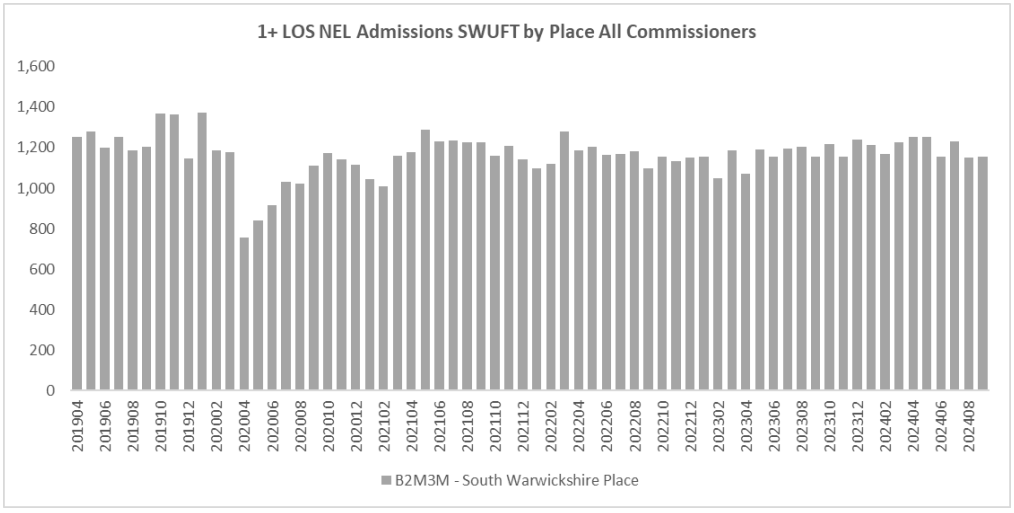
The graph below shows how pathway 1 discharges home with support have changed in the last two years, showing the growth in packages especially around CRS with rehabilitation support. P1 discharges for South Warwickshire Place are generally circa 40% of the total P1 Discharges across the ICB as a whole, it is these discharges which impact on the need for community bedded rehabilitation.

Figure 2 P1 Discharge Packages Starting by Type from April 2022



The next graph shows how overnight admissions have changed over the past few years, and that we have not seen any growth overall from pre-covid levels for South Warwickshire patients.

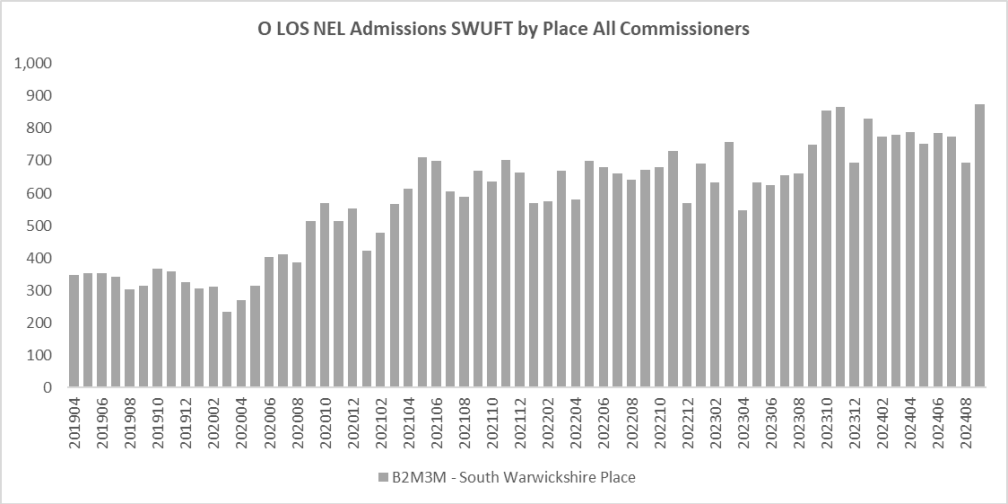
Figure 3 1+ LOS NEL Admissions SWFT



There has been growth from non-ICB patients being admitted overnight coming from Worcestershire, and Birmingham but these patients have their rehabilitation needs post discharge delivered outside Coventry and Warwickshire.

Zero length of stay admissions have increased significantly over the same period reflecting the development of SDEC services and is one of the mechanisms which has allowed for the reduction overall of overnight stays.

Figure 4 0 LOS NEL Admissions SWFT



The ICB therefore remains confident that the capacity described in Options A & B is sufficient to meet the needs of the population and increased population growth for at least the next 5 years, with potential to flex capacity if required beyond this period.

3.5 Overview of Population around Shipston on Stour

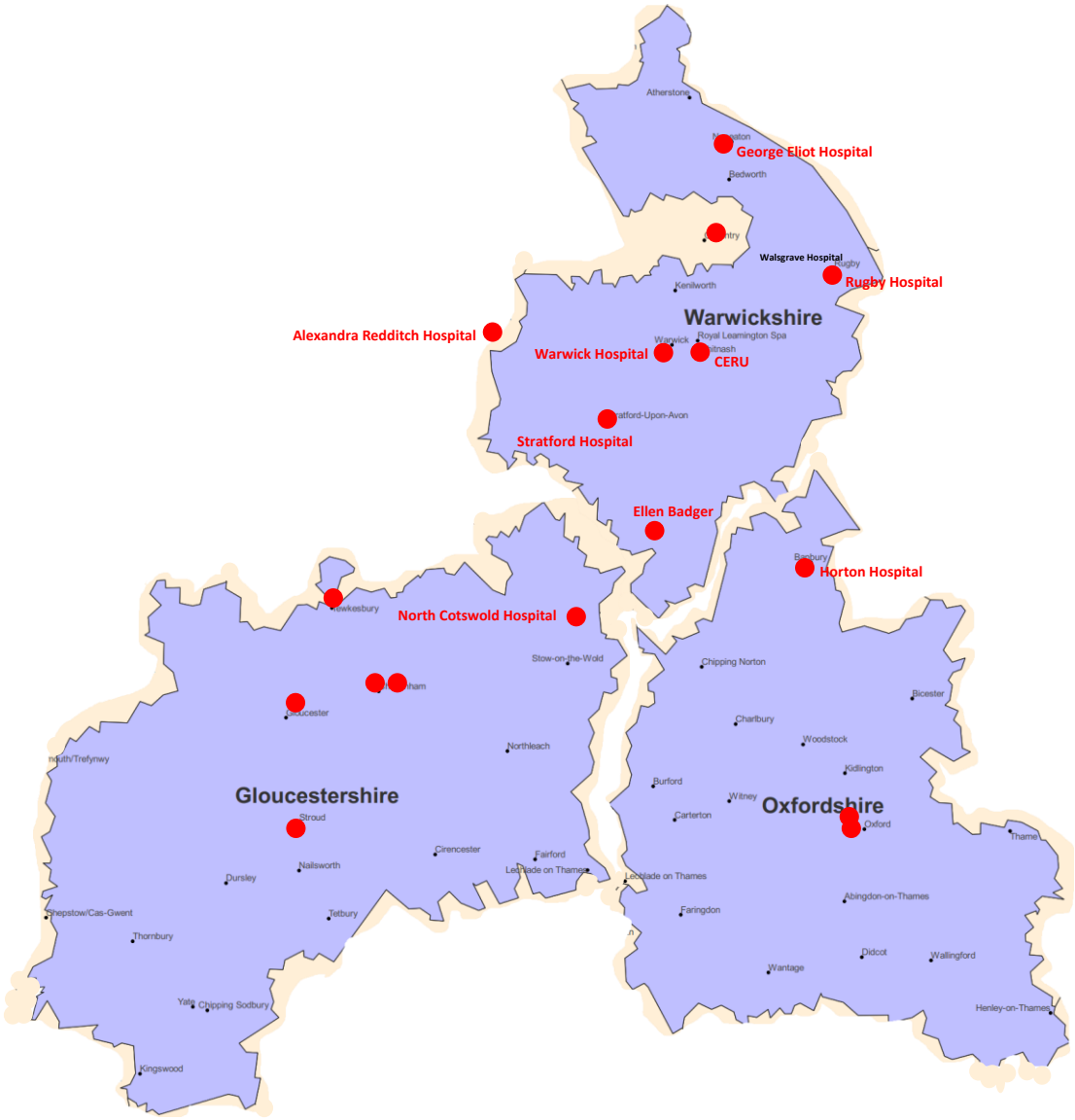
The Health Impact Assessment Report (Appendix 3 Health Impact Assessment Report April 2022) undertaken by Public Health Registrar at South Warwickshire University NHS Foundation Trust identified the population most affected from any change of service at Ellen Badger.

- Population: Shipston-on-Stour has around 5,200 residents, with the surrounding rural area totalling about 28,850 people.
- Housing and Growth: New housing developments have led to an increase in the town's population, with potential for further growth.
- Pandemic Impact: There has been an increase in registrations at the local GP practice, particularly among working-age adults.
- Age Profile: The 2019 census indicates that Shipston-on-Stour has a slightly older population compared to Warwickshire and England overall.

Summary of the Joint Strategic Needs Assessment (JSNA) data for the area:

- Health Outcomes: The population is very healthy, with better life expectancy and lower rates of obesity, smoking, and diabetes compared to the region.
- Young Carers: There are high rates of young carers in the area.
- Dementia: Dementia prevalence rates are below the national average, suggesting many cases may be undiagnosed. In 2019, the diagnosis rate for dementia in patients aged 65 and over by South Warwickshire CCG was 60.5%, lower than the England rate (68.7%) and the NHSE goal (66.7%).

- Employment: In 2018, nearly 9,000 people (54.1%) were employed in manufacturing in



Wellesbourne, Kineton & Shipston, the highest proportion in any JSNA area in the county.

3.6 Overview of Populations near to Ellen Badger

There are two external ICBs where patients could potentially look to utilise services at Ellen Badger - NHS Buckinghamshire, Oxfordshire and Berkshire West ICB and NHS Gloucestershire.

Both of these ICBs, have their own hospitals close to the population that might look to use Ellen Badger, there is Horton Hospital in Banbury 15 miles from Shipston, and The North Cotswold Hospital in Moreton-in-Marsh.

The main GP practices closest to Ellen Badger are:

Gloucestershire	Chipping Camden Surgery, and Mann Cottage Surgery
Oxfordshire	Bloxham Surgery, and Sibford Surgery

The combined GP Registered Populations for these practices combined is 21,522 of which 5,940 of these patients are aged over 64 (September 2024). If we extend the practices to all practices with the same PCNs, then the potential population size would be 83,365 with 22,337 aged over 64.

Looking at SUS spell data for the last 12 full month for emergency admissions at South Warwickshire University Foundation NHS Trust (SWFT), there were 402 total non-elective admissions for more than 1 day for the PCNs, with 156 of these admissions being for people aged over 64.

For the 4 practices the admissions were 227 total admissions, of which 125 were for those aged over 64. Showing that these practices were responsible for the majority of admissions from out of area Oxfordshire and Gloucestershire.

Of the admissions at SWFT for both either the PCNs or named practices, there were no episodes in the last 12 months where patients were in the community ward beds.

Overall, from 2018 to August 2024 there were 6 spells found to have episodes where they were in the SWFT community beds in total.

Horton Hospital is an acute general hospital providing a wide range of services, including:

- emergency department (with an emergency admission unit)
- acute general medicine and elective day case surgery
- trauma
- maternity (midwifery-led unit) and gynaecology
- paediatrics
- critical care
- Brodey Centre (treatment for cancer).
- medical assessment unit
- day hospital as part of specialised elderly care rehabilitation services
- cardiology service.

North Cotswold Hospital is a community hospital, and offers inpatient and outpatient services, a minor injuries unit, x-ray and ultrasound services, occupational therapy and physiotherapy.

3.7 Impact of Temporary Change in Community Bed Demand

Over the past two years, the GP registered population in Coventry and Warwickshire has grown by an average of 2.7% annually, driven by an influx of working-age individuals and an ageing population. This growth increases the demand for health and social care services, particularly for the elderly, who require more resources due to higher morbidity rates.

To address these needs, there are more community-based services to reduce the reliance on acute inpatient care. Initiatives like virtual wards and community rehabilitation support patients at home or in

community settings. Transfers from acute hospital beds to community beds are part of the same admission process, with patients often moving between wards based on their clinical needs.

In the last year, emergency admissions for patients over 64 in South Warwickshire remained stable at around 8,900 overnight admissions. Strategies focus on discharging patients' home with appropriate support to avoid long-term residential care and to allow end-of-life care outside hospital settings.

Discharge pathways include:

1. Pathway 0: Direct discharge home with no additional support.
2. Pathway 1: Discharge home with additional support like domiciliary care or therapy.
3. Pathway 2: Discharge to a care home for assessment of long-term needs.
4. Pathway 3: Discharge for permanent nursing care or end-of-life care

The recently implemented Community Rehabilitation Service (CRS) project has enhanced support care packages for Pathway 1 patients discharged from the hospital, offering temporary therapy at home to help maintain their independence. Some patients on a CRS pathway also receive additional support like domiciliary care.

When reviewing the proposed options that form the PCBC, option B 'Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital)' reflects the current temporary relocation of the beds.

The temporary change to the placement of the community beds across South Warwickshire[3] (refer to 5.1.1) has had the following impact. (Appendix 4 Community Bed Episodes SUS dataflows 2018-2024 and Appendix 5 EB_Campion Discharges - Postcode Visualisation and Appendix 6 Nicol Discharges - Postcode Visualisation)

- Community Bed Use: Annually, 500 patients from Warwick and Stratford-on-Avon use community beds for rehabilitation, a figure that has remained stable over the past five years, although there has been a slight upward change in admissions for the population to the North of South Warwickshire which has seen the age/sex, ethnicity and deprivation makeup of these admissions more closely match the overall demographics for South Warwickshire as a whole, previous to the change in bed location the proportions of people were less closely matched.
- From the 2018/19 baseline of circa 500 admissions a year activity has increased before stabilising at around 550 admissions per year. Growth has been seen mostly in postcodes to the centre and north of South Warwickshire. Activity from patients with a Shipston Postcode have remained mostly stable over the whole seven years from 2018/19 any reduction in episodes having occurred before the transfer to the use of the Campion beds.

[3] 16 beds were temporarily relocated from the Ellen Badger Hospital (EBH) in January 2022 due to construction works on the site. For further details on the temporary relocation refer to Chapter 5 section 5.1.1

Overall there has been a change in the patients utilising the community beds over this period, mainly in the middle deprivation IMD deciles 5,6, and 7 and then in the top decile 10 (least deprived).

Comparison for the last full 12 months as shown below indicates a high correlation, with the make-up of the population in South Warwickshire by where they live by deprivation for people aged over 64, as the majority of patients using the community beds are of retirement age. This would indicate that there are no obvious unwarranted variation in access due to deprivation, with some evidence of equalising differences seen in 2018/19.

- In terms of analysis by ethnicity there is an issue of small numbers of people overall in the population in relation to ethnic minorities ethnicities, which gives rise to larger small number variation. For this reason it is better to use full year figures rather than monthly analysis.

  Coding in primary care of ethnicity is generally good with over 97% of patients having a recorded known ethnicity, of the remaining approximately half of patients have chosen not to state their ethnicity after being asked, with around 1.5% actually being unknown. GP population figures are reported each month from GP systems, so the NHS has a relatively good understanding of its' ethnic population make up.

  Recording of ethnicity at Trust level reflects a similar position in terms of absolute patients where ethnicity is unknown, but that there is a larger proportion of patients in hospital where the ethnicity is given as not stated.

  Overall, around 95% of the population aged over 64 is white, 1.5% Asian and 1% other (Chinese, Asian) and the rest unknown. The breakdown of the admissions very closely reflects the ethnicity of patients found in South Warwickshire aged over 64, and there doesn't appear to be any unwarranted variation of access relating to ethnicity for use of the community beds.

- Mortality rates for patients in the community beds is roughly 6.7-8.1% but has been stable over the years from 2018/19. The average age of patients in the community beds (median) is over 81 years. The change of ward from Ellen Badger to Campion have not seen any significant alteration of mortality rates.

  Looking at mortality rates by deprivation (Appendix 2 ICB Population), there is the issue of small numbers of people especially by lowest decile in the population, only 0.7% of South Warwickshire's population is found in the poorest decile, with a further 1.2% in the next poorest decile. Therefore, only 1.7% of the population of South Warwickshire overall are found in Core20 areas.

  For this reason and to avoid number suppression for numbers less than 5, the mortality rates by Quintile (20% groups) have been analysed, this doesn't show any variation between crude mortality rates across the deprivation quintiles, again supporting that there is no unwarranted variation in this measure related to deprivation.

Key points:

- Daily Admissions: On average, 81 Warwickshire patients are admitted to South Warwickshire University Hospital NHS Trust, with 75 from Warwick or Stratford-on-Avon. Of these, 24 patients aged over 64 are admitted overnight.
- Daily Discharges: On average, 75 patients are discharged as Pathway 0, 4 as Pathway 1, 1.5 as Pathway 2, and 0.5 as Pathway 3.
- Community Bed Use: Annually, 500 (from 550 patients total) from Warwick and Stratford-on-Avon use community beds for rehabilitation, a figure that has remained stable over the past five years.
- Overnight Admissions: Despite population changes, overnight non-elective admissions have remained constant after increases in overall residents within South Warwickshire, due to new community and home based service alternatives being available.
- In the years since 2018/19 the use of community beds has increased slightly, with more admissions from the North of South Warwickshire, this means that occupancy matches closely the demographic make up of the overall population in South Warwickshire for patients aged over 64.
- Mortality rates have remained relatively static over this period.
- No inequalities are apparent from analysis of the community bed admissions in regard to ethnicity, or deprivation.

3.8 Expectations for services into the future

The Home First approach remains the current policy for hospital discharge and community support, emphasising independent living at home over bed-based care. Reinforced by the Government's Health and Social Care White Paper and updated Hospital Discharge Guidance (January 2024), it aims to minimise the use of hospitals and care homes in favour of home-based, strengths-based care.

Key points:

- Timely and Safe Discharge: Ensures patients are discharged promptly and safely, with ongoing community support.
- Integrated Services: Combines health and social care to support patients at home, reducing reliance on institutional care.
- Personalised Care: Focuses on home-based care tailored to individual needs, promoting independence.
- The Discharge to Assess (D2A) service supports earlier discharge from hospitals by coordinating care in alternative settings. It includes trusted assessments, in-house reablement and rehabilitation, and care coordinators to assist patients and families.

3.9 Challenges and priorities for health and wellbeing

The main challenges include managing the demand for non-elective care throughout the year, especially during winter, and ensuring sufficient capacity. Separating rehabilitation wards from general medical beds helps maintain capacity for ward-based rehabilitation, which has managed a stable demand of around 500 South Warwickshire patients annually over the past five years.

A strong focus on prevention is embedded in all plans and strategies, addressing wider health determinants such as housing, employment, safety, community connection, green space, and active travel.

Resources are allocated to support prevention, with Place-based Health and Wellbeing Partnerships driving these efforts.

The system aims to protect the most vulnerable and embed personalised care at all levels, empowering individuals to have more choice and control over their health and wellbeing. This approach ensures better experiences and improved health outcomes for residents.

Urgent and Emergency Care (UEC) services need to be stabilised and transformed to ensure quicker patient care, whether it is ambulance wait times, A&E waiting times, or hospital stays. Key strategies include:

- Increasing Capacity: More flexible hospital beds and greater number of ambulances to improve patient experience and outcomes.
- Improving Discharge Processes: Focus on early, timely discharge to prevent deconditioning and promote independence through reablement.
- Integrated Urgent Care Models: Operational in South Warwickshire as well as the other Places of Coventry and Warwickshire, ensuring same-day care and reducing UEC demand.
- Virtual Ward Programme: Continued implementation to maximise utilisation.
- Same Day Emergency Care (SDEC): Expanding provision and improving access through strengthened relationships with paramedics, 999, and NHS 111.
- Collaboration with Local Authorities: Maximising capacity and resilience through the Better Care Fund and Adult Social Care Discharge Fund.
- Standardising Hospital Processes: Reducing Emergency Department pressures by maximising admission prevention and urgent care access closer to home.
- Community Recovery Service: Fully embedding in Warwickshire for improved discharge processes.
- Improving Lives Programme: Transforming pathways in Coventry to prevent long waits and extended stays for frail elderly people.
- Enhancing Urgent Community Response Teams: Pilots and trials for service expansion, developing frailty pathways with Virtual Ward teams, and deploying Odyssey Triage software.

Both Options A and B will be reviewed against the key strategies that will support the stabilisation and transformation of health for the population of South Warwickshire (please refer to chapter 8 that explores the clinical model considerations).

In 2024/25, efforts will focus on redesigning urgent care services through geographical Care Collaboratives, including the 4 Places, the Primary Care Collaborative, and wider Collaboratives, to develop a robust integrated urgent care model.

A major challenge is balancing finances, as current spending on health and social care exceeds government funding. A comprehensive transformation programme aims to improve efficiency, increase productivity, eliminate duplication, and shift towards prevention to reduce expensive acute care needs. This financial constraint necessitates careful and considered investment in service developments, ensuring effective returns on investment, maximising health outcomes, and making tough decisions.

3.10 Conclusion

Coventry and Warwickshire's health needs are shaped by a growing and aging population, with South Warwickshire in particular seeing a significant proportion of residents aged over 64. Despite these demographic shifts, the demand for rehabilitation beds has remained stable over recent years. This consistency is a reflection of the system's strategic investment in community-based services and home-care support.

Looking ahead, the Integrated Care System (ICS) must continue to balance financial sustainability with the need for targeted services that meet the needs of this aging population. The stability in demand for rehabilitation beds, despite the demographic challenges, highlights the importance of maintaining robust community-based services to alleviate pressure on inpatient care while addressing the broader health inequalities across the region.

4. The NHS in Coventry and Warwickshire and the need for change

This chapter describes the current commissioning arrangements for the 1 million people currently living in Coventry and Warwickshire. It outlines the current configuration of provision including GP practices, community and mental health services and acute hospitals, and the interface between services, transport and local authority provision.

The chapter goes on to describe the need for change, particularly addressing the workforce and financial challenges Coventry and Warwickshire ICB will face without change. The chapter concludes that Coventry and Warwickshire ICB must reconfigure services to live within its means and enable staff to deliver the volume of care that is needed in the most effective and efficient way.

4.1 Overview of the NHS in Coventry and Warwickshire

The Integrated Care Board (ICB) is at the heart of health decision making in Coventry and Warwickshire and is delivering our shared strategic priorities within the NHS connecting to partnerships across our wider Integrated Care System in Coventry and Warwickshire.

The ICB is a statutory organisation, responsible for planning and commissioning NHS services on behalf of people in Coventry and Warwickshire. In consultation with local partners, it plans the delivery of services in a way that both meets local health and care needs and reduces inequalities between different groups.

Our ICB uses its resources and powers to achieve demonstrable progress on the core purposes of the ICS, collaborating to tackle complex challenges, including:

- improving the health of children and young people,
- supporting people to stay well and independent,
- acting sooner to help those with preventable conditions,
- supporting those with long-term conditions or mental health issues,
- caring for those with multiple needs as populations age,
- getting the best from collective resources so people get care as quickly as possible,
- improving access, experience and outcomes for groups and communities underserved by current health and care provision.

Everyone working in health and social care in Coventry and Warwickshire has a common purpose; we want people to start well, live well, and age well and we want to prevent them from becoming unwell wherever possible. If they are ill, we want to support them to get better as quickly as possible and we want to help everyone to manage as independently as they can.

To do this, we need to work together in partnership, removing the barriers between services and joining up care around people and communities, putting people at the heart of everything we do.

Providing good health care and social care is only one way to improve people's health and wellbeing. Working together in an Integrated Care System (ICS) enables us to address the other factors that might affect people's health such as housing, education and access to jobs.

Our overall aim is to continue to work across the System, governed by leaders from across health and care, to deliver the four aims of our ICS:

- Improve outcomes in population health and healthcare,
- Tackle inequalities in outcomes, experience and access,
- Enhance productivity and value for money,
- Help the NHS support broader social and economic development

The below diagram shows the makeup of our wider system and the organisations within it.

4.2 Our current quality of care delivery

Table 2 Current CQC Ratings for Trust Providers

Trust	CQC rating
South Warwickshire University Foundation Trust (SWFT) (2019)	Outstanding
University Hospital Coventry and Warwickshire (UHCW) (2020)	Good
George Eliot Hospital (GEH) (2023)	Requires Improvement
Coventry and Warwickshire Partnership Trust (CWPT) (2018)	Good

Table 3 CQC Ratings for SWFT Services

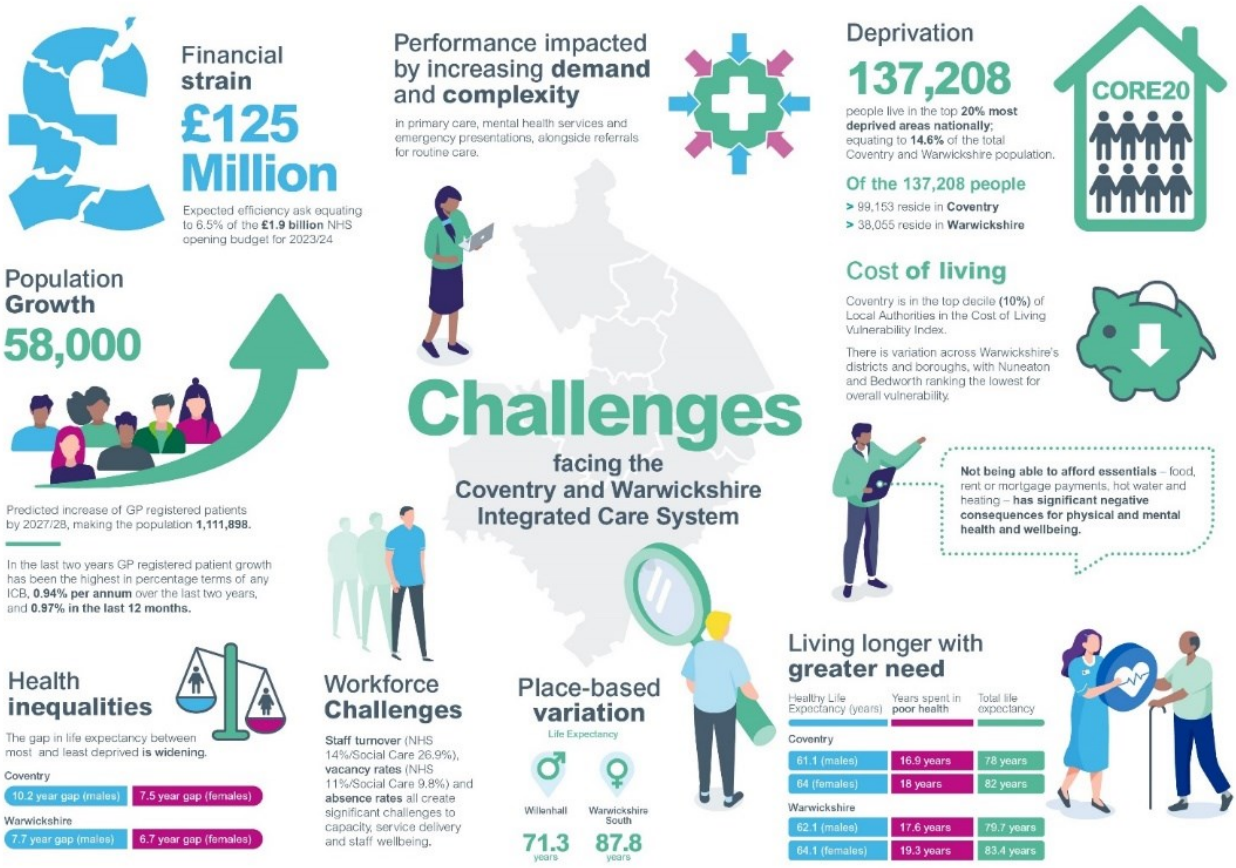
Trust	CQC rating
South Warwickshire University Foundation Trust (SWFT) (2019)	Outstanding
Community Health Services for Adults (2019)	Outstanding
Community Health Services for Children, Young People and Families (2019)	Outstanding

Community Health Inpatient Services (2016)	Good

4.3 The challenges facing our system

We know there are a wide range of challenges which are facing the local system.

Figure 5 Challenges faced by the System



4.4 Our workforce challenges

The Coventry and Warwickshire Health and Care system faces significant workforce challenges which are largely reflective of the national workforce picture. The demand for workforce has grown significantly in recent years in response to increased demand for services, exacerbated by an increasingly ageing population and the demands of post pandemic recovery. Although we have made significant in roads in closing the gap between demand and supply, we have been heavily reliant on international recruitment.

For our partners in social care, the changes in legislation around Visas is a particular challenge particularly in respect of the ability to attain dependent visas. Immigration rules are complex and costly, this is not always the case for our global competitors who are keen to attract our skilled workforce to alternative global markets.

Nationally there has been a downturn in numbers of applications for nursing undergraduate programmes with mental health and learning disability strands being particularly impacted. We have performed well locally in this regard for this academic year but our modelling shows that we face an increasing gap between demand and supply as higher education applications will continue to decline as a result of cost of living challenges. Our system are fully committed to utilising the apprenticeship model to close such workforce gaps which gives us the opportunity to grow a local workforce from a diverse range of social and economic backgrounds and increase economic activity locally. However, apprenticeship models are costly alternatives to undergraduate programmes.

In addition to facing recruitment challenges, our retention rates for specific staff groups are of concern. We have seen demonstrations of dissatisfaction with pay and, although we have much to celebrate locally in terms of staff survey results, there is still work to be done to improve staff satisfaction with many staff leaving to achieve better work life balance or for health reasons.

Gaps in our substantive workforce, increase levels of temporary staffing namely agency and bank workers, this is both a more costly model of delivery and less favourable for continuity of care.

In specific pockets of our workforce we have an ageing workforce profile which include areas such as GP practice nursing, GPs, healthcare support workers. Overall 15.8% of our workforce is over the age of 55. Despite improvements in the diversity of our workforce overall, these are not replicated at more senior levels in the organisations and therefore leadership roles are less representative of the communities they serve.

In community hospital settings, the workforce managing rehabilitation beds comprises a multidisciplinary team, including nurses, physiotherapists, occupational therapists, healthcare assistants, and support staff, who collaboratively deliver patient-centered care.

There is significant dialogue around the productivity of our workforce, with workforce growth not seeing a commensurate growth in our outputs. Identifying the precise reasons for this is complex and requires us to review the way we work across complex pathways of care and think about the future skills of our workforce, particularly those relating to our digital capability. Some of our reduced productivity is related to increased levels of sickness and absence, with our most impactful reason for absence being mental health and anxiety. Sickness levels are running around 1.5% than pre pandemic which would suggest this is a response to the impact of the pandemic.

4.5 Our growing financial challenges

Over the past few years as a system we have delivered some significant improvements in how we deliver health and care and how we bring our services together.

However, this has come at a cost. The amount of money the NHS spends delivering health and care across Coventry and Warwickshire is more than the amount of money that we receive. Inflation means that delivering our services and keeping our hospitals running is more expensive. At the same time we have a growing population who are living longer with greater need for our services. We are spending more on packages of care to support people with complex health needs as well as what we need to invest in

Mental Health services. The cost of the workforce that we need to deliver care has increased, partly through an increase in what we spend on agency staff.

Over the past three years we have managed to balance our budget across the system so we break even, but this has relied heavily on one-off resources and hasn't solved the underlying problem.

In 2024/25 for the first time Coventry and Warwickshire Integrated Care System will have a deficit which means we are forecast to end the year having spent more money than we have received. We must live within our means and we have already taken actions to reduce the size of the deficit but even with that work our budget shows that we will spend £20m more than we will receive.

As a system we must prioritise restoring financial balance. This means that there will be no money for us to invest in any new services or pilots and we must consider every service that we currently have to ensure that it is delivering value for money. We will be considering some difficult decisions around the future of services but we will not compromise on quality and safety and will be mindful of the impact that changes will have on both those who use our services and those who deliver them.

4.6 Our health infrastructure and estates challenges

Our Integrated Care System (ICS) faces critical infrastructure and estates challenges as we work to meet growing healthcare demands across Coventry and Warwickshire. With over 1 million people served across 284 properties, our estate comprises a wide range of facilities, from acute hospitals to community clinics and GP surgeries, many of which vary in age, condition, and capacity. Maintaining, modernising, and repurposing these facilities requires significant investment and a strategic approach to align with our healthcare priorities.

Our Infrastructure Strategy, approved in May 2024, addresses these challenges by guiding the evolution of our estate to support current and future healthcare demands. Key priorities include:

- **Responding to Population Growth and Complexity**: Adapting our estate to address the growing and aging population, especially in areas with increased demand.
- **Optimising Estate Utilisation**: Ensuring facilities are adaptable and flexible to support integrated, community-based care closer to home.
- **Capital Constraints and Prioritisation**: Given limited capital resources, projects are strategically prioritised to maximise impact, focusing on reducing critical infrastructure risks, backlog maintenance, and aligning with Place-based developments.
- **Advancing Technological Integration**: Incorporating digital infrastructure to enhance service delivery and improve patient access.

Additionally, the Strategy relies on continuous input from clinical, digital, and workforce leads, with Local Estates Forums at Place level working closely with the Strategic Estates Group to assess local needs, explore standardisation opportunities, and plan for sustainable growth.

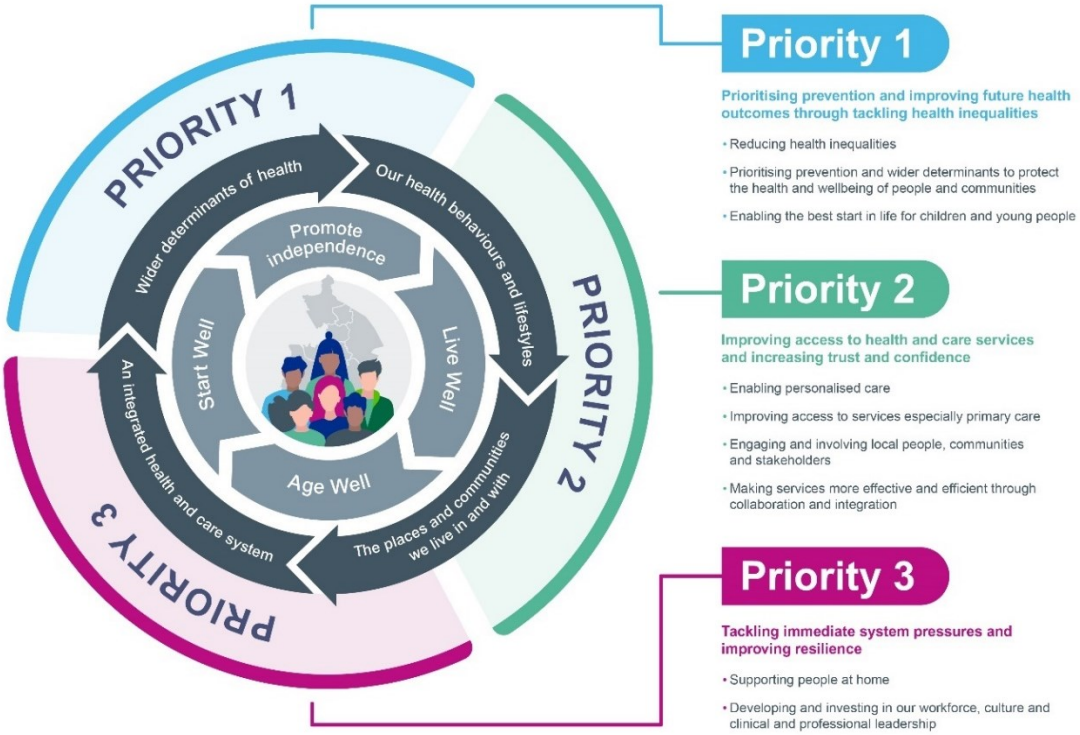
Rehabilitation bed provision is an essential focus within this framework. The Ellen Badger Hospital (EBH) and Stratford Hospital developments reflect our commitment to modernising community hospital rehabilitation services while supporting the broader shift to a “Home First” approach, emphasising community and home-based care

4.7 Our Integrated Care Strategy

In order to meet the challenges outlined above we need a fundamental transformation in our health and care system. Integration remains a huge opportunity and we are already transforming our system to do things differently. Integrating care can reduce duplication in services, shift care to community settings, prevent unnecessary tests and treatments, and cut hospital admissions which will drive significant cost savings as well as improving the efficiency in how we do things and relieving the pressure on our workforce.

At the start of the autumn of 2022, partners in the Coventry and Warwickshire Integrated Care System came together through the Coventry and Warwickshire Integrated Care Partnership to embark on a journey to develop the first Coventry and Warwickshire Integrated Care Strategy to meet the challenges facing the system. Building on the two local Health and Wellbeing Strategies and feedback from a range of engagement activities, the Integrated Care Strategy sets out the Integrated Care Partnership’s vision and ambitions for what partners in our Integrated Care System can achieve together, framed around three strategic priorities, nine areas of focus and a number of enablers.

Figure 6 Integrated Care Strategy Priorities



The Integrated Care Strategy reflects what is important to partners collectively and our strong shared belief that working together towards common goals is the best way to integrate and transform health and care services, tackle inequalities and improve health and wellbeing outcomes. The strategy is underpinned by our local Population Health Framework, which recognises not only the wide range of factors that impact the health and wellbeing of people and communities in Coventry and Warwickshire, but also the diverse resources that different partners, and communities themselves, can offer when we come together in partnership.

Across the spring of 2023, the ICB, Coventry City Council, Warwickshire County Council and other partners in the Coventry and Warwickshire health and care system worked together to develop the Coventry and Warwickshire Integrated Health and Care Delivery Plan 2023/24 – 2027/28 – to act as the shared health and care system delivery plan for the Coventry and Warwickshire Integrated Care Strategy. The ICB again took# an inclusive approach to the development of the plan, engaging broadly with a range of partners, and system groups and forums, to ensure that the plan builds on and reflects the strengths and assets of our diverse system.

The plan sets out our aims and priorities for the next five years to ensure that we will:

- Meet the needs of our population;
- Respond to the three strategic priorities, nine areas of focus and enablers identified in the Coventry and Warwickshire Integrated Care Strategy;
- Align our priorities to those of our local Health and Wellbeing Boards as reflected in the Coventry and Warwickshire Health and Wellbeing Strategies;

- Make tangible progress in addressing the four core aims of our wider Integrated Care System – improving outcomes in health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development;
- Deliver the national NHS Long Term Plan and wider priorities, all of which resonate from a Coventry and Warwickshire population health perspective; and
- Meet the statutory requirements of our Integrated Care Board.

It is in the context of this wider need for change, the challenges facing the system and the steps which we are already taking, in which our case for change for community hospital rehabilitation beds is set.

4.8 Our case for change regarding community hospital rehabilitation beds

Our ICS is committed to providing high-quality, patient-centered care that adapts to the changing needs of its residents. In recent years, demographic shifts, evolving patient needs, and national policy directions mean we need to examine our community bed provision to ensure resources are optimally allocated for patient recovery and independence.

The need for this reconfiguration is twofold: to meet growing patient demand in South Warwickshire while aligning our community bed provision with the financial and clinical sustainability required by current health policies. This dual focus ensures we optimise resources while upholding high standards of patient care.

Our key drivers for change include:

- Increasing demand and complexity of our patients
- Healthcare accessibility
- System alignment with national goals
- Infrastructure limitations

4.8.1 The development of the case for change

The development of a case for change has been driven by a series of reviews and assessments between 2019-2024, to understand whether services in South Warwickshire offered value for money and met patients' needs.

a) Discharge to Assess (D2A) Review (2020-2021)

The Discharge to Assess (D2A) Review for 2020-2021, led by Warwickshire County Council and SWFT with support from system partners, aimed to evaluate the current delivery and future needs of D2A pathways and community hospital bed provision in South Warwickshire.

Key points:

1. Community Hospital Inpatient Facilities: Provide Pathway 2 level support with nursing care for patients needing ongoing care, assessment, and rehabilitation, who cannot be managed in the community.
2. Review Recommendations: Included a dedicated review of the Community Hospital model to ensure it meets future requirements.

b) Dedicated review of community hospitals: Community Bed Review Case for Change (2021)

A Community Bed Review: Case for Change (Appendix 7 Community Bed Review Case for Change) completed a strategic review of community hospital bedded provision in South Warwickshire between April 2018 and February 2021 due to Community Hospital inpatient services never having been strategically reviewed.

The full background and Case for Change was presented to SWFT Management Board in May 2021. The Case for Change outlined the need to review current community hospital utilisation and to agree the future service configuration to ensure this remains in line with operational and clinical need and aligns to the local and national policy context.

c) Strategic review of Community Hospital inpatient services (2023)

The Community Bed Review, developed by SWFT, appraised a series of options regarding the future delivery of South Warwickshire Place community hospital inpatient and community at home services. This review was driven by the Discharge to Assess (D2A) models and aimed to:

- Understand and right-size community bed requirements and support needs.
- Present options based on feedback from service users, families, carers, and stakeholders.
- Use population health data to target support effectively.
- Collaborate with partners on future service design and delivery.
- Define the vision for the next 1-4 years.

The review led to SWFT's commissioning intentions for the future of Community Hospital provision, with the SWFT Trust Board approving recommendations on April 5, 2023. The outcomes of the review were then submitted to the ICB Board in July 2023 to consider a series of options regarding the future delivery of community hospital inpatient services/beds in South Warwickshire Place that would support:

- Improving outcomes in population health and healthcare
- Tackling unequal outcomes, experience and access
- Enhancing productivity and value for money

The recommended way forward in the Community Bed Review proposed an increase in the number of community beds, improvements and additional community and care at home services, and a change in location of the community beds from the Ellen Badger Hospital to Leamington Spa Hospital.

d) Consideration of the findings of the Strategic Review by the ICB

In July 2023, the ICB Board considered the SWFT Community Hospital Business Case, (Appendix 38 Pg76-82 South Warwickshire Place Community Hospital Bed Review ICB Paper 19 July 2023) which recommended '*in the context that the potential changes flowing from the Community Bed Review constitute significant service change, and in line with a recommendation from the Commissioning, Planning and Population Health Committee, the Board is asked TO APPROVE that the ICB proceeds with the development of a commissioning pre-consultation business case'*

The ICB Board approved the recommendation and in August 2023 the ICB engaged the Consultation Institute (tCI) and Capsticks Solicitors to review the SWFT business case. This identified the need for a broader review of Rehabilitation Services across Coventry and Warwickshire and the impact on other services at Ellen Badger Hospital, such as the First Aid Centre.

Key points identified for further consideration as a result of the work conducted with the Consultation Institute (tCI) and Capsticks Solicitors are listed below with the outcomes of the discussions:

- **Rehabilitation Services across Coventry and Warwickshire**: The ICB is responsible for the Coventry and Warwickshire patient population and therefore consideration should be given to rehabilitation services across Coventry and Warwickshire. A review of broader rehabilitation services across Coventry and Warwickshire was undertaken (November 2023).

  Legal and regulatory duties require public involvement for significant service changes

- **Impact on the Ellen Badger Hospital (EBH):** The impact on the Ellen Badger Hospital (EBH) would mean transitioning from an inpatient and outpatient facility to potentially an outpatient-only facility.

  The First Aid Centre, closed during COVID-19, had low utilisation and alternative minor injuries services are available nearby. Consideration for the future of the first aid centre would be included within the Urgent Care review.

- **Rehabilitation Bed Prioritisation**: Focus on South Warwickshire was required due to essential improvements required.

- **ICB Responsibilities**: Legal and regulatory duties require public involvement for significant service changes.

e) Revalidation and data refresh

The time between the decision to proceed with a PCBC (July 2023) and the completion of the review of rehabilitation services across Coventry and Warwickshire (May 2024) resulted in the need to revisit and revalidate the recommendations put forward by SWFT in their business case prior to developing a PCBC, to ensure options being proposed were viable for a public consultation. This work took place between June and August 2024 with a view to ensure all viable options for community rehabilitation beds were explored and aligned with current health and care needs.

This process included refreshing data to address current needs and circumstances, focusing on activity from April 2019 to quarter 1 of 2024.

4.8.2 Key Drivers for Change

4.8.2.1 Increasing demand and complexity of our patients

An ageing population with higher rates of chronic conditions requiring ongoing rehabilitation and support demonstrates an ongoing need for bedded rehabilitation for our residents who need it.

The Strategic review of Community Hospital inpatient services found that over 90% of community hospital activity is linked to the D2A model. Evidence showed good patient experiences but also indicated that many could benefit from home or care home recovery. It highlighted the limited flexibility in acute units during high-pressure periods and a lack of alternative community services.

Factors likely to impact future community bed offers include:

- Frailty Model of Care: Reducing A&E attendances and non-elective admissions for those over 55.
- Proactive Care in Care Homes: Reducing urgent care usage by 30% in Warwickshire North, with similar expectations for South Warwickshire.
- Telehealth Deployment: Supporting community living through remote health monitoring.
- Reconfigured Place-Based Teams: Focusing on enhanced community support and prevention.
- Therapy Teams: Providing urgent response and supporting higher dependency patients at home.
- D2A Pathways: Enhancing Pathway 1 to support more people at home.
- Restricted Mobility Pathway: Enabling more people to return home.
- Hospice Redesign: Ensuring a robust hospice offer with continued inpatient presence in South Warwickshire.

Push Factors for Increased Demand:

- Pandemic Pressures: Continued winter pressures and potential new waves of infection impacting acute services and COVID-19 management.
- Annual Winter Pressures: Ongoing challenges.
- Stroke Rehabilitation: Full utilisation of Feldon Ward for stroke rehabilitation, reducing non-stroke patient support.
- Elective Procedure Recovery: More patients needing rehabilitation post-procedure.
- Care at Home Market: Need for a resilient market to support increased home-based care.
- Demographic Pressures: Ageing population with more long-term conditions, including dementia and frailty.
- Wider Health Determinants: Impact of undiagnosed dementia and hip fractures.

Needs Assessment Highlights:

- Average Age: Patients accessing community beds average 83 years, with the largest group being 85-89 years.
- Gender: 62% of admissions are female.
- Ethnicity: 93% of admissions identify as ‘White’.
- Discharge Outcomes: Most patients return home; 10.5% of Nicol patients exit as RIP, indicating end-of-life care.
- Geographic Origin: 19% of admissions from the Stratford JSNA area.

Future Bed Needs: Without changes, an additional 5-15 beds will be needed within 3 years.

4.8.2.2 Healthcare Accessibility

Data shows the highest demand for community beds in central and the northern area South Warwickshire, reinforcing the need for accessible services in these areas.

The rolling 12 months number of episodes (yearly recurrent activity) has remained reasonably stable since 2020 at a level of 520-550 episodes (Appendix 4 Community Bed Episodes SUS dataflows 2018-2024).

93.3% of all episodes relate to admissions for people from South Warwickshire.

From the 2018/19 baseline activity has increased before stabilising, with growth seen mostly in postcodes to the centre and north of South Warwickshire.

Since 2019 on a rolling 12-month basis admissions to community rehabilitation beds from Shipston, Kineton, Wellesbourne and Stratford Villages have remained relatively stable showing no overall change in access. Over the same period admissions from other areas of South Warwickshire have slightly increased.

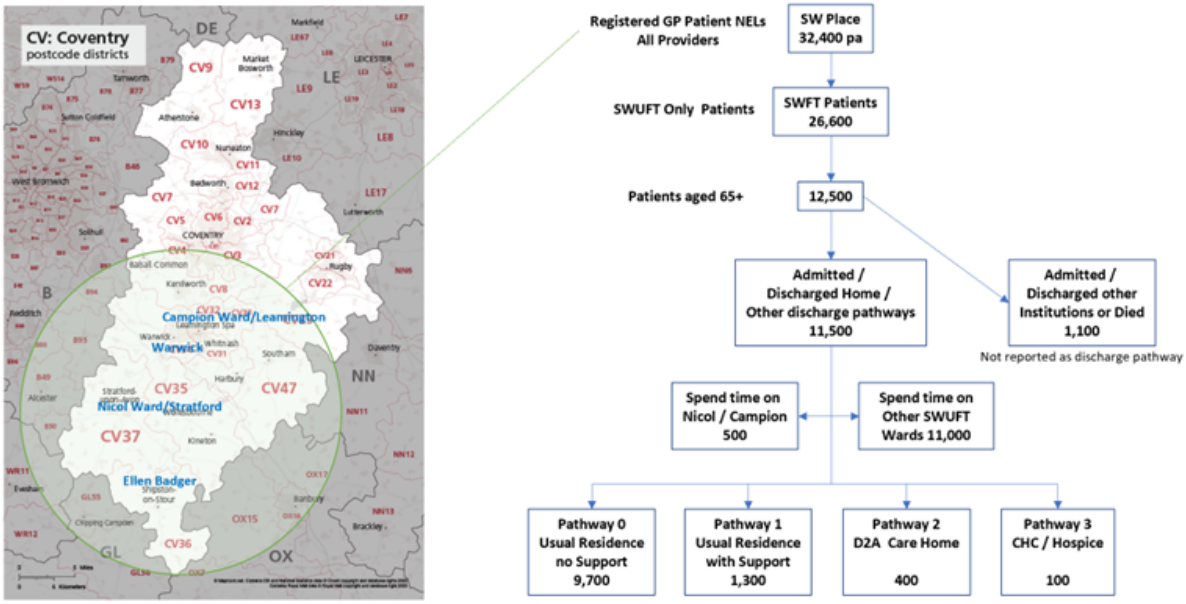
There is no evidence that access to community rehabilitation beds for residents of Shipston, Kineton, Wellesbourne and Stratford Villages has been negatively impacted by the reprovision of beds away from Ellen Badger.

The overall requirement for community beds, despite a growth in overall population size for South Warwickshire, has remained below the previous 35 commissioned rehabilitation beds from Nicol ward and Ellen Badger.

The impact of greater admissions to rehabilitation beds from other areas of South Warwickshire, now means that the admissions profile now closely matches that of the total South Warwickshire profile for those aged over 64 years, whereas the admissions profile previously showed greater variance to the overall population profile of over 64s – meaning that provision now more closely matches the need for rehabilitation beds than it did previously.

Figure 7 Yearly non-elective admissions - South Warwickshire Registered GP patients

Yearly Non Elective Admissions – South Warwickshire Registered GP patients
(population 350,905 June 2024)



Clinical audits revealed that there is no specific eligibility criteria for community hospital beds, and their use can vary based on pressures at Warwick Hospital. Generally, these beds support discharge, recovery, and rehabilitation, not elective recovery pathways. Most patients admitted have experienced trauma or unexpected illness.

Travel analysis (Appendix 8 Travel Analysis) linked to the Equality Impact Assessment (Appendix 9 Equality Impact Assessment) examined the use of community hospital beds by the over-65 population in South Warwickshire. Patient audits from April-May 2021, June 2022, and July-August 2024 assessed who used the beds and why, considering if alternative services could have met their needs.

Key findings:

- All 24 patients at Campion Ward, Leamington, and 16 out of 19 at Nicol Ward, Stratford, required rehabilitation support.
- Patients not needing rehabilitation had end-of-life diagnoses or were awaiting Continuing Health Care (CHC) fast track.

The review concluded that the current community hospital bed model is unsustainable and should be integrated into a new rehabilitation strategy aligned with the “home first” approach. Many patients could be better supported in alternative settings, promoting independence and well-being.

4.8.2.3 System Alignment with National Goals

In alignment with the NHS Long Term Plan and the Home First approach, South Warwickshire aims to enhance recovery pathways that support patients in home and community settings whenever possible. This reconfiguration will not only improve resource efficiency but also prioritise patient-centred care that enhances independence and well-being. By shifting to a more adaptable community-based model, we address the policy mandate to reduce hospital reliance and improve service accessibility for all residents.

The Home First approach is effective for frail and elderly patients by reducing hospital-related decline and complications from multiple care transfers. The goal is to strategically position resources to support community-based care, minimizing hospital stays and promoting quicker, safer recoveries.

It also aligned with the Discharge to Assess (D2A) model, ensuring efficient use of resources and prioritising home-based care where appropriate.

Likewise, locally enabling and supporting people to maintain their independence at home is at the heart of our approach in Coventry and Warwickshire, where “Supporting People at Home” is one of the nine areas of focus outlined in the system wide Integrated Care Strategy.

Supporting “Home First”

The Hospital Discharge Community Recovery Programme in Warwickshire is designed to support patients transitioning from hospital to home, prioritising independence and community-based recovery. This programme aligns with the 'Home First' approach, where patients are assessed and supported at home rather than in a hospital setting whenever possible. By providing tailored recovery support, the programme reduces the need for extended inpatient rehabilitation, facilitates faster hospital discharges, and prevents unnecessary hospital readmissions. This approach also helps to optimise bed availability for those with the most critical needs.

Integrating this programme into our local health and care strategy allows us to reshape and strengthen our community rehabilitation services. As a result, the need for inpatient rehabilitation beds is reduced, with resources redirected towards enhancing community support and facilitating earlier discharges. This aligns with our strategic goals of sustainability, high-quality care, and reduced reliance on bed-based care

The key aims of our Delivery Plan to support care at home are

- An improved and more responsive coordination and delivery of health and care within an individual’s own home when urgent and emergency care is required – this will help prevent people making unnecessary visits to hospitals.
- Where ongoing support, health or care or both, is required, people are enabled to continue to live independently – this is reliable, sustainable and responsive to change as people’s requirements change.
- Where people need to visit hospital for treatment, this is undertaken in a patient-centred and effective manner, with the focus on people returning home as soon as possible.
- Where people have had a change in their health as a result of deterioration or a specific episode in their life, they are supported to recover and re-able to maximise their individual health and wellbeing outcomes.

Expanding care delivered outside of hospital so that people can access the care that they need closer to home without the need for hospital admission will be critical in supporting the delivery of the overall aims above.

The role of Community Hospitals

Community Hospitals in South Warwickshire are integral to the Discharge to Assess (D2A) Pathway 2 model. The two hospitals, Ellen Badger Hospital in Shipston on Stour and the Nicol Unit at Stratford

Hospital, provide inpatient care with medical cover from local GPs and therapy and nursing support from SWFT.

Since July 2013, these hospitals have uniquely co-existed with the D2A pathways. Their identities have evolved based on patient needs, staff skills and leadership, clinical culture, and the care environment. The service criteria at these hospitals are broad and adaptable to operational demands.

The Community Hospital Bed Offer primarily provides acute discharge (step down) beds, accounting for about 90% of admissions. These beds cater to patients recovering from acute illnesses who need short-term, 24-hour medical or nursing care, or further assessment, therapy, and discharge planning.

Additionally, the offer includes admission prevention (step up) beds, which make up less than 10% of admissions. These beds are for patients with deteriorating health conditions that require medical or nursing intervention but do not need acute admission and cannot be managed at home.

4.8.2.4 Infrastructure Limitations

The retained estate at Ellen Badger which hosted the original 16 beds was not fit for purpose and has needed reconfiguration to address issues such as asbestos in the original building structure. This work means that in is now only possible to host a maximum of 12 beds on the site, meaning that we cannot return to the original configuration of 16 beds at the Ellen Badger site.

The redevelopment of Ellen Badger Hospital in Shipston-on-Stour was planned in phases alongside the Discharge to Assess (D2A) review and the Community Hospital Case for Change/Strategic Review. The first phase aimed to establish a Health and Wellbeing Centre with clinical facilities, (see section 4.6 estates) while the second phase focused on future plans for inpatient beds.

In January 2022, 16 community beds were temporarily moved to Leamington Spa Rehabilitation Hospital to accommodate construction. As work progressed, the hospital's footprint had to be revised, reducing the number of beds it could house. The facility no longer met acute inpatient standards, requiring significant capital investment for updates, including asbestos clearance, new windows, a back-up generator, catering facilities, and infection prevention compliance.

It was clear that if inpatient beds were to return to Ellen Badger Hospital, it would be part of Phase 2, following the completion of the first phase (March 2025).

The ageing infrastructure of hospitals underscores the need for change. A comprehensive public consultation will ensure patient needs are central to service redesign, meeting the demands of an ageing population and allocating resources effectively.

4.8.3 Summarising our case for change

The evidence presented highlights an undeniable need to reconfigure community hospital rehabilitation bed services in South Warwickshire. The case for change is driven by increasing demand, the evolving needs of an ageing population, infrastructure limitations, and alignment with national policies like the NHS Long Term Plan and "Home First" principles.

Key takeaways include:

- The demographic pressures of an ageing population demand a sustainable approach to rehabilitation that prioritises home and community-based care.

- Existing infrastructure, particularly at Ellen Badger Hospital, is no longer fit for purpose, necessitating a reimagined bedded provision.
- The shift toward enhanced home and community care aligns with national goals to reduce reliance on hospital stays and improve patient outcomes.
- Data and reviews underscore the necessity for resource optimisation, balancing accessibility and quality with financial and operational sustainability.

This section lays the foundation for the proposed changes outlined in the Pre-Consultation Business Case (PCBC). The recommendations prioritise patient-centered care, equity in access, and sustainability, ensuring that South Warwickshire's community hospital and rehabilitation services can meet current and future needs effectively. The journey forward will involve collaboration, public consultation, and a commitment to reshaping services to achieve the best outcomes for our population.

5. Understanding the services we are reviewing

This chapter outlines the current situation regarding community hospital services in Coventry and Warwickshire, focusing on South Warwickshire. It highlights the need for further development to ensure equitable access to these services across the geographical footprint for which the Integrated Care Board (ICB) is responsible. The chapter also explains why South Warwickshire was prioritised for review and how this aligns with the wider community strategy and planned rehabilitation services.

5.1 Community Hospitals in South Warwickshire Place

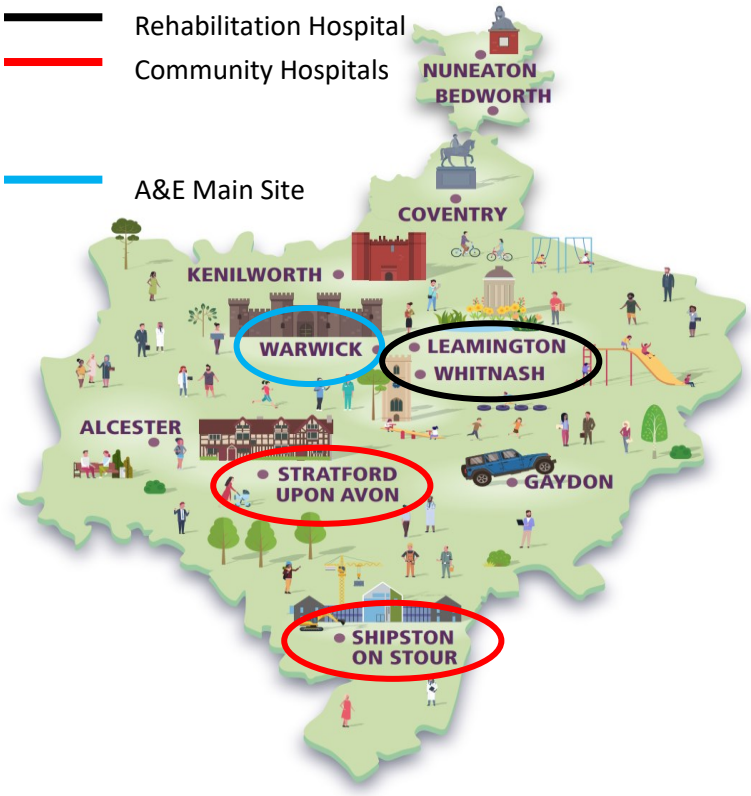
Community hospitals play a crucial role in expediting discharges from acute hospitals and, to a lesser extent, preventing admissions. These are small, bedded units that provide a range of services, including treatments, rehabilitation, and end-of-life care. Medical cover is provided by local GPs rather than on-site consultants, while nursing and therapy services are delivered by South Warwickshire University NHS Foundation Trust (SWFT).

In South Warwickshire, there were two community hospitals with inpatient units:

- Ellen Badger Hospital in Shipston on Stour
- Nicol Unit at Stratford Hospital

These hospitals are part of the Discharge to Assess (D2A) Pathway 2 model, where patients are discharged from acute hospitals to be assessed for ongoing care needs in community settings. Medical cover is provided by GPs, while therapy and nursing are managed by SWFT.

Figure 8 Map of Coventry and Warwickshire and South Warwickshire Hospital Locations



Since July 2013, South Warwickshire has maintained its community hospital model alongside D2A pathways. Over time, the identity and services of both community hospitals have evolved, shaped by patient needs, staff expertise, and local demand. However, recent developments have resulted in only one functioning community hospital, Stratford upon Avon, while decisions are being made about the future of Ellen Badger Hospital.

5.1.1 Development of the Ellen Badger Hospital (EBH) Site

The redevelopment of the Ellen Badger Hospital (EBH) in Shipston will create enhanced clinical spaces for hospital and community services, bringing more specialties and clinics closer to the local communities in and around Shipston. The development also includes the infrastructure to bring on-site mobile diagnostics and spaces for the local hospice, which will benefit from integration with our community nursing teams..

The modernisation of Ellen Badger Hospital will see the provision of a Health and Wellbeing Centre which is an opportunity for Shipston to expand on their existing pro-active approach to health and wellbeing. It will support the health and wellbeing needs of the community in Shipston and the surrounding villages, by delivering conventional healthcare alongside activities to address social factors.

To ensure the Health and Wellbeing centre is reflective of community needs, SWFT have worked closely with the Stour Health and Wellbeing Partnership (SHWP). The Health and Wellbeing space at the new Ellen Badger Hospital has been developed with input from the SHWP and informed by local Healthwatch engagement (Appendix 3 Health Impact Assessment Report April 2022).

Initially approved in October 2018, this development has always been driven by the vision of enhancing healthcare access, in alignment with national policy on integrated care. The new Ellen Badger Hospital will provide:

- **Community and Preventative Services**: Classes on healthy lifestyle habits, physical exercise, and support groups targeting conditions such as cardiovascular disease.
- **Enhanced Outpatient and Diagnostic Capacity**: Dedicated spaces for outpatient services and mobile diagnostics, allowing access to specialist nurses and healthcare professionals close to home..
- **Hospice and Community Nursing Integration**: Spaces for local hospice care in coordination with community nursing teams, ensuring seamless support for end-of-life care.

Phase one of the EBH redevelopment is currently under construction. Phase two—initially intended to restore inpatient beds—has been re-evaluated in light of modern healthcare standards. Given the shift towards the “Home First” model and the evolving demands on healthcare infrastructure, the focus is now on home-based and outpatient care that promotes independence and supports patients in their own homes..

This is a separate programme of work to the Community Bed Review although it instigated the need to temporarily relocate the beds and has changed the building footprint.

During construction, 16 community beds were temporarily relocated to Campion Ward at Leamington Spa Hospital to ensure patient and workforce safety. As SWFT progressed with the EBH redevelopment, structural limitations, including the discovery of asbestos, reinforced the need to adapt their approach to a more sustainable model of care. This strategy aligns with national policies that emphasise community-based care, ensuring that EBH serves as a comprehensive integrated healthcare facility while optimising inpatient resources across the ICS to meet the highest levels of need.

Phase two—initially intended to restore inpatient beds—has been re-evaluated in light of modern healthcare standards. Given the shift towards the "Home First" model and the evolving demands on healthcare infrastructure, the focus is now on home-based and outpatient care that promotes independence and supports patients in their own homes. This strategy aligns with national policies that emphasise community-based care, ensuring that EBH serves as a comprehensive health and wellbeing hub while optimising inpatient resources across the ICS to meet the highest levels of need.

5.1.2 Leamington Spa Rehabilitation Hospital

Leamington Spa Rehabilitation Hospital, located in Warwickshire, provides specialist rehabilitation for patients recovering from complex conditions like neurological disorders, major trauma, and strokes. It is renowned for its Neuro Rehabilitation Centre, offering multidisciplinary services tailored to improve patient independence and quality of life.

In 2022, the 16 beds from Ellen Badger Hospital were temporarily relocated to Campion Ward, a vacant ward that would accommodate the needs of the patients at Leamington Spa Rehabilitation Hospital to accommodate Ellen Badger's redevelopment.

5.1.3 Community Hospital Beds and Equality of Provision

Community bed provision is not uniform across Coventry and Warwickshire. In South Warwickshire, the focus is on current provision and the relocation of beds from Ellen Badger Hospital. In comparison, other areas, such as North Warwickshire, rely on care homes with spot-purchased beds, which may not provide the same level of rehabilitation support.

There are currently 44 community beds in Rugby, 16 beds moved from EBH now in Leamington Spa, and 19 beds at the Nicol Ward in Stratford.. These beds are essential in providing step-down care for patients from acute services. Alongside this core bed stock there is flexibility for additional beds during periods of peak demand such as winter which allows Campion Ward in Leamington Spa to go up to a maximum of 29 beds and 21 beds in Nicol Ward in Stratford. Note, these beds are unfunded and only support through additional winter funding allocations. In North Warwickshire, rehabilitation care is provided in care homes, but it is often less integrated and dependent on demand.

The ICB aims to address these inequities by developing community contracts and rehabilitation strategies, ensuring more consistent and effective rehabilitation services across the region. A range of opportunities aligned to this ambition have been identified throughout the rehabilitation review across CW ICS.

5.2 Understanding the role of community hospitals

Community hospitals bridge the gap between acute care and home-based or primary care. They offer services such as rehabilitation, palliative care, and step-down care from acute hospitals, while often acting

as hubs for outpatient services. Their role has evolved in response to healthcare system pressures, including an aging population and increasing prevalence of long-term conditions.

Key roles of community hospitals include:

- Intermediate Care: They offer a step-down option for patients who no longer need acute care but require ongoing medical supervision and rehabilitation.
- Rehabilitation and Recovery: Particularly for elderly or chronically ill patients, community hospitals enable recovery and the regaining of independence.
- Palliative and End-of-Life Care: Many hospitals provide palliative services in a less clinical environment than acute hospitals.
- Local Accessibility: Community hospitals are typically more accessible for local populations, reducing the strain on larger hospitals.
- Support for Primary Care: These hospitals support local primary care providers through outpatient clinics, diagnostic services, and chronic disease management.

5.3 Community vs. Acute Hospital Rehabilitation Beds

Understanding the difference between community hospital rehabilitation beds and acute hospital beds is key to recognising the value of each in the patient care journey.

- Purpose of Care:
  - Community Hospital Beds focus on rehabilitation after the acute phase of illness or surgery, providing extended support.
  - Acute Hospital Beds focus on immediate, high-intensity care for serious conditions or surgeries.
- Length of Stay:
  - Community Beds: Longer stays (weeks to months) focused on rehabilitation.
  - Acute Beds: Shorter stays (days to weeks) for stabilising acute conditions.
- Intensity of Treatment:
  - Community Beds: Less intensive, with structured rehabilitation routines.
  - Acute Beds: High-intensity care, with 24/7 monitoring and specialist intervention.

This distinction highlights how both types of beds serve vital but different roles in patient care and recovery.

5.4 What is rehabilitation and the future of community care?

Rehabilitation is critical in helping individuals recover and live independently after illness or injury. As outlined by the NHS Long Term Plan, rehabilitation must shift towards integrated, community-based services that reduce reliance on hospital care. This approach emphasises early intervention and ongoing support within the patient's home environment.

The ICB is committed to improving community-based rehabilitation services, ensuring they are accessible, holistic, and aligned with the future needs of the population.

5.5 Discharge to Assess (D2A)

The *Discharge to Assess (D2A)* service (see chapter 3 section 3.6 for a detailed breakdown of the pathways) allows patients to be discharged from acute hospitals to alternative care settings where their ongoing needs are assessed. This approach prevents long hospital stays and allows patients to receive care in a more appropriate, less intensive setting, such as their own home, a community hospital, or a nursing home. The service aims to ensure no long-term care decisions are made in acute hospitals, instead focusing on personalised care plans developed in the community.

5.6 Summary

In summary, South Warwickshire's community hospital services, particularly within the framework of ongoing redevelopment and the Discharge to Assess (D2A) pathway, are critical in supporting patient rehabilitation, preventing hospital readmissions, and alleviating pressure on acute services. As these services continue to evolve, the focus will remain on equity, accessibility, and patient-centered care.

Despite an aging population, Chapter 3 highlights that demand for community hospital beds has remained stable over the past five years. The current review is centered on determining the most appropriate permanent geographical location for these beds, rather than reducing the number of beds.

Community hospitals provide intermediate care, acting as a step-down option for patients who no longer require acute care but still need medical supervision and rehabilitation. These are distinct from acute beds, which cater to high-intensity care for severe conditions or surgeries.

6. The National Context

This chapter outlines the national context in which we are undertaking our Community Hospital Rehabilitation Bed Review. It summarises the challenges the NHS is facing at the national level and NHS England's strategy, ambitions and measures. This includes recent government guidance on hospital discharge, community services, and community hospitals which emphasises collaboration between the NHS, local authorities, and other sectors to ensure a smooth transition for patients from hospital to home or community-based settings. The NHS Long Term Plan (published January 2019) is due to be refreshed in the Spring 2025, but the key goals remain focused on improving patient outcomes, increasing efficiency, and addressing health inequalities.

6.1 Challenges nationally and delivering NHS England's Long-Term Plan

The NHS across England is, as highlighted in the recent "Independent investigation of the National Health Service in England" report, commissioned from Lord Darzi by the Secretary of State for Health & Social Care, is "in serious trouble".

The Darzi Report identifies that, at a national level, the NHS is missing many of its key targets, from access to GPs, community, mental health services, and for accident and emergency, with waiting time targets, for routine surgery and treatment significantly above national target standards, alongside cancer and cardiac service standards.

The report also identifies the challenges facing the NHS in terms of the wider health and wellbeing of the population. The report states that "overall life expectancy increased in the 2000s, but plateaued during the 2010s, before decreasing during the Covid-19 pandemic. It has started to rise once again, with the absolute and relative proportion of our lives spent in ill-health has increasing.

"Many of the social determinants of health – such as poor-quality housing, low income, insecure employment – have moved in the wrong direction over the past 15 years resulting in the NHS being faced with rising demand for healthcare from a society in distress.

"There has been a surge in multiple long-term conditions, and, particularly among children and young people, in mental health needs. Fewer children are getting the immunisations they need to protect their health and fewer adults are participating in some of the key screening programmes, such as for breast cancer. The public health grant has been slashed by more than 25 per cent in real terms since 2015 and the country's main public health institution was abolished – split into two new bodies."

Although the NHS is currently refreshing the national Long-Term Plan, with a view to developing a new ten-year plan, part of the stated purpose of the *Darzi Report* was to identify the major themes for the forthcoming 10-year health plan.

Of those themes – there are two of particular relevance to the move to community care.

- Lock in the shift of care closer to home by hardwiring financial flows. General practice, mental health and community services will need to expand and adapt to the needs of those with long-term

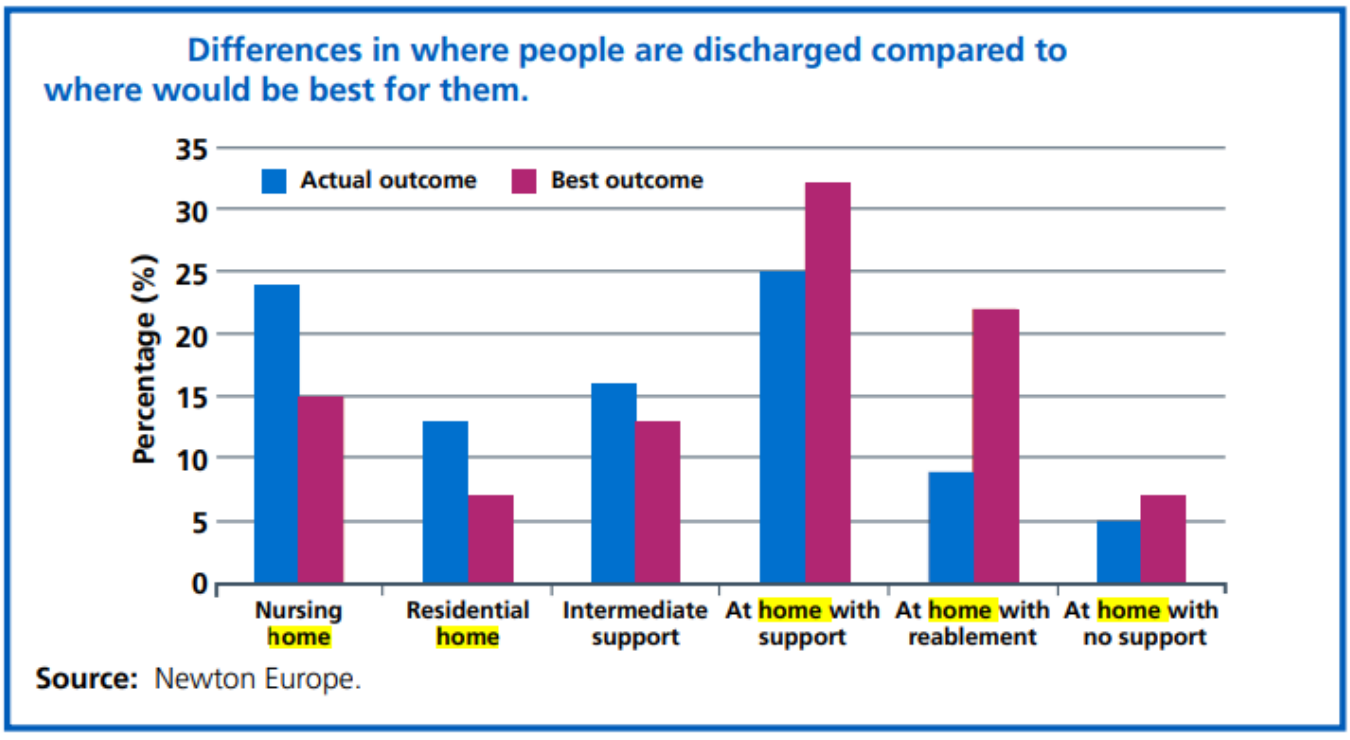
conditions whose prevalence is growing rapidly as the population age. Financial flows must lock-in this change irreversibly or it will not happen.

- Simplify and innovate care delivery for a neighbourhood NHS. The best way to work as a team is to work in a team: we need to embrace new multidisciplinary models of care that bring together primary, community and mental health services.

This is already a key area in the current NHS Long Term Plan which states that if care is required at hospital, its goal is treatment without having to stay in as an inpatient wherever possible. And, when people no longer need to be in a hospital bed, they should then receive good health and social care support to go home. To do this it sets the goal of boosting 'out-of-hospital' care, and finally dissolving the historic divide between primary and community health services.

The Long Term Plan also sets out the need for more people to be discharged directly to their homes, through the below graph, which shows the difference in where people are discharged compared to where is best for them, with too many people being discharged to nursing homes, residential support and intermediate support (such as community rehabilitation beds), where the best outcome would have been for them to be discharged home.

Table 4 Differences in where people are discharged compared to where would be best for them



6.2 The national 'Home First' approach

Prolonged stays in hospital are bad for patients, especially for those who are frail or elderly. Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, infection spread and sometimes mental and physical deconditioning. Despite this, nearly 350,000 patients spend more than three weeks in acute hospitals each year.

The national approach to “Home First” is a focus on supporting people to be discharged home as the default discharge pathway, with alternative pathways for people who cannot go straight home, as is outlined in the “Hospital discharge and community support” statutory guidance.

Hospital discharge is the final stage in an individual’s journey through hospital following the completion of their acute medical care, when they leave an acute setting and move to an environment best suited to meet any ongoing health and care needs, they may have. This can range from going home with little or no additional care (simple discharge), to a short-term package of home-based or bed-based care and recovery support in the community, pending assessment of any longer-term care needs (complex discharge). Whether at home or in a community setting, individuals should be discharged to the best place for them to continue recovery (if needed) in a safe, appropriate, and timely way.

Health and social care professionals should support and involve the patient to be discharged in a safe and timely way to ensure they do not spend longer than necessary in an acute or community hospital, or local authority run community setting. People should be discharged once they no longer need care in that setting. Timely discharge from acute settings improves a person’s outcomes and reduces the risk of medical complications such as deep-vein thrombosis, hospital acquired infections and loss of independence, Evidence suggests that even 10 days of bedrest is associated with significant muscle loss in older adults.

The guidance outlines that local areas should adopt discharge processes that best meet the needs of the local population. NHS bodies and local authorities in local areas should work together to plan, commission, and deliver discharge services that are effective and affordable within the budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Under the discharge to assess model and home first approach to hospital discharge, the vast majority of people are expected to go home (that is, to their usual place of residence) following a spell of care within an acute setting.

The discharge to assess model is based on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. It is best practice that any assessment of longer-term (ongoing) needs should be anticipated and initiated during a person’s recovery journey but not fully completed until the person has reached a point of stability where it is possible to make an accurate assessment. The transition from recovery support to ongoing support should be seamless.

This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence and quality of life as soon as possible. It also supports hospital flow, maximising the availability of acute hospital beds for people requiring inpatient care and elective surgery.

Local areas should agree how to use their resources most effectively to improve discharge including, where necessary, developing more home-based, strengths-based care (drawing on the person’s strengths and assets) to support, and reduce reliance on bed-based provision. Home may be someone’s own home or usual place of residence.

The guidance also notes that people should not be routinely discharged to a community step-down bed simply to free up a hospital bed availability, nor should they routinely be discharged to a community bed simply because home-based care is not available. Where this does happen, it should be a short-term solution and reviewed quickly following discharge. Effective demand and capacity planning will support the provision of adequate therapy and rehabilitation packages. Further information can be found in Chapter 4 Case for Change where the Coventry and Warwickshire approach to supporting people at home is outlined.

Both options being proposed are aligned to the national direction of travel and Coventry and Warwickshire's priorities outlined in Chapter 4.

7. Stakeholder Engagement

This chapter describes a summary of Coventry and Warwickshire ICB's approach to stakeholders, how we have involved stakeholders and used their views in the development of proposals for public consultation.

7.1 How we engaged stakeholders

In line with S.14Z45 and S.242 of the National Health Service Act 2006, SWFT took early steps to involve patients and the public in planning the future of community hospital rehabilitation beds and developing proposals for potential changes in service provision.

Engagement began in 2021 with the establishment of a Communications and Engagement work stream. This group, supported by the Consultation Institute oversaw stakeholder analysis and management, as well as the development and delivery of a comprehensive communications and engagement plan (Appendix 10 - Community Inpatient Review Involvement and Engagement Plan).

Stakeholders were categorised into 'previous', 'current' and 'potential future patients' as well as 'professionals', including the community inpatient teams. In accordance with S.13G and S.14T of the National Health Service Act 2006, and the Equality Act 2010, engagement activities were carefully targeted, using the Equality Impact Assessment (EIA) (Appendix 9 - Equality Impact Assessment) these activities aimed to ensure inclusivity and reduce health inequalities in terms of access and outcomes. Consideration was given to diversities throughout the stakeholder engagement process.

7.2 Overview of key stakeholder activity

SWFT commissioned the Consultation Institute to provide independent expert advice and guidance to ensure a robust and comprehensive approach to engagement and involvement in line with statutory duties and Common Law. The Consultation Institute also provided advice following NHS England Guidance with respect to service change.

Stakeholder panels

Following advice from the Consultation Institute, SWFT initiated a Technical Expert Panel, which first convened in November 2021 and then re-convened in January 2022 (see Appendix 11 - Technical expert panel November 2021 and January 2022). The panel's role was to assess the viability of proposals derived from the initial engagement with past, current and potential patients. Only those proposals deemed viable were progressed at this stage. A detailed description of the options development process is set out in Chapter 11, including the full list of options.

In December 2021 a panel of community representatives was convened to review the inpatient proposals shortlisted by the Technical Expert Panel. Whilst the original intention was to hold this panel in person, due to the high prevalence of Covid-19, SWFT's Infection Prevention Lead advised that the session be conducted virtually.

Representatives were invited to participate in the Community Panel (see Appendix 12– Organisations and individuals invited to Community Panel and Appendix 13 – Community Panel presentation). The final attendees comprised of representatives from patient forums, senior citizens groups, hospital league of

friends, carers organisations, faith groups, health and wellbeing partnerships, Citizens Advice Bureau, Heath Watch, community support groups, dementia support groups, disability support groups, community and voluntary action (CAVA). Attendees were provided with information prior to the panel session (see Appendix 14 - Community Panel Pre Session Information).

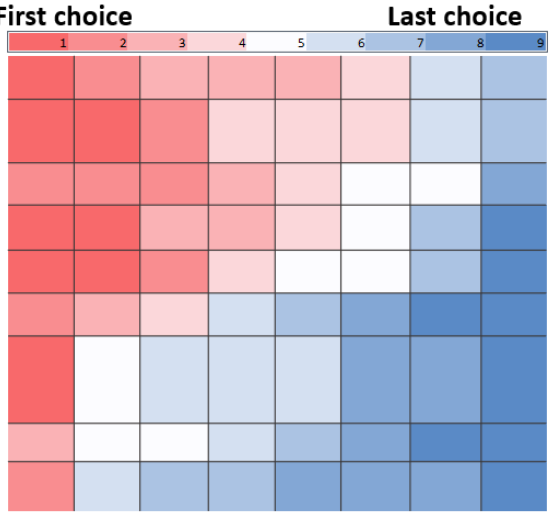
During the session, the panel agreed on things that were important to them which made the options more desirable. Below is a visual representation of the words that panel members submitted.

Figure 9 Visual representation of outputs from panel members

The Community Panel also ranked the options available in order of their preference and the wider communities they represent and scored each based on their preferences for the most and least favourable options. The chart below illustrates how the options were scored.

Figure 10 Scoring of Options by the Community Panel

Rank	Options
1	Keep the community hospital as is but change the type of services on offer: **Frailty Chair**
1	**Continue with some** of the community hospital beds and also provide some additional services in the individuals 'own home' to support and compliment this such as a package of care and therapy.
2	Keep the community hospital as is but change the type of services on offer: **Diagnostics**
3	Keep the community hospital as is but change the type of services on offer: **combination of Frailty chair and Diagnostics**
4	**Reduce the number** of community hospital beds and invest in care at home and therapy.
5	Keep all of the community beds but **change the location** in terms of where these are situated in Warwickshire
6	Ensure that people who need **end of life care** are supported within inpatient or hospice in your 'own home' rather than use a community hospital inpatient bed. In addition to this, provide an enhanced 'own home' model providing enhanced therapy and care within the patients own home
7	Ensure that people who need **end of life care** are supported within inpatient or hospice in your 'own home' rather than use a community hospital inpatient bed
8	**Cease community hospital beds** and provide an enhanced 'own home' model providing enhanced therapy and care within the patients own home



The Community Panel ranked preferences illustrated that their top five options were:

1. Retain the community hospital as is but change some of the services on offer (frailty chair)
2. Continue with some of the community hospital beds as well as offering some additional support in people's own homes.
3. Retain the community hospital as is but change some of the services on offer (diagnostics).
4. Retain the community hospital as is but change some of the services on offer (combination of frailty chair and diagnostics).
5. Keep all of the community beds but change the location in terms of where those were situated in Warwickshire.

The Technical Expert panel who met for a second time in January 2022 and were then provided with the outputs and scores of the Community Panel. The Technical Panel were then asked to review the options once again against the feedback.

When combining the outputs of all the engagement activities it was noted that it would be appropriate to merge several of the options (1.Retain the community hospital as is but change some of the services on offer (frailty chair), 3.Retain the community hospital as is but change some of the services on offer (diagnostics and 4.Retain the community hospital as is but change some of the services on offer (combination of frailty chair and diagnostics)) as they were significantly similar.

The fifth option selected was to retain the Community Hospital offer but change the location, this option was included based on the service offering at Leamington and being able to co-locate the ward with other inpatient services which will provide clinical cover and access to dedicated therapy areas. It was also reflective of the post code analysis, which highlighted that many patients were having to travel significant distances for the inpatient facilities in Shipston on Stour and Stratford. With both units located in the Stratford upon Avon district of south Warwickshire, there were inequities for our populations located centrally and further north of the county. Leamington Spa Hospital is centrally located and closer to a much higher proportion of the users of community hospital inpatient services.

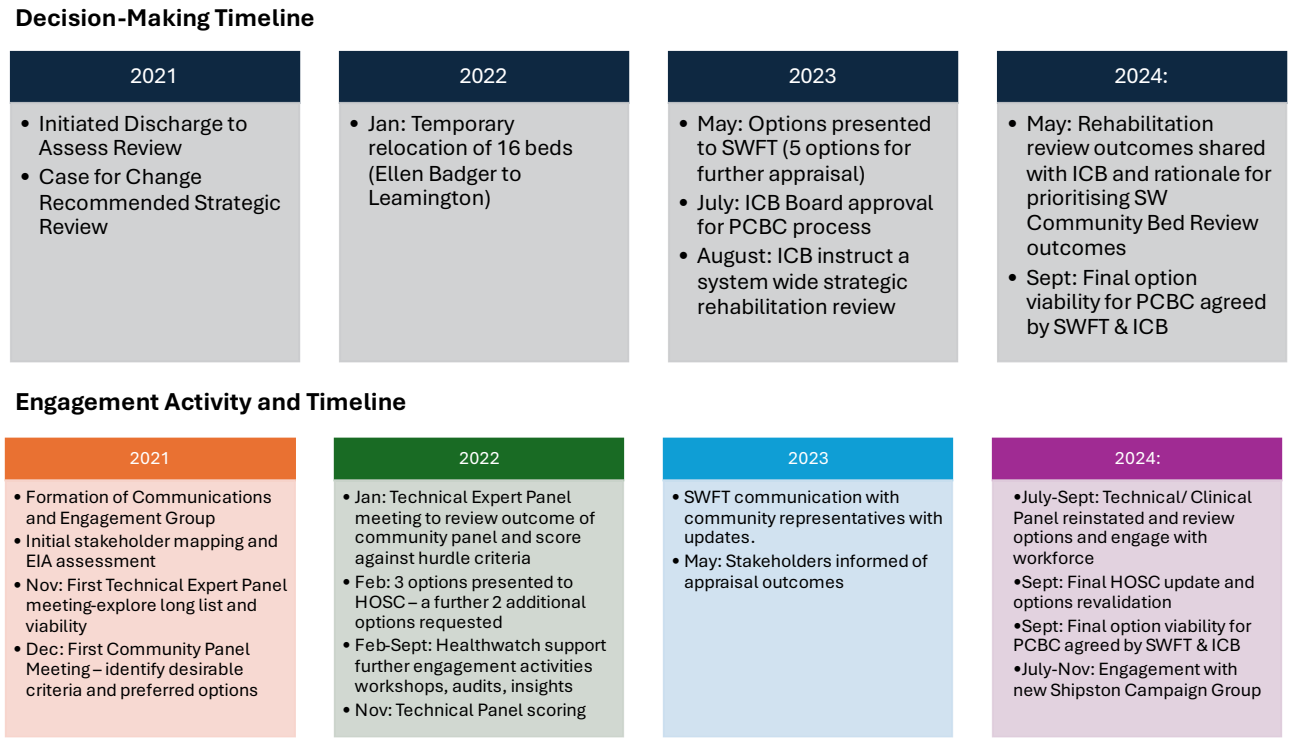
In line with S.244 of the National Health Service Act 2006, the outputs of all the engagement activities and a final list of three potential proposals were considered by the Warwickshire Health Overview and Scrutiny Committee ('the Warwickshire HOSC') in February 2022. Discounting the bottom three options which are listed above the final proposals shared with the HOSC are identified in the following table:

Table 5 Final list of proposals submitted to HOSC 2022

No	Proposal
1	Retain the Community Hospitals offer but change the type of services e.g: • Diagnostics • Frailty Chair • A combination of the above or 'other' to be identified service offers alongside BAU or reduced number of Community beds.
2	Continue with some of the Community Hospital beds and invest in homebased alternatives such as package of care or therapy and/or a virtual ward in the community.
3	Retain the Community Hospital offer but change the location.

At this meeting Warwickshire HOSC did request that two additional proposals were taken forward to Options Appraisal (keep the bedded offer the same in both location and number or to increase the number of beds), which resulted in five options being fully appraised within the Community Bed Review. Following this, the Portfolio Holder for Health and Care received regular briefings on the progress of the review.

Figure 11 Decision-making timeline and Engagement Activity 2021-2023



Technical and community panel members were kept informed on the progress of the review, with a direct email sent in May 2023, making them aware of the recommendations SWFT were proposing to the ICB for their consideration.

In June 2024, NHS Coventry and Warwickshire ICB recognised the need to revisit the proposed options due to the time elapsed since their development. This review aimed to incorporate any new key considerations regarding community hospital bed provision, drawing on insights from the rehabilitation review, system-wide financial constraints, and emerging estates strategy developments.

Members of the original Technical Panel, or their successors and key leads from SWFT and the ICB, reconvened regularly to reassess the original list of options. In addition, communication with Shipston Town Council and the newly formed campaign group, 'Beds for Badger,' provided valuable input that helped shape the revised list of options (see Chapter 11 for further details on the additional options considered).

Further dedicated engagement with staff will take place during the consultation.

7.3 Overview of stakeholder engagement to date

Engagement with potential users/patients of community hospitals;

SWFT commissioned Healthwatch Warwickshire to distribute and promote surveys to target groups; previous patients (see Appendix 16 - past patient survey), potential patients and wider public and stakeholders (see Appendix 17 - potential patient survey). Healthwatch also independently analysed all survey results and published these findings on their website which can be found here; South Warwickshire community beds review | Healthwatch Warwickshire

Current patients;

To gain further insight into current patients' experience of Community Hospitals a series of face-to-face interviews were conducted with inpatients on the Ellen Badger and Stratford Hospital wards in June and July 2021 (see Appendix 18 - Current inpatient interviews).

Patients were selected on the basis that they consented to take part and that undertaking the interview would not compromise their own health or wellbeing. Patient with levels of cognitive impairment were also in scope and able to take part in the interviews with appropriate support and guidance from ward staff.

All notes from the interviews were transcribed, anonymised and shared with Sarah Barnett, Independent Research Consultant who objectively compiled these into a thematic analysis and who also highlighted key quotes directly from patients that brought this to life (see Appendix 19 - Report by Sarah Barnett, Independent Research Consultant, Warwickshire Community Hospitals Analysis).

More recently, Shipston Town Council and the newly formed 'Beds for Badger' campaign group have provided the ICB with feedback on their concerns regarding the original proposed options and the two proposed viable options (Option A and Option B). In response, the ICB has actively engaged through a range of communication methods, including emails and formal letters, and by attending a Shipston Town Council meeting in July 2024. We have also kept the Health Overview and Scrutiny Committee (HOSC) informed, attending meetings to provide updates and seek their views throughout the process.

Staff and wider professionals

It was important to capture feedback from other key stakeholders including the staff members on community inpatient wards at Ellen Badger and Stratford hospitals (see Appendix 20 – Community hospital staff survey), as well as wider professionals who worked closely within or referred to the community inpatient wards, including teams from acute hospitals, out of hospital services, primary care, the voluntary sector or social care (see Appendix 21 - Wider professionals survey).

During the review of options between July and August 2024, the ICB engaged with the ICS Clinical Forum (See Appendix 22 – Clinical Forum Presentation) to validate the proposed options and ensure alignment with broader strategic plans. In addition, we consulted with the ICB's senior leadership team and leads from the rehabilitation review to incorporate their insights. The Clinical Quality and Strategic Group also engaged with wider staff across the system to update them on progress and share the latest thinking. The process that led to the identification of the two viable options is detailed in Chapter 11.

Following the general election in May 2024 the ICB and SWFT have reached out to the newly elected MP for Stratford-On-Avon, with an intent to offer updates on the progress and development of options, in addition to the ongoing contact which we have with the re-elected members for Kenilworth and Southam and Warwick and Leamington. We remain open to engaging with all MPs to ensure alignment with the views and concerns of the constituencies as we move forward in this process.

7.4 Stakeholder materials

The resources used to date are:

- Past patient survey (Appendix 16)
- Potential patient survey (Appendix 17)
- Current inpatient interviews (Appendix 18)
- Community hospital staff survey (Appendix 20)
- Wider professionals survey (Appendix 21)
- Community Panel Presentation (Appendix 13)
- Community Panel Pre Session Information (Appendix 14)
- Clinical Forum presentation (Appendix 22)

8. Models of Care

This chapter describes the features of the best possible care for people in South Warwickshire across the key clinical pathways relating to community rehabilitation including the role of the community hospital. It describes the models of care proposed; covering how the patient will access the service through to caring for themselves at home, through primary, community and secondary care. The chapter also describes the input that the Clinical Task and Finish Groups and Clinical Care Forum had in developing the descriptions of best possible care. The chapter also includes the outcome of the independent clinical review that took place in October 2024 to assess the appraisal of the clinical proposals

8.1 Overview of the Models of care

For more information on the role of Community Hospitals please refer to Chapter 5: Understanding the services we are reviewing.

The models of care for community hospital rehabilitation beds were developed in consultation with clinical leads between 2021 and 2024: The original task and finish group, the Community Hospital Criteria and Clinical Engagement Group and subsequent group was established in 2024, the Clinical Quality and Strategic Group . The ICS Clinical Care Forum have also been engaged and reviewed the models of care and proposed options aligned to the wider clinical areas of development across Coventry and Warwickshire.

All evidence of the review can be found in Appendix 23 - Clinical Review Excel including the risks associated with each option. Patient feedback and engagement activity can be found in Chapter 7 Stakeholder Engagement.

The models of care and proposed options focus on:

- Patient-centred care: Tailoring rehabilitation to the individual needs of each patient, ensuring coordinated support from multi-disciplinary teams (MDTs) that includes general practitioners, nurses, therapists, and allied professionals.
- Integrated Care Pathways: Promoting seamless transitions between hospital, community, and home care settings to facilitate early discharge and reduce hospital readmissions. This includes a coordinated approach between hospitals and community services.
- Home First: Emphasising recovery in a home setting wherever possible, in line with NHS policy and local investment in community programmes and initiatives. Rehabilitation services, when delivered at home, aim to improve patient outcomes and reduce reliance on bed-based care.

The key focus of all models of care is to ensure that any future community model saw that individuals are discharged to the best place for them to continue recovery (if needed) in a safe, appropriate and timely way.

When reviewing the development of the clinical models of care all agreed the shared vision:

‘All patients with ‘rehabilitation’, ‘reablement’ and ‘recovery’ needs will be supported in the right place to continue their recovery away from an acute hospital environment.’

The clinical groups have had extensive discussions about current services, best practice care pathways and potential models of care for their service area, and around the potential options for delivering these in South Warwickshire, using data to inform need.

In addition to specific recommendations, a consistent set of core principles and themes supported by all clinicians emerged. This section describes those recommendations and principles.

8.2 Key Principles

The operation of intermediate care and community hospital rehabilitation bed-based services should exhibit certain core principles:

- Shifting from Acute to Community-Based Care: Patients stay in hospital only as long as is necessary to enable them to achieve the best possible level of personal independence.
- Patient-Centred Rehabilitation: Emphasise the importance of personalised rehabilitation plans based on the specific recovery needs of each patient.
- Holistic Approach: Patients' social, psychological, health and well-being needs will be assessed and planned for before they leave hospital leading to better patient outcomes.
- Agreed clinical pathways will be used for admission to and discharge from community beds.

8.3 Intermediate care

This model of care is supported by NHS England and may be home, or bed based. This framework is focused on step-down intermediate care – time-limited, short term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover[4]. The 'step-down phase' is essential if the flow through acute hospital beds is to be maintained and the needs of sick patients at the hospital front door met.

Services must integrate with primary care, social care, and the community-based services for this to be effective. Evidence suggests that admission within 2 days of referral gives the best results.

NHSE Discharge to Assess and national hospital discharge guidance indicates that 95% of patients admitted urgently to an acute hospital should be discharged home, with around 4% of discharges of patients needing rehabilitation going to an inpatient bedded setting which might be an NHS community hospital bed and could be a local authority funded place. The residual 1% of patients leaving acute hospitals are expected to require long-term residential or nursing home care. The services are principally nursing and various forms of therapy, with medical cover usually provided by general practitioners.

The Home First approach has evolved locally over the years resulting in the recently launched Community Integrator Service (Appendix 24 - What is the Community Integrator Service), providing high quality, responsive, safe and effective healthcare to people in the place they call home.

The future model of care will bring relevant health and care professionals together into a single team with a shared caseload, built around local neighbourhoods. The service will interface with hospital services,

[4] Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge, NHSE, 2023

and work in close partnership with primary care, dissolving the historic divide between Primary and Community services to align operational and clinical workforces developing an 'Integrated Neighbourhood Team' model that makes sense in the context of its local population, services and geography.

The original community bed offer was designed to include both step-down and step-up care across the three sites. Each of the three sites—Nicol, Campion, and Ellen Badger—has implemented the use of step-up beds differently, resulting in varied levels of uptake across locations. During Covid this was not feasible but during the last 12-months the use for step-up has been utilised (Appendix 25 - Step Up Referral Data).

The Nicol Ward has also used beds for end-of-life (EOL) and palliative care providing a compassionate and dignified approach to managing symptoms and ensuring comfort in the final stages of life. The beds are utilised for this at Nicol due to the specialist skills of the local GP practice.

The future model for intermediate community hospital rehabilitation bed services will address the issues identified in the case for change:

- Evidence of patients using a community hospital bed who would have been better supported elsewhere.
- Community Hospital buildings in need of significant capital investment and modernisation to ensure they meet modern design and safe delivery standards.
- Patient feedback regarding travel concerns and accessibility for family and friends to support the rehabilitation journey (Appendix 8 Travel Analysis).

Lord Darzi's Report on the NHS, released in September 2024 called for a major reform to shift focus from hospitals to community care and prevention. The issues in the case for change and Lord Darzi's report will support us:

- Ensuring the 'right' cohort of patients are admitted to intermediate community beds.
- Addressing unwarranted variation in the way in which intermediate community beds are used.
- Improving outcomes for the patients in the intermediate community beds.

The approach to the future model of intermediate community beds is to introduce consistent pathways, underpinned by common access criteria and standardising staffing levels. This will consequently deliver:

- Better care for people; and
- Clinical models of care in the community.

New clinical criteria for access to the bedded units in all scenarios will be refined as part of the design and implementation phase of the programme. The following are the framework and principles of the envisaged future clinical criteria:

- For each patient considered for transfer to a community hospital bed the referrer will need to consider each of the following pathways and state reasons why the patient has been assessed as not suitable for direct discharge home with any of the following services:
    - Community Recovery Service Short term bridging support needs from health or social care
    - A care at home package provided by social care or domiciliary care or Home-Based Therapy/ Restricted Mobility Team

- Community Response Team support or Virtual Ward
- Delirium pathway
- A D2A care home placement – nursing or residential
- A hospice inpatient bed or hospice at home package
- OPAT service to enable any of the above services
- Reablement

If the above list has been fully considered and these opportunities discounted, then a Community Hospital inpatient stay is considered if the patient has clear rehabilitation/recovery goals. Therefore, the patient may present as;

- Highly dependent but medically stable with realistic rehabilitation goals which will significantly impact on subsequent support provision or quality of life and cannot be provided at home.
- High level of unpredictable medical and nursing need that cannot be met in a care home or their own home;
- Requiring complex rehabilitation where the intensity / equipment/ expertise cannot be offered at home but can be provided in a Community Hospital rehabilitation unit.

An additional consideration to be factored into the criteria will be the best geographical location for the community hospital stay especially if the 35 beds are dispersed across 3 sites.

8.4 Influence on Proposed Options

Our vision for our approach to wider generalist specialist rehabilitation is yet to be fully developed following a strategic review but recommendations (yet to be approved) are for the development of a co-produced Coventry and Warwickshire vision and strategy including development of quality outcome measures, adhering to national best practice and guidance.

A principle driver for the PCBC and the proposed consultation is to settle on a configuration for the 35 community beds that will meet the needs of the local population and continue to further develop the community offer, achieving our shared vision that ‘all patients with ‘rehabilitation’, ‘reablement’ and ‘recovery’ needs will be supported in the right place to continue their recovery away from an acute hospital environment.’

The proposed options are:

A. Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision.

   This option supports:
   - Geographic accessibility for those in rural areas such as Shipston: Offering care closer to patients’ homes, particularly benefitting those in rural areas such as Shipston. This helps ensure that patients and their families experience fewer travel barriers when accessing rehabilitation services.

B. Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision.

This option supports:

- Operational efficiency: Concentrating resources on two sites improves efficiency in staffing and resource management, optimising the use of existing facilities whilst maintaining high standards of care.
- Streamlined service delivery: Reducing the number of sites allows for more coordinated service delivery and patient pathways, ensuring that patient care is maintained at a high standard while responding to financial and operational constraints.

Both options support:

- The agreed principles for care.
- Alignment to the ICS Home First approach.
- Support the wider programmes contributing to 'supporting people at home' such as the Community Integrator Service, Integrated Neighbourhood Teams, Frailty Virtual Ward, 2hr and same day Urgent Community Response and the Community Recovery Service (CRS) but to name a few.

However, it was noted that Option A could have a negative impact on the following:

- The availability of beds in the right locations to meet future demand: Data from the past five years shows that 15-16% of patients using community beds were discharged to addresses in Shipston, Kineton, or Wellesbourne. While bed modelling indicates we have the appropriate number of beds, redistributing them across three sites—and reducing the number at Stratford and Leamington—could lead to accessibility challenges for patients and their families due to geographical distances.
- Flexibility in bed-usage: Reducing the number of beds in Stratford and Leamington will reduce the flexibility to manage local demand and patient flow more effectively. Currently, when demand is great, due to geographical proximity to acute provision, the community beds can be used for patients that are acutely ill where appropriate. Provision in Shipston would not facilitate this flexibility due to the skillset of the workforce available and distance to acute service provision in case of an emergency.
- Financial delivery: A reduction in the number of beds in Stratford and Leamington will impact on financial pressure during times of increased demand due to requiring an increased workforce to support the full capacity of the ward. Please refer to Chapter 12 Economic and financial analysis of the options for further financial implications.

General implications noted by the clinical groups were:

- The distribution of admissions across different wards, such as Nicol at Stratford and Campion at Leamington Spa, shows consistency with the broader population's demographics. However, the geographic proximity of patients' homes to these facilities plays a critical role in admission patterns. The majority of patients that could be admitted to Ellen Badger in Shipston from acute wards, would be a greater distance from their homes compared to being admitted to Stratford or Leamington Spa, which may impact patient outcomes and satisfaction, as well as making it difficult for their relatives to visit them in hospital.
- Recent investment into the Nicol Ward has improved the building and service provision available.

It was also noted that there has been no detrimental impact on success indicators since the community beds were temporarily relocated to Campion Ward, Leamington:

- The average length of stay on Campion ward is 26.9 days and Nicol ward is 28.2 days. The internal target for the discharge of medically fit patients is 28 days. Both wards are adhering to this internal target. (Appendix 26 - Average Length of Stay Data)
- *Appendix 27 - Patient discharge* data demonstrates that the majority of patients are discharged home or to another bedded facility.
- *Appendix 28 - Readmission data* highlights the readmissions back to the acute within 30 days of being admitted to a community hospital bed. The numbers demonstrate the increased acuity of patients that we are now seeing. These wards are in close proximity to the acute provider. This factor would need to be considered if beds were to return to Shipston due to the rurality of location.
- When reviewing mortality rates, Nicol Ward shows a higher number of deaths. It is important to note that these were all expected end-of-life (EOL) deaths. The higher rate at Nicol is attributed to the provision of step-up EOL beds for patients who choose to spend their final days in a hospital setting. Additionally, many GPs in Stratford have a special interest in EOL care, further contributing to the ward's focus on supporting patients during this phase. The data for Shipston EBH 2021/22 shows no deaths. This would be expected as the beds were used for stable patients with no criteria to reside.

Improving our care at home provision

Our commitment to improving care at home will be delivered through the Community Integrator Service (Appendix 24 - What is the Community Integrator Service), which supports patient pathways and the objectives of community hospital beds. As Lead Provider for Community Integrator, SWFT plays a strategic role in coordinating services around the needs of communities, in partnership with primary care, secondary care, and social care providers.

The core purpose of the Community Integrator is to provide preventative and proactive care within community health services, helping patients manage long-term conditions and achieve their individual goals. The service is also designed to address the changing needs of patients, offering urgent response services to prevent hospital admissions when their conditions deteriorate.

SWFT also acts as the Lead Commissioner of Discharge to Assess (D2A) services across Warwickshire, taking a leading role in coordinating seamless discharges and working with partners to deliver discharge pathways based on a ‘home first’ approach.

The community bed review in South Warwickshire has taken place within the broader strategic framework of the Community Integrator model, which is now entering its delivery phase. SWFT is collaborating closely with partners to mobilise the Community Integrator, including the development of integrated neighbourhood teams.

The Community Recovery Service (CRS) is a key component of the Community Integrator. Initially piloted from April 2023 to March 2024 as one of six national pilot sites for NHS England’s Discharge Front Runner Programme, CRS has demonstrated significant benefits. Despite the conclusion of Front Runner funding,

the decision has been made to continue CRS into a second year due to the positive outcomes experienced across Warwickshire, including the three local acute hospitals.

Key benefits of CRS to date:

- CRS has supported over 4,000 discharges since its launch in April 2023, serving as the primary D2A Pathway 1 service in Warwickshire.
- The service delivers rehabilitative care at home for up to six weeks, with domiciliary care commissioned from the care market and therapy provided by SWFT. Notably, 87% of CRS patients receive therapy input, a 154% increase from previous Pathway 1 services.
- CRS's block-commissioned care, with KPIs requiring a response within 24 hours, has resulted in increased discharge capacity and faster sourcing of care packages. Previously, packages could take 11–13 days to arrange, leaving patients in hospital beds despite being medically fit for discharge. Now, most CRS packages are sourced within 2 days.
- At SWFT Warwick Hospital, the Pathway 1 Acute Length of Stay (LoS) has decreased by 2.36 days, from 21.15 days in FY 22/23 to 18.79 days in FY 23/24.

Further refinement and review of CRS are ongoing, with the goal of transitioning the service from an extended pilot into business as usual.

The introduction of CRS is influencing the level of care that can be provided at home versus care that requires a bedded placement. It's now possible that patients who needed a bedded placement in 2021, with similar needs in 2024, could be supported at home through a combination of care and therapy oversight provided by CRS. This allows community hospital beds to be reserved for patients with higher levels of need or acuity.

8.5 Patient pathways

Effective patient pathways are critical to ensuring that individuals receive the appropriate level of care during their rehabilitation journey. In South Warwickshire's community hospitals, the focus is on providing tailored, patient-centred rehabilitation plans that align with each patient's unique recovery needs and goals. This approach enables smooth transitions from acute hospital settings to community-based care, followed by ongoing support at home. The following pathways outline how patients are managed from their admission to community hospitals through to their discharge and beyond, with a case study to illustrate how these pathways are applied in practice.

- Tailored Rehabilitation Journeys: All patients admitted to the community hospitals receive a personalised plan of care cased on their rehabilitation goals and their wishes
- Step-Down Pathways from Acute Care: Once patients are deemed medically fit for discharge they are referred onto the rehabilitation list on SWFTs Digit system. There is a daily community bed meeting where the patients are discussed and accepted for transfer
- Ongoing Support at Home: Care is delivered via CRS Routine Therapy, Reablement and other outpatient therapeutic services.

8.6 Outcome of the Clinical Senate Review

The Clinical Senate conducted a review to assess the viability of community rehabilitation bed options in South Warwickshire. The Senate confirmed there were no material concerns and ongoing engagement with the Senate would be beneficial. The review process provided a sufficient level of assurance for the Integrated Care Board (ICB) to proceed with public consultation, but several areas could be strengthened.

Key Recommendations and Findings:

1. **Clear Communication and Narrative**: The Clinical Senate emphasised the need to improve the clarity and transparency of the business case. They recommended that documentation should better articulate the historical service provisions, engagement activities, and the vision for future services, specifically addressing public concerns about potential service losses.
2. **Comprehensive Documentation and Data Integration**: The Senate suggested consolidating all available documentation into a single, comprehensive narrative. This would directly link data and evidence to decision-making processes, making the case more accessible and understandable for stakeholders and the public.
3. **Focus on Local Population Needs and Equity**: The Senate highlighted the importance of using detailed population health data to fully address the needs of the local population, particularly in rural and underserved areas, ensuring equity in access to care.
4. **Alignment with Broader Community Service Plans**: Given the interdependencies with broader community service transformations, the Senate recommended ongoing reviews to harmonise local changes with system-wide strategic goals. This approach would prevent potential misalignments and maintain service quality.
5. **Robust Service Modelling and Future Projections**: The Senate recommended further analysis of future demands for community rehabilitation beds in South Warwickshire. This should consider demographic shifts and policy changes, such as the "Home First" model, to ensure the service model remains fit for purpose over time.

The full Clinical Senate report is available as Appendix 29, providing detailed insights into these recommendations and the rationale behind them.

The table below outlines how each recommendation from the West Midlands Clinical Senate has been addressed.

Table 6 Recommendations from the Clinical Senate and ICB response

Recommendation	Response
1. Review communication strategy and materials	The **Ellen Badger Hospital (EBH)** site redevelopment has a separate communication strategy managed by South Warwickshire University NHS Foundation Trust (SWFT) and is outside the scope of this public consultation. The strategic review of community rehabilitation beds, including their distribution, is an independent piece of work.

Recommendation	Response
	While the redistribution of beds has been influenced by construction works at EBH, the **primary focus** of this review is to identify the most suitable geographical location for the 35 beds to meet population needs. Although the PCBC references EBH, it does not currently include all details recommended (e.g., specific build timelines, which are anticipated to complete by **May 2025**). Going forward, a **communication strategy** will be developed for the broader strategic rehabilitation vision, and we will continue to engage with the Clinical Senate on this.
2. Consolidate documentation into a cohesive narrative	All documentation, including evidence, data, and decision-making processes, has been consolidated into a **cohesive narrative** within the PCBC. This ensures clear alignment between the data and decisions made, highlighting the **robustness** of the process.
3. Detailed population health data to address local needs	**Population Health Management (PHM)** approach has been used throughout the analysis to determine bed requirements. Future plans will focus on ensuring **equitable access** and avoiding increased health inequalities. The analysis includes a breakdown of need from non-elective admissions to bed usage, with deprivation data demonstrating a **better alignment** with the over-64 population of South Warwickshire compared to previous arrangements at EBH.
4. Ensure changes align with wider community service strategies	This review aligns with the **Strategic Rehabilitation Steering Group (SRSG)**, which is developing a **system-wide vision** for rehabilitation services. The implementation of the chosen option will include an **impact evaluation** at **6 and 12 months** to assess travel and equality impacts, benchmarked against current analyses. These findings will inform the broader SRSG work to ensure alignment with long-term strategic objectives
5. Future service modelling with robust data to ensure sustainability	Future service modelling has been strengthened with **detailed activity and demand data** to ensure the proposed service is **sustainable** and fit for purpose now and in the future. A significant piece of work is commencing to develop a **unified rehabilitation strategy** across Coventry and Warwickshire. The **Steering Group** will lead this collaborative effort to enhance accessibility, quality,

Recommendation	Response
	and effectiveness of rehabilitation services, ensuring alignment across all stakeholders.

Ongoing Engagement

We continue to engage with the West Midlands Clinical Senate to ensure their recommendations are addressed effectively and that the proposed changes align with national best practice and governance requirements.

8.7 Conclusion

The models of care developed for community hospital rehabilitation beds in South Warwickshire are rooted in providing patient-centered, recovery-focused services that ensure effective transitions from acute to community-based care. These models align with NHS strategies that emphasise home-based recovery wherever feasible, reducing dependency on bed-based care.

The Clinical Senate's review of the proposed models provided important recommendations for improvement, which have been incorporated to strengthen the clarity, equity, and transparency of the business case. The Senate's feedback underlined the importance of addressing local needs, consolidating data to support decision-making, and ensuring alignment with broader community healthcare strategies.

The two options presented for community hospital bed provision reflect these refined models:

- **Option A**: This option proposes a distribution of 35 beds across three sites, enhancing accessibility for rural populations, particularly in areas such as Shipston. However, the distribution could pose operational challenges in efficiently meeting demand in high-need areas like Stratford and Leamington, potentially impacting flexibility in bed allocation.
- **Option B**: By consolidating 35 beds across two centrally located sites, this option prioritizes operational efficiency and concentrates resources where patient demand is highest. While geographic accessibility is reduced for rural areas like Shipston, data indicates that these areas have lower utilisation rates for community beds. This configuration allows services to be strategically focused where they are most needed.

SWFT’s close partnership with primary care, community services, and other health providers ensures that patient pathways will remain integrated and adaptable. Both options demonstrate a commitment to delivering sustainable, high-quality, and equitable care. The proposed models align with the overarching goals of the Integrated Care System (ICS), supporting both rural needs and the wider population’s demand for accessible, community-based rehabilitation services.

This approach reflects our commitment to building a future model of care that is both flexible and sustainable, addressing the specific healthcare needs of South Warwickshire in alignment with national priorities.

9. Impact Framework

This chapter describes the impact of both the proposed options and how these proposed changes align with the strategic objectives. This framework focuses on key outcomes such as enhancing the quality of life for individuals transitioning from acute care settings to community-based rehabilitation. By evaluating the impact we can ensure that community hospital beds are optimised to support timely, needs based, patient-centered care and long-term recovery outcomes for people that are expected following the implementation of the vision. The evaluation process for selecting the optimal model of care is detailed in Chapter 11: Development of Options.

9.1 Context

The proposed changes resulting from either of the 2 proposed options relate to the proposed permanent change in geographical location, redistribution of the 35 beds and further refinement of the clinical model relating to access criteria and are intended to enhance service delivery without compromising patient care.

As this is not a new service, it is essential that the reconfiguration maintains or improves the existing standards and outcomes. The focus remains on ensuring that patients continue to receive high-quality care, with any changes aimed at further optimising the service to meet evolving needs while safeguarding performance and quality.

SWFT arranges the transfer of patients from acute care to community rehabilitation beds, as well as the subsequent transfer of patients from the rehabilitation bed back into the community.

To ensure that the proposed changes are feasible, sustainable, and aligned with our strategic goals, we have applied a set of hurdle criteria within our impact framework. These criteria help assess each option's ability to meet the necessary standards for quality, accessibility, financial viability, and sustainability, ensuring that the proposed changes can be effectively delivered and maintained over time.

The key hurdle criteria include:

- Quality care for all
- Access to care for all
- Affordability and value for money
- Sustainability and deliverability

Each of these areas has been rigorously evaluated to guarantee that any changes will maintain high standards of care, ensure broad access, provide value for money, and be both sustainable and achievable.

Please refer to the information contained in the following appendices for further information about the assessment of the options:

Appendix 23 Clinical Options Appraisal Summary
Appendix 30 Estates Appraisal June 2022 V2 1 1
Appendix 31 Estates Commentary - August 2024 V1
Appendix 32 Financial Appraisal Community Beds options sent 3 Sept
Appendix 33 Option Appraisal - Use of second floor for beds Oct 2024 V1_

9.2 Quality care for all

Definition: The extent to which the option maintains or improves the quality of care, ensuring patient safety, positive outcomes, and clinical effectiveness.

Assessment Questions:

1. Does the option ensure high-quality care across all settings?
2. Will patient outcomes and clinical effectiveness be upheld or improved?
3. Are patient safety measures and standards met or exceeded?

9.3 Access to care for all

Definition: Ensuring equitable access to care for all patient groups, with a focus on geographical location and ease of access for rural and underserved populations.

Assessment Questions:

1. Does the option ensure equitable access to care for all populations, including rural areas?
2. Will it enhance or maintain access for underserved or vulnerable groups?
3. Are there potential challenges in reaching care due to geographical changes?

9.4 Affordability and value for money

Definition: The financial viability of the option, ensuring that it delivers value for money and operates within budget constraints while being cost-effective in the long term.

Assessment Questions:

1. Is the option financially sustainable and within budgetary limits?
2. Does it offer value for money compared to other alternatives?
3. Are the long-term costs, including operational and staffing expenses, manageable?

9.5 Deliverability

Definition: The option's ability to be implemented effectively and sustainably, considering factors such as workforce availability, infrastructure, and alignment with long-term strategic goals.

Assessment Questions:

1. Is the option deliverable within the necessary timeframes and with available resources?
2. Does it align with long-term strategic goals and local/national healthcare priorities?
3. Can the option be maintained sustainably, considering infrastructure and workforce capacity?

9.6 Assessment of the criteria

Using the impact framework both options were assessed. For further information please refer to chapters 3, 8 and 12.

Table 7 Assessment of the criteria

	Criteria	Option A: Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision.	Option B: Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision
1	**Quality care for all**	May affect quality of care due to reduced flexibility in managing local demand and flow. Ellen Badger may not have the workforce skillset or proximity to acute services needed for complex cases. With 12 beds being reinstated the space available would present as a constraint in respect of providing both clinical and non-clinical support functions such as therapy and dining area. They could be provided however this would invariably impact on the space available for bed provision.	Maintains current quality of care by concentrating resources and expertise in Leamington and Stratford, where demand is higher.
2	**Access to care for all**	Improves geographic accessibility for rural areas like Shipston, reducing travel barriers for a small portion (15-16%) of patients visitors. However, Shipston patients may have reduced access to complex care.	Concentrates care in areas with higher demand (Stratford, Leamington), where most patients (84-85%) reside. Limits accessibility for rural areas but focuses on serving the majority population effectively.
3	**Affordability and value for money (See Chapter 12 Economic and financial analysis of the options)**	Higher costs due to maintaining three sites and requiring additional workforce to support full capacity, particularly in rural areas like Shipston, where recruitment and staffing are more challenging. Capital investment required.	Offers greater financial efficiency by reducing the number of sites, consolidating resources, and optimising staffing, leading to better value for money and fewer workforce issues.
4	**Sustainability and deliverability**	Potential challenges with workforce recruitment and retention in rural Shipston due to transport links and small ward size. Difficult to cover staff absences and sickness. Increased operational costs.	More sustainable and deliverable due to better workforce availability, easier staff management, and lower operational costs by focusing on larger, better-supported sites. Easier to maintain service delivery.

Key Points from the Table:

- **Option A** improves **geographic accessibility** for a small percentage of rural patients but faces challenges in workforce recruitment, flexibility, and operational costs.

- **Option B** optimises **operational efficiency** and **resource management**, focusing on high-demand areas like Stratford and Leamington, while offering better financial and workforce sustainability.

9.7 How will we measure the impact of the options

Regardless of the outcome of the public consultation it will be critical that we continue to review the data and assess the impact of the decision.

9.7.1 Measuring quality of care for all

Patient Outcomes: Regular audits can track changes in patient recovery times, re-admission rates, and overall health outcomes post-rehabilitation.

Patient Safety: Monitor adverse events, infection rates, and the quality of care provided in each setting, using national clinical benchmarks and safety audits as a guide.

Patient Experience: Use patient feedback tools, such as surveys and qualitative interviews, to measure satisfaction levels before and after the changes. Metrics like the Friends and Family Test (FFT) or bespoke local surveys can be valuable.

Link to Data: Continuous data collection from clinical systems, patient-reported outcome measures (PROMs), and local clinical audits will feed into this evaluation. National databases such as NHS Digital or CQC inspections will also provide comparative insights to ensure the quality of care is upheld or improved.

9.7.2 Measuring access to care for all

Service Usage by Area: Analyse the patient flows and postcode data to determine whether relocation of beds has improved or worsened accessibility, particularly for underserved populations in rural or deprived areas.

Equity of Care: Ensure that access metrics account for socioeconomic factors (e.g., deprivation index) to monitor whether vulnerable groups are adversely affected by bed reallocation.

Link to Data: Patient address data, public transport availability, and real-time travel analysis (using tools like Google Maps or local council transport data) can help determine whether access to services has improved across different population groups.

9.7.3 Measuring affordability and value for money

Cost Per Bed: Track the cost of maintaining rehabilitation beds at each site and compare these to projected budgets. The financial working group should model this based on both capital expenditure (e.g., refurbishment) and operating costs (e.g., staff, utilities).

System-wide Impact: Assess the financial benefit of preventing unnecessary acute admissions, reducing lengths of stay, and enabling quicker discharges, all of which help reduce the overall system deficit.

Efficiency Gains: Monitor resource utilisation rates (e.g., bed occupancy rates) and assess whether the system is maximising its financial resources. Including the ability to safely increase bed numbers during periods of peak demand.

Link to Data: Financial reports, income/expenditure analyses, and cost-benefit modelling will continuously provide the data needed to track affordability and value. Integration with NHS financial tools and regular reviews from finance departments will ensure ongoing oversight.

9.7.4 Measuring deliverability

Project Timelines: Track key deliverables such as refurbishments, bed transfers, and workforce reallocations. Any delays or adjustments to timelines should be monitored closely.

Workforce Impact: Monitor staff turnover, retention rates, and overall workforce satisfaction post-implementation. Ensure there are enough skilled healthcare professionals to meet the needs of the patient population.

Patient Flow Management: Ensure that the patient allocation criteria are applied correctly and evaluate the smoothness of the patient transfer process between sites. The ability to handle unplanned surges in patient numbers should also be reviewed.

Link to Data: Data on project milestones, workforce surveys, and hospital bed allocation systems will all be critical in ensuring that the changes remain deliverable and operational.

9.8 Conclusion

The table highlights that **Option B** is more favourable in terms of **sustainability, affordability, and quality of care**, whereas **Option A** supports better **geographic accessibility** for rural patients but comes with significant operational and workforce challenges.

This table makes it easier to compare the two options and assess them based on the outlined criteria, showing that the service itself remains unchanged, but the location impacts key factors like access, cost, and sustainability.

For further information about implementing the framework refer to Chapter 15.

10. Assurance and Governance

This chapter outlines the extensive internal and external assurance processes the programme has undergone. The clinical proposals have been externally assured, and the programme has successfully met the four tests for reconfiguration set by the Secretary of State, with evidence submitted to NHS England. Additionally, this chapter details the approval process leading up to the final decision by the Coventry and Warwickshire Integrated Care Board (ICB), including the review and approval of the pre-consultation business case.

10.1 Introduction

It is the ICB's responsibility to commission services to meet the needs of the population. The ICB therefore needs to consider the commissioning requirements for community beds in relation to the national and local strategic direction and priorities detailed throughout this PCBC. To make this decision the ICB should take account of the scale of the changes, the wider implications and its statutory responsibilities.

NHS England must also consider any significant service changes and they do this via a Strategic Service Change Assurance Process. The aim of this process is to ensure that commissioners apply a best practice approach when planning complex programmes of service change and to mitigate the risk of successful legal challenge which might otherwise significantly delay or derail service change proposals. The assurance process tests that any proposal satisfies the government's four tests of service change, NHS England's test for proposed bed closures best practice checks, and legal duties, and is affordable in capital and revenue terms.

Assurance checks, both formal and informal, will look at service change with regard to the above, as well as its impact on other organisations in the wider health and social care system. In relation to the Community Bed Review, the ICB commenced this process with NHS England with a Stage One meeting on the 18th September 2024.

The ICB has a statutory responsibility under Section 14z45, to involve people and communities in the planning of services and decisions having an impact on services. This is reinforced in the NHS England statutory guidance 'Working in Partnership with People & Communities'. Where service changes are deemed 'significant'/'substantial' they may require public consultation. There is no legal definition of or criteria on what constitutes a 'significant' or 'substantial' service change, and as such each case must be examined individually.

Health Overview and Scrutiny Committees play a significant role in scrutinising service change and reconfiguration. HOSCs will scrutinise options presented to them and advise whether they recommend a formal public consultation is required.

10.2 Statutory Framework

In compliance with the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the programme has adhered to all necessary statutory assurance processes. This includes maintaining the quality of care for residents of Coventry and Warwickshire, with a particular focus on benchmarking current outcomes against best practices. The review process also considered the challenges of social and economic variation, including rural and urban healthcare disparities.

Throughout the review, patient choice has been integral to the development of potential care models. Healthwatch was consulted to gather feedback, which informed the long list and shortlisting process. The programme aims to ensure that all patients in South Warwickshire continue to receive high-quality care in the right setting, while also providing value for money within the financial constraints of the local healthcare economy.

10.3 Health Overview and Scrutiny Committees

The Warwickshire HOSC has been consistently engaged throughout the review process. Key updates were shared at various stages, ensuring full scrutiny of the proposed options, consultation plans, and decision-making processes. This continued engagement ensures that the HOSC is well-informed and able to provide oversight on the development of the proposals.

Figure 12 Key HOSC Meetings and Updates

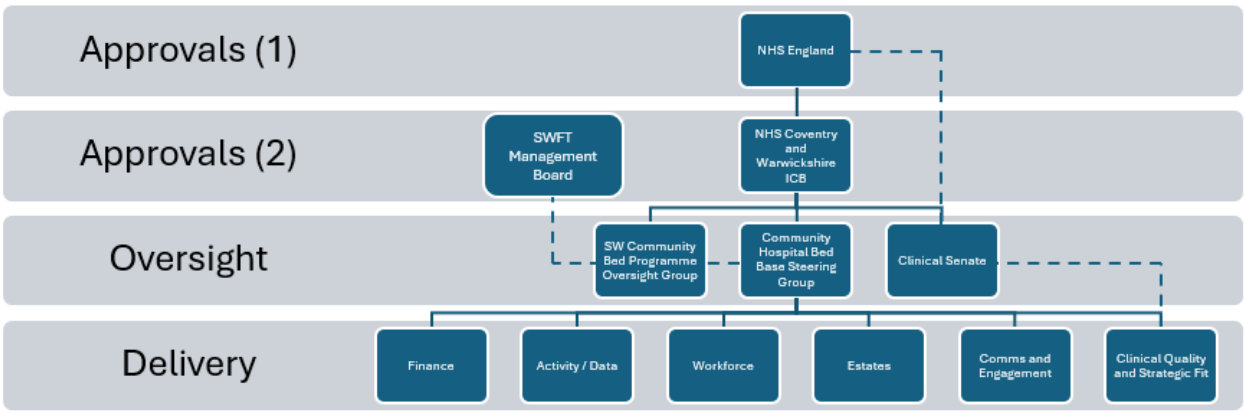
February 2022	Final list of potential proposals shared with Health and Overview Scrutiny Committee (HOSC) by SWFT, to determine if options represent 'substantial variation' to the current offer. Two additional options requested
June 2023	SWFT CEO provided an update on the outcomes and recommendations of the bed review..
June 2023	Letter received from HOSC following meeting requesting further public consultation is completed on potential options
November 2023	ICB attended Stratford and District HOSC to provide update on pre-consultation business process and need for wider rehabilitation review
September 2024	Update to HOSC planned on progress and seeking endorsement re the approach to formal consultation and the reduction of the public consultation from 12-weeks to 6-weeks enabling the future decisions about the 35 community hospital rehabilitation beds to be approved by the end of March 2025
November 2024	Update via briefing note

10.4 Internal Assurance and Governance

The internal assurance of the Community Hospital Bed Review was overseen by several governance structures. The South Warwickshire Community Bed Steering Group played a key role in reviewing and approving the process, ensuring governance and risk mitigation were thoroughly addressed. This group met regularly to assess financial modelling, clinical evidence, and engagement feedback, leading to the final shortlist of options for public consultation.

Figure 13 SWFTs original internal programme governance

Figure 14 NHS CW ICB Programme Governance (2024)



Since July 2024 SWFT and the ICB formed an Oversight Group who met fortnightly to oversee progress and agree a way of working that would ensure options were viable, reviewed in a timely way and the process was fully supported to ensure a decision could be made in 2025 relating to the outcome of the community hospital beds.

10.5 External Assurance

NHS England has been a critical partner in the assurance process. Regular meetings between South Warwickshire Clinical Commissioning Group (SWCCG) and subsequently, NHS England and Coventry and Warwickshire ICB ensured that progress was continually assessed and any issues escalated in a timely manner. The programme adhered to the NHS England Major Service Change Assurance Process, which involved two key stages: a strategic sense check and formal assurance of the proposed options.

The dates for the stage 1 assurance meetings were:

- 27 July 2022
- December 2022
- 18 September 2024

In addition, the West Midlands Clinical Senate (WMCS) provided independent, strategic advice, reviewing the clinical elements of the proposed changes. This external validation helped shape the final proposals and reinforced the programme's clinical credibility. Further details can be found in Chapter 11 relating to the outcome.

The WMCS completed a desktop review between 18 September 2024 and the 12 October 2024 resulting in a meeting between SWFT, ICB and WMCS on the 14 October 2024.

10.6 Public Sector Equality Duty (PSED)

In line with the Public Sector Equality Duty (PSED) under the Equality Act 2010, the review process ensured that good practice was followed to assess the impact of changes on all protected characteristics. Age was a key consideration and due to the decision relating to the geographical location of the 35 beds, rural isolation was also considered and prioritised due to the profile of patients using community hospital services. These patients have already undergone acute treatment and are clinically assessed for the need for community hospital rehabilitation beds. The focus on rural isolation reflects the geographical and healthcare disparities faced by these communities. Importantly, the proposed changes are not expected to disproportionately impact other protected characteristics.

Chapter 7 and Chapter 16 articulate how we have engaged with key stakeholders and plan to engage when we go out to public consultation ensuring due diligence is adhered to relating to our PSED. An EQIA (Appendix 9 Equality Impact Assessment) and HEAT process (Appendix 34 HEAT Analysis) were undertaken as part of the strategic review and subsequent revalidation of the options and will continue to be reviewed regularly.

Both documents were supported by service leads and presented to the Senior Leadership Team (ICB) in October 2024 for endorsement.

10.7 Meeting the Four Tests for Reconfiguration

The programme meets the four tests for reconfiguration as set out in the 2014/15 Government Mandate to NHS England:

- Strong Public and Patient Engagement (refer to Chapter 7): The programme has involved significant engagement with stakeholders and the public throughout its development. Following the ICB's approval, a formal public consultation will take place, allowing for further public input into the final decision-making.
- Patient Choice (refer to Chapter 8): The reconfiguration maintains alignment with patient choice by ensuring flexible rehabilitation options tailored to individual recovery needs. While clinical decisions drive the allocation of community hospital beds, the programme offers a range of rehabilitation settings, including at-home care and community hospitals, ensuring that patient preferences are considered where clinically appropriate. This approach also takes into account the needs of rural patients, allowing them to access services closer to home when possible.
- Clear Clinical Evidence Base (refer to Chapter 8): The proposals were guided by a Clinical Quality and Strategic Group and independently reviewed by the West Midlands Clinical Senate, ensuring that the clinical rationale is robust and aligns with best practices.

- Support from Clinical Commissioners: The Coventry and Warwickshire ICB, which leads the commissioning function, has been fully engaged in the development of these proposals, ensuring clinical commissioner support throughout the process. SWFT have also expressed their support for the proposed options. (Appendix 41 SWFT Support).

Regular updates have been submitted to the Finance and Performance Committee and subsequently the ICB Board.

Finance and Performance Committee	June 2024
Finance and Performance Committee	September 2024
Finance and Performance Committee	November 2024

10.8 The Fifth Test: NHS England Bed Test

The number of community hospital rehabilitation beds across South Warwickshire will remain at 35, ensuring that capacity is aligned with current and projected future demand. If option A is identified as the preferred choice then the 35 beds will be redistributed across 3 sites resulting in fewer beds being available at the Stratford and Leamington sites. A thorough analysis of patient flow and rehabilitation needs (refer to Chapter 3, 13 and 14) confirms that the proposed configuration will continue to meet demand but option A will result in increased travel for the workforce, families and carers in the central and north parts of South Warwickshire where need is greater. We do recognise that option B would result in similar issues for those in rural parts of South Warwickshire but the data highlights less demand in Shipston and surrounding areas even prior to the change in bed location. The flexibility in bed use across the region ensures that quality of care and patient outcomes remain unaffected.

10.9 Emergency Preparedness, Resilience and Response (EPRR)

The impact of the proposed changes on emergency preparedness has been carefully evaluated (please refer to chapters 13 and 14). The Local Health Resilience Partnership (LHRP) was engaged to assess potential risks or vulnerabilities, ensuring that the local health economy can continue to plan for and respond to major incidents. The LHRP's assessment confirmed that the changes do not compromise the region's capacity to manage public health emergencies.

- Initial meeting August 2024
- 4 December 2024

10.10 Business Impact Analysis and Continuity Planning

Business continuity plans have been reviewed and will be updated to reflect any bed redistribution, ensuring that in the event of disruption, services can be maintained or quickly restored. All impacted organisations will align their continuity plans to maintain resilience and protect patient care during unforeseen events.

10.11 Decision-Making Process and Timeline

The ICB Board aims to make final decisions on the proposed changes by March 2025. The decision will consider public consultation feedback, clinical assurance, and the latest health and health inequalities impact assessments. Post-consultation analysis will be independently conducted, and the results will be

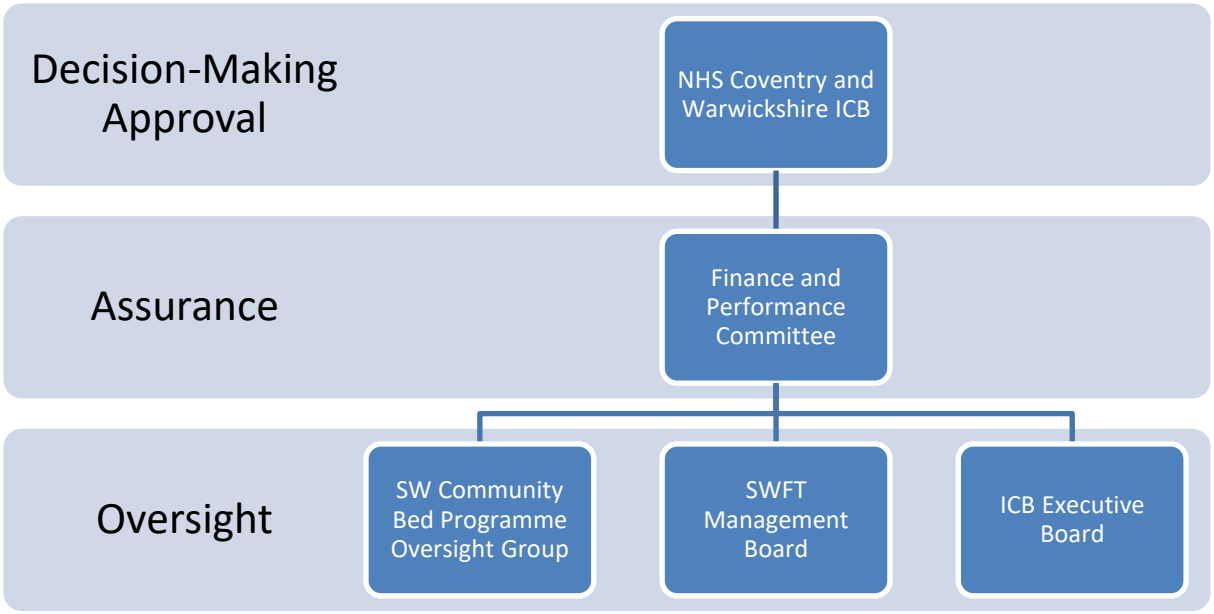
shared with the Joint Health Overview and Scrutiny Committee and the public. High-level implementation planning will begin once a final decision is made, allowing the programme to mobilize changes as quickly as possible.

The following key dates are to be adhered to ensuring that the public consultation can commence in January 2025:

Table 8 Key Dates for Approvals

18 September 2024	NHS England Stage 1 Assurance Check Point
14 October 2024	Clinical Senate Review of the clinical evidence base
7 November 2024	Integrated Care System (ICS) Prioritisation Panel review of the PCBC providing assurance of due diligence
8 November 2024	Finance and Performance Committee
8 November 2024	SWFT Management Board
11 December 2024	NHSE Stage 2 Assurance Check Point
18 December 2024	NHS Coventry and Warwickshire ICB approval to commence the Public Consultation
End of December 2024	NHS England decision is communicated
6 January 2025	Public Consultation launches
14 February 2025	Public Consultation closes
Feb-March	Analysis and consideration
19 March 2025	Formal decision (subject to outputs of the consultation)

Figure 15 Overview of Governance for Decision-Making



11. Development of options

This chapter outlines the systematic process we used to develop the options for community hospital rehabilitation beds in South Warwickshire. Our approach involved a combination of stakeholder engagement, evidenced reviews, and analysis of existing care pathways. By incorporating both qualitative insights and quantitative data, we identified a range of viable options designed to meet patient needs while optimising resource allocation. This development process was grounded in best practices and aligned with national healthcare priorities to ensure the proposed options are both practical and patient centered.

For a detailed breakdown of the expected patient outcomes and system-wide benefits, refer to the Impact Framework in Chapter 9.

11.1 Background and Governance

The process of developing options for community hospital rehabilitation beds in South Warwickshire has been systematic and evidence-based, adhering to the principles of the Treasury's Green Book guidance. The programme was led by SWFT, under a governance framework that included collaboration with NHS Coventry and Warwickshire ICB, local stakeholders, and key decision-making bodies such as the Clinical Quality and Strategic Group , ICB and Warwickshire's Health Overview and Scrutiny Committee (HOSC). The governance process ensured alignment with national priorities and local health strategies, as well as compliance with regulatory requirements.

The Community Hospital Bed Review (Appendix 1 Strategic Review of community hospital rehabilitation beds in South Warwickshire (2021-2023)), started in 2021 by SWFT aimed to address current and future needs for community hospital rehabilitation bed provision while optimising resource allocation. It involved rigorous stakeholder engagement, clinical review, and financial assessments to ensure the options were viable and aligned with strategic objectives.

The result of the review was for SWFT to set out their commissioning intentions for the future of Community Hospital bed provision in South Warwickshire.

In July 2023, SWFTs Community Hospital Strategic Review outcomes were considered by the ICB and approval granted for the ICB to begin a pre-consultation business process. This work commenced in August 2023 with the ICB engaging the Consultation Institute (tCI) and Capsticks Solicitors to review and consider the SWFT business case process against the ICB statutory duties and responsibilities to identify the additional actions and steps that the ICB needed to complete prior to commencing the public consultation.

This identified the need for a wider review of Rehabilitation Services for the whole Coventry and Warwickshire population and further consideration regarding the impact of changes to other services impacted at Ellen Badger.

With a comprehensive overview of our broader rehabilitation provision complete (May 2024) and awaiting next steps, we recognised that several essential improvements are required to enhance our services. However, we cannot address all of them simultaneously. Therefore, we prioritised the rehabilitation beds in South Warwickshire.

Due to the additional work carried out between August 2023 and May 2024, a joint project team was established to deliver the pre-consultation and consultation next steps adhering to the ICB's legal and regulatory responsibilities before implementing any service change, including the permanent geographical relocation of services. The ICB considered that the potential changes flowing from the Community Bed Review constituted a significant service change and consequently there was a need for further involvement of the public on the proposed options and their wider implications.

The aims of the project were to:

- Review the current status of the proposed options.
- Revisit and validate the proposed options.
- Secure approval from Warwickshire Health and Overview Scrutiny Committee for a formal consultation due to the service change proposed being considered substantial and therefore warrant public consultation.
- Conduct further pre-consultation engagement as required relating to proposed options.
- Conduct a public consultation followed by feedback and analysis to enable final decision-making.

11.2 Key Decision Makers and Stakeholder Engagement

SWFTs Management Board made the decision in May 2021 to commence a strategic review of community hospital inpatient bed provision that would lead to an appraisal of options for the future model of community hospital inpatient bed provision.

The options appraisal process involved multiple groups and decision-makers between 2021 and 2024 (see Chapter seven for panel involvement).

Technical and Community Panels

The **Technical Expert Panel**, convened in November 2021 and then reconvened in January 2022 (Chapter 7 and Appendix 11- Technical expert panel November 2021 and January 2022), comprising clinicians and senior staff from SWFT, played a central role in developing and assessing the longlist of options, alongside the Community Panel (Chapter 7 and Appendix 12 - Organisations and individuals invited to Community Panel, Appendix 13 - Community Panel presentation, Appendix 14 - Community Panel Pre Session Information).

The Community Panel (Chapter 7 Appendix 12 - Organisations and individuals invited to Community Panel) reviewed the long list of options in December 2021, derived from the engagement outlined in Chapter 7 and considered the viability and desirability of the options identifying a reduced list of options to be further considered by the Technical Expert Panel.

Subsequently, as outlined in Chapter 7, the Technical Panel reconvened as the Clinical Quality and Strategic Group in June 2024 to evaluate the original options against new key considerations and determine the viable options moving forward.

Warwickshire Health Overview and Scrutiny Committee

Warwickshire's Health Overview and Scrutiny Committee (HOSC) received the initial findings of the review in February 2022 and requested that two additional proposals were considered and that they continued to be updated with progress.

HOSC then received a presentation from Glen Burly, Chief Executive of SWFT in June 2023, which outlined the outcomes of the bed review and SWFTs preferred outcome.

The Health Overview and Scrutiny Committee (HOSC) was regularly updated and at their meeting on 18 September supported the decision to reduce the proposed consultation period from 12 weeks to 6 weeks, in recognition of the substantial nature of the proposed service change and the requirement for public consultation.

SWFT Management Board

In February 2023, SWFTs Management Board approved the review outcomes for presenting to NHS Coventry and Warwickshire ICB.

NHS Coventry and Warwickshire ICB

The NHS Coventry and Warwickshire ICB Board received a paper at their meeting in July 2023 which outlined the findings of the bed review and proposed changes within it. The Board approved the commencement of a Pre-Consultation Business Case (PCBC), recognising that the proposed changes constituted a significant service change, necessitating further public involvement on the options and their wider implications.

A joint SWFT and ICB project group was formed to expedite the process and ensure timely decision-making through appropriate governance structures. This group oversaw the revalidation of options and endorsed the two viable options proposed for consultation.

Other groups

Throughout the review period, the project team engaged with the Clinical Quality and Strategic Group, various stakeholders, including the finance teams, workforce leads, business intelligence, Shipston Town Council, and members of the newly formed Beds for Badger campaign group, whose feedback helped shape the final options.

The ICB acknowledges that any final decisions will be made taking into account the outcome of the public consultation.

11.3 Development of the Longlist of Options

In response to the case for change in the Community Rehabilitation Bed Review a long list of options was developed through collaborative efforts by clinicians and senior staff (the Technical Expert Panel) with a thorough understanding of the service needs and what 'viability' would entail. Please refer to Chapter 7 (7.2) and Appendix 12 - Organisations and individuals invited to Community Panel for further information about the panel. The key considerations guiding this process were the hurdle criteria explained further in section 11.4.

Additional options were considered by the reconvened technical panel, the Clinical Quality and Strategic Group , between June and September 2024, and included further suggestions from the Beds for Badger campaign group.

11.3.1 The clinical design process

In addition to the governance and decision-making processes, the clinical design process was led by service clinical leads, working with inclusive, multi-professional teams. These teams used a variety of data sources to review and benchmark current performance, assess national clinical guidance, and consider patient insights and best practices from other organisations.

Consistent hurdle and evaluation criteria were applied throughout, ensuring rigorous clinical and non-clinical challenges were considered by the Technical Panel, the reconvened Clinical Quality and Strategic Group , ICS Clinical Care Forum, and relevant SWFT and ICB committees and boards.

11.3.2 Compliance with the Reconfiguration Tests

As part of the options appraisal process for the Community Hospital Rehabilitation Bed review, it is essential to ensure that all proposed changes meet NHS England's reconfiguration tests. These tests provide a structured framework to assess the impact of service changes on patient care, workforce sustainability, and financial viability. Compliance with these tests has been central to our evaluation of options, ensuring that any changes are aligned with national guidance and best practices.

The reconfiguration tests include:

1. Strong public and patient engagement
2. Consistency with current and prospective need for patient choice
3. Clear, clinical evidence base
4. Support from commissioners

In March 2017, NHS England introduced a fifth test specifically for significant hospital bed closures. While the proposed changes in this review do not involve significant bed closures, the review has applied the first four tests throughout the development and appraisal of options. Our self-assessment against these tests (Appendix 35 ICB PCBC Checklist (Stage 2) Template KLOEs) demonstrates full compliance..

11.3.3 Internal and external assurance throughout the development of the options

To support the development of options and compliance with these tests, the project took clear steps to ensure robust assurance arrangements were in place. This included:

- Internal and external clinical and non-clinical assurance through multi-disciplinary teams at all levels.
- Planned reviews from the Consultation Institute, providing independent oversight and feedback.
- Independent, external clinical feedback to validate the proposals.

Key aspects of the assurance process involved:

- Stage one assurance check by NHS England (18 September 2024) (Appendix 36 FINAL NHSE Stage 1 Checkpoint Pack).

- Clinical review conducted by the West Midlands Clinical Senate of all proposed options (October 2024) (Appendix 29 - Independent Report from Clinical Senate); and
- A pre-consultation assurance check by NHS England, which concluded in December 2024. Working in partnership with NHS England, this check confirmed the clinical and financial sustainability of the proposals. NHS England's 'assured' position further supports the viability of the options being taken forward. The outcome of this assurance review can be found in the supporting documentation (Appendix 37 Outcome of NHSE Stage 2 Assurance Meeting *Awaiting*).

11.4 Hurdle Criteria and Rationale

To assess the longlist, the technical expert panel reviewed viability of the options against the hurdle criteria in the longlist in November 2021, then the community panel developed 'desirable criteria' in December 2021. The hurdle criteria included:

1. Patient safety & quality: Does the suggestion promote patient safety and clinical quality for patients in south Warwickshire?
2. Workforce Delivery: Will the workforce be able to deliver the suggestion?
3. National and local direction: Does the suggestion meet the strategic direction of travel for hospital discharge services?
4. Affordability: Is the suggestion affordable and sustainable?

11.5 Review and Appraisal of the Longlist

Each option from the longlist was carefully reviewed (see Chapter seven for panel involvement) against the hurdle criteria (11.4) and a 50% agreement level acknowledged for viable options.

For a breakdown of the options and the supporting narrative see Appendix 30 Estates Appraisal June 2022 V2 1 1, Appendix 31 Estates Commentary - August 2024 V1, Appendix 32A Hurdle Criteria appraisal 1 and 2, Appendix 32 Financial Appraisal Community Beds options sent 3 Sept, Appendix 33 Option Appraisal - Use of second floor for beds Oct 2024 V1_.

The figures below outline the journey of the long list of options, development of the options aligned to decision-making and the considerations against the hurdle criteria that was provided to the Community Panel in December 2021.

Figure 16 2021-2022 Journey for Long List of Options

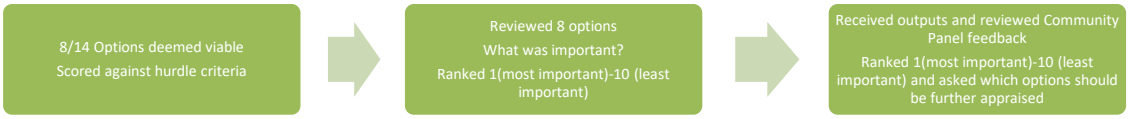


Figure 17 Development of the options aligned to the decision-making

Decision-Making Timeline

2021	2022	2023	2024:
• Initiated Discharge to Assess Review • Case for Change Recommended Strategic Review	• Jan: Temporary relocation of 16 beds (Ellen Badger to Leamington)	• May: Options presented to SWFT (5 options for further appraisal) • July: ICB Board approval for PCBC process • August: ICB instruct a system wide strategic rehabilitation review	• May: Rehabilitation review outcomes shared with ICB and rationale for prioritising SW Community Bed Review outcomes • Sept: Final option viability for PCBC agreed by SWFT & ICB

Engagement Activity and Timeline

2021	2022	2023	2024:
• Formation of Communications and Engagement Group • Initial stakeholder mapping and EIA assessment • Nov: First Technical Expert Panel meeting-explore long list and viability • Dec: First Community Panel Meeting – identify desirable criteria and preferred options	• Jan: Technical Expert Panel meeting to review outcome of community panel and score against hurdle criteria • Feb: 3 options presented to HOSC – a further 2 additional options requested • Feb-Sept: Healthwatch support further engagement activities workshops, audits, insights • Nov: Technical Panel scoring	• SWFT communication with community representatives with updates. • May: Stakeholders informed of appraisal outcomes	•July-Sept: Technical/ Clinical Panel reinstated and review options and engage with workforce •Sept: Final HOSC update and options revalidation •Sept: Final option viability for PCBC agreed by SWFT & ICB •July-Nov: Engagement with new Shipston Campaign Group

Table 9 Considerations of the options against the hurdle criteria provided by Technical Expert Panel to Community Panel

Suggestion	Hurdle Criteria	Yes	No
Reduce the number of community hospital beds and invest in home based alternatives.	Patient Safety and Quality	90%	10%
	Workforce delivery	95%	5%
	National and local delivery	100%	0%
	Affordability	95%	5%
	Average	95.0%	5.0%
Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this.	Patient Safety and Quality	90%	10%
	Workforce delivery	95%	5%
	National and local delivery	90%	10%
	Affordability	90%	10%
	Average	91.3%	8.8%
Keep the community hospital as is but change the type of services on offer:	Patient Safety and Quality	90%	10%
c. Diagnostics	Workforce delivery	80%	20%
	National and local delivery	80%	20%
	Affordability	95%	5%
	Average	86.3%	13.8%
Keep the community hospital as is but change the type of services on offer:	Patient Safety and Quality	80%	20%
a. Fraility Chair	Workforce delivery	90%	10%
	National and local delivery	80%	20%
	Affordability	90%	10%
	Average	85.0%	15.0%

Suggestion	Hurdle Criteria	Yes	No
Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patients own home.	Patient Safety and Quality	70%	30%
	Workforce delivery	90%	10%
	National and local delivery	90%	10%
	Affordability	90%	10%
	Average	85.0%	15.0%
Keep the community hospital as is but change the type of services on offer:	Patient Safety and Quality	90%	10%
d. Continuation of some of the BAU beds alongside each of the above offers	Workforce delivery	70%	30%
	National and local delivery	80%	20%
	Affordability	80%	20%
	Average	80.0%	20.0%
Retain the community hospital offer but change the location	Patient Safety and Quality	90%	10%
	Workforce delivery	90%	10%
	National and local delivery	40%	60%
	Affordability	60%	40%
	Average	70.0%	30.0%

Suggestion	Hurdle Criteria	Yes	No
Investment in hospice model to divert pressure from community hospital of those that are dying plus continuation of a proportion of community beds.	Patient Safety and Quality	80%	20%
	Workforce delivery	60%	40%
	National and local delivery	50%	50%
	Affordability	60%	40%
Referred to Hospice Review 16/12/21	Total	62.5%	37.5%
Investment in hospice model, cease community beds and investment in community alternative model such as suggested in solution 7 – *Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patient's own home.*	Patient Safety and Quality	70%	30%
	Workforce delivery	50%	50%
	National and local delivery	50%	50%
	Affordability	50%	50%
Referred to Hospice Review 16/12/21	Total	55.0%	45.0%

Suggestion	Hurdle Criteria	Yes	No
Retain the community hospital offer exactly as is now?	Patient Safety and Quality	90%	10%
	Workforce delivery	90%	10%
	National and local delivery	30%	70%
	Affordability	60%	40%
Deselected (did not meet one of the hurdle criteria by 70%) 21/11/21	Average	67.5%	32.5%
Keep the community hospital as is but change the type of services on offer:	Patient Safety and Quality	10%	90%
b. En-suite rooms	Workforce delivery	60%	40%
	National and local delivery	30%	70%
	Affordability	20%	80%
Deselected (did not meet one of the hurdle criteria by 70%) 21/11/21	Average	30.0%	70.0%
Increase the number of community hospital beds.	Patient Safety and Quality	70%	30%
	Workforce delivery	30%	70%
	National and local delivery	10%	90%
	Affordability	20%	80%
Deselected (did not meet one of the hurdle criteria by a 70%) 21/11/21	Average	32.5%	67.5%

Suggestion	Hurdle Criteria	Yes	No
Cease community hospital beds as is and provide support within current or new care home provision (new build or development).	Patient Safety and Quality	50%	50%
	Workforce delivery	30%	70%
	National and local delivery	30%	70%
	Affordability	50%	50%
Deselected (did not meet one of the hurdle criteria by 70%) 21/11/21	Average	40.0%	60.0%
Reduce the number of community hospital beds and commission a proportion of beds within the care market or create new care capacity (new build or development).	Patient Safety and Quality	50%	50%
	Workforce delivery	30%	70%
	National and local delivery	40%	60%
	Affordability	30%	70%
Deselected (did not meet one of the hurdle criteria by 70%) 21/11/21	Average	37.5%	62.5%

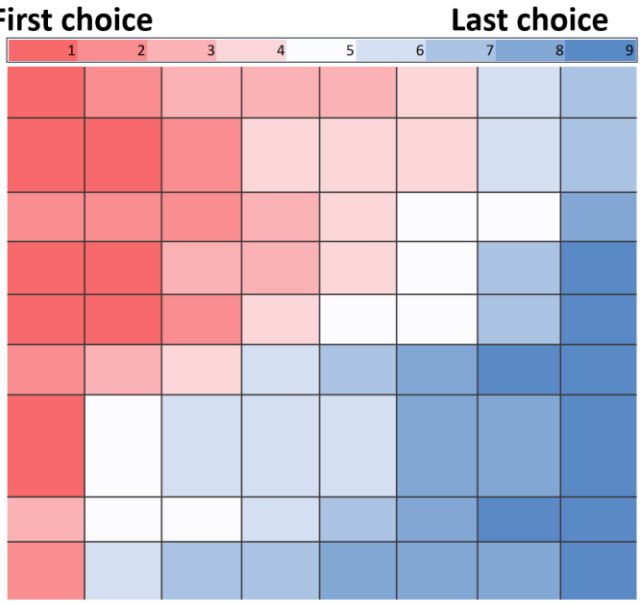
Table 10 Summary of selection by Technical Panel (Nov 2021)

Question		Decision
1.	Retain the community hospital offer exactly as is now	**NO**
2.	Keep the community hospital as is but change the type of services on offer:	
	a. Frailty Chair	**YES**
	b. En-suite rooms	**NO**
	c. Diagnostics	**YES**
	d. Continuation of some of the BAU beds alongside each of the above offers	**YES**
3.	Reduce the number of community hospital beds and invest in home based alternatives.	**YES**
4.	Increase the number of community hospital beds.	**NO**
5.	Retain the community hospital offer but change the location	**YES**
6.	Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patients own home.	**YES**
7.	Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this.	**YES**
8.	Cease community hospital beds as is and provide support within current or new care home provision (new build or development).	**NO**
9.	Reduce the number of community hospital beds and commission a proportion of beds within the care market or create new care capacity (new build or development).	**NO**
10.	Investment in hospice model to divert pressure from community hospital of those that are dying plus continuation of a proportion of community beds. Referred to Hospice Review	**YES**
11.	Investment in hospice model, cease community beds and investment in community alternative model such as suggested in solution 7 – *Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patient's own home.* Referred to Hospice Review	**YES**

The following are the outcomes from the Community Panel in December 2021. Refer to 7.2 for the visual representation of outputs from panel members.

Table 11 Community panel ranking in order of preference

Rank	Options
1	Keep the community hospital as is but change the type of services on offer: **Frailty Chair**
1	**Continue with some** of the community hospital beds and also provide some additional services in the individuals 'own home' to support and compliment this such as a package of care and therapy.
2	Keep the community hospital as is but change the type of services on offer: **Diagnostics**
3	Keep the community hospital as is but change the type of services on offer: **combination of Frailty chair and Diagnostics**
4	**Reduce the number** of community hospital beds and invest in care at home and therapy.
5	Keep all of the community beds but **change the location** in terms of where these are situated in Warwickshire
6	Ensure that people who need **end of life care** are supported within inpatient or hospice in your 'own home' rather than use a community hospital inpatient bed. In addition to this, provide an enhanced 'own home' model providing enhanced therapy and care within the patients own home
7	Ensure that people who need **end of life care** are supported within inpatient or hospice in your 'own home' rather than use a community hospital inpatient bed
8	**Cease community hospital beds** and provide an enhanced 'own home' model providing enhanced therapy and care within the patients own home



In January 2022 at the second Technical Expert Panel meeting a comparison of outcomes were shared from Technical panel and community panel.

Table 12 Comparison of outcomes from Technical panel and community panel

Suggestion	Technical panel hurdle criteria score Scored 1st to last out of 14	Community panel preference rank Ranked most to least out of 8
Reduce the number of community hospital beds and invest in home based alternatives.	1	4
Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this.	2	1
Keep the community hospital as is but change the type of services on offer: c. Diagnostics	3	2
Keep the community hospital as is but change the type of services on offer: a. Frailty Chair	4	1
Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patients own home.	4	8
Keep the community hospital as is but change the type of services on offer: d. Continuation of some of the BAU beds alongside each of the above offers	5	3
Retain the community hospital offer but change the location	6	5
Investment in hospice model to divert pressure from community hospital of those that are dying plus continuation of a proportion of community beds. Referred to Hospice Review 16/12/21	7	6
Investment in hospice model, cease community beds and investment in community alternative model such as suggested in solution 7 – *Cease community hospital beds and provide an enhanced 'own home' model/virtual ward providing enhanced therapy and care within patient's own home.* Referred to Hospice Review 16/12/21	8	7

During the January 2022 meeting the Technical Expert Panel were asked to:

1. Select solutions for further appraisal
2. Deselect solutions with reasons

The original longlist review resulted in five options going forward for further appraisal undertaken by SWFT.

Table 13 The proposed 5 options to be further appraised

Option 1	Retain the community hospital offer exactly as is now?	Bed numbers stay the same and beds return to new EBH site from Campion when works complete.
Option 2	Increase the number of community hospital beds.	Increase the beds, same locations, return to EBH and continue at Nicol
Option 3	Keep the community hospital as is but change the type of services on offer: c. Diagnostics	Change the offer for instance Frailty Chair or Diagnostics
	Keep the community hospital as is but change the type of services on offer: a. Frailty Chair	
Option 4	Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this.	Reduce bed numbers and invest in alternatives as follows; • Increased Home Based Therapy Capacity by an additional 14 patients per month • Operationalise a Delirium pathway inclusive of short term overnight care • Increase the number of D2A beds commissioned in a care home by 3 beds • Increase access to CERT and Virtual Ward
Option 5	Retain the community hospital offer but change the location	Change the location of the beds – the only viable location is a permanent move to Campion this would result in no return of inpatient beds to EBH

11.6 Shortlisting of Original Options

It was further noted that it would be appropriate to merge several of the options as *retaining the community hospital as is but change some of the services on offer* were significantly similar.

A final list of three potential proposals were considered by the Warwickshire Health Overview and Scrutiny Committee ('the Warwickshire HOSC') in February 2022.

Table 14 Final list of 3 options presented to Warwickshire HOSC Feb 2022 (also referred to in Chapter 7 (7.2))

No	Proposal
1	Retain the Community Hospitals offer but change the type of services e.g: • Diagnostics • Frailty Chair • A combination of the above or 'other' to be identified service offers alongside BAU or reduced number of Community beds.
2	Continue with some of the Community Hospital beds and invest in homebased alternatives such as package of care or therapy and/or a virtual ward in the community.
3	Retain the Community Hospital offer but change the location.

At the February 2022 Warwickshire HOSC meeting it was requested that two additional proposals were taken forward to Options Appraisal:

- To keep the bedded offer the same in both location and number
- Increase the number of beds

Table 15 The final 5 options following the HOSC meeting for appraisal

Option 1	Retain the community hospital offer exactly as is now
Option 2	Increase the number of community hospital beds.
Option 3	Change the type of services provided at community hospitals such as diagnostics or frailty chair
Option 4	Reduce beds and invest in community alternatives (Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this)
Option 5	Retain the community hospital offer but change the location

Between February 2022 and 2023 the options were appraised with further engagement activities taking place including a stakeholder engagement session held in September 2022 (refer to Chapter 7 (7.3) for further information.

This activity culminated in the development of a strengths, weaknesses, opportunities, and threats (SWOT) summary for each option to highlight key points. These were included within the final Strategic Review (Appendix 1 Strategic Review of community hospital rehabilitation beds in South Warwickshire (2021-2023)). Each analysis recommended whether the option should proceed to a business case.

Table 16 SWOT Analysis for all 5 options

1. **Retain the community Hospital bed base 'as is**.	
Strengths Less political, community or media response with reduced likelihood of potential reputational damage to SWFT or ICB. Sufficient capacity to support demand. No need to invest in alternatives.	**Weaknesses** Not in line with strategic direction of 'home first' as the bed model continues to include capacity for patients that should be supported elsewhere. Most patients have to travel to use the bedded units, the sites are not centrally located, so these patient will have to continue to travel and may be a barrier to access. Patient may not be supported to optimise their individual outcomes. Additional transfers (acute to community hospitals to longer term setting) that are not required are likely to build dependency and length of stay.
Opportunities There may be an opportunity to refine the clinical criteria whilst keeping the model the same, although this may be difficult whilst bed numbers remain the same and alternative options are reduced. This can be mitigated by providing community alternatives whilst keeping bed numbers consistent and only changing the model once community alternatives are well established.	**Threats** Cost: 7-14million per site for new build and 2.5 million for short term remedial capital and estate works with no identified funding available to support extra costs. Increased likelihood that patients have increased levels of ongoing care needs.
Recommendation for option 1	**It is recommended that this option is not progressed.**

2. **Increase the number of Community Hospital beds**

Strengths	Weaknesses
Less political or community or media response with reduced likelihood of potential reputational damage. Capacity remains predominately within beds, can use this as overflow and flex demands for acute – overall bed base is higher than other options. Learning from Winter around capacity required – and the need for appropriate capacity to support pressures in response to national Urgent and Emergency Services Recovery Plan.	Not in line with strategic direction of 'home first' as the bed model continues to include capacity for patients that should be supported elsewhere. Continue to support people in the wrong place and results in no resources to reinvest in alternatives. Patient may not be supported to optimise their individual outcomes. Additional transfers (acute to community hospital to longer term setting) that are not required are likely to build dependency and length of stay.
Opportunities	**Threats**
There may be an opportunity to refine the clinical criteria whilst increasing the beds although this is likely to reinforce the message that bed is the preferred location for the patient cohort which is at odd with national policy. Viable but only across Nicol and Campion – EBH has no flex opportunities in terms of bed numbers.	Does not future proof capacity in line with direction of travel of other services for instance creating more capacity in community. This can be mitigated by providing community alternatives whilst keeping bed numbers consistent and only changing the model once community alternatives are well established. Increased number of beds only possible with new purpose-built unit at a cost of 7-14million per site for new build million and 2.5 million for short term remedial capital and estate works with no identified funding available to support extra costs. Increased likelihood that patients have increased levels of ongoing care needs. However presence of community recovery service as part of front runner will mitigate this.
Recommendation for option 2	**Progress in conjunction with option 4 and 5.**

3. Change the type of services provided at community hospitals such as diagnostics or frailty chair

Strengths	Weaknesses
Frailty chair may support admission prevention. Diagnostics may reduce need for Community Hospital patients to travel and may result in quicker diagnoses and treatment.	As confirmed within SWFT estates strategy, a Diagnostic Hub is being pursued as part of Stratford Hospital re-design and not high demand for this patient group. Frailty chair – changes the offer from discharge support to admission prevention. Less bed availability.
Opportunities	**Threats**
The frailty chair model has been worked up as part of this review and will be shared with frailty leads as there are opportunities to deliver this model in various settings not just a Community Hospital.	Risks using Community Hospital discharge support resources on other patient groups at a different stage of the pathway. Although the Frailty Chair model can support admission prevention this is not projected to be at the scale that would remove requirement to make provision for services to support discharge of frail, elderly people and therefore there is a continued need to model and make service provisions for this group. Staff required may need a different skill staff from the staff already working in the community hospitals.
Recommendation for option 3	**It is recommended that this option is not progressed as an outcome of this review.**

4. Reduce beds and invest in community alternatives:

Community beds reduced to 22 a year with a flex up to 29 to support operational pressures.

And investment in community alternatives including;

- Increase Home Based Therapy capacity by an additional 14 patients a month.
- Increase D2A Pathway 2 beds by an additional 3 beds.
- Develop a home-based overnight care pathway to support patients with delirium in South Warwickshire for approx. 12 patients a month (to be tested as a Plan Do Study Act).
- To enhance and optimise CRT capacity (Community Response Team formally CERT).
- Investment into Hospice provision – equivalent to 1 patient

Strengths	Weaknesses
Evidence that some people are utilising a bed that should be supported at home but there may be a lack of capacity or options to do this. This model targets and builds additional capacity within the pathways that have been identified as providing an alternative option to a bed for this patient cohort. There is buoyant supply of care home placements in South Warwickshire and therefore increasing D2A beds is feasible. Home Based Therapy is now well established in South Warwickshire with a clear process, pathway and infrastructure therefore increasing capacity to this pathway will be feasible. There will be an ongoing provision of community hospital beds (22 – 29 beds) – which is more than modelling requirement of 19 beds and allows for demographic growth.(See figure 7 bed modelling) Flexible capacity with tight criteria to support periods of pressure within the acute.	Changes in the bed offer may be unpalatable to the public and any perceived 'loss' of services will result in an adverse public response. This option also involves a period of transition to move from current to future state which will be handled carefully with a risk mitigation plan but will carry clinical risk. Winter learning is that reduction of beds before community alternatives and fully in place and established would result in an operational risk.
Opportunities	**Threats**
Increased choice for patients. Increases the overall capacity of services to support the patient cohort discharge from hospital. Reduced risk of decompensation in hospital with patients being supported in the right time and place. More likely to have reduced on going care needs. Reduced Los within the acute.	Care workforce requires focused market shaping to ensure care sector can support – this work has started. NHS workforce, management of change risk – staff may move onto other roles if they don't want to work in a different setting e.g. staff that may need to support the community pathways and not inpatient e.g. AHP's Culture change - education and awareness raising with staff, patients, and partners to ensure that when the model of change decisions, ethos of care and support around this also shifts as people may still be supported to the wrong place.

Recommendation for option 4	**Progress partially (community alternatives only) in conjunction with Option 2 and 5**

5 Retain the Community Hospital offer but change the location*. *Estates and Clinical colleagues confirmed only viable alternative location within SWFT estate would be a permanent move to Campion ward at Leamington Spa Hospital. This option is best considered with another option that describes the operational model. This option is about the potential closure of EBH and/or Nicol unit and permanent relocation to Campion ward.	
Strengths Management of staff and workforce is easier from one base. Campion is centrally located and closer to the majority of patients based on post code analysis. Campion provides flex capacity whilst other sites don't. Campion is in line with modern ward standards, already undergone Capital improvements and supports good IPC standards.	**Weaknesses** Within Campion there is a bay of 4 beds past a set of double doors within a corridor. From a clinical oversight and safety perspective these beds would need to be part of the 'flex' element of the bed base and only operationalised at times of pressure with the correct staffing cohort to ensure safe ward staffing levels.
Opportunities Ward co-located with other inpatient services (stroke and Level 1 ABI) which presents a range of operational and qualitative benefits in respect of clinical cover, access to established therapy areas and amenity spaces which help promote rehabilitation and recovery and independence.	**Threats** Staff who are temporarily working at Campion whose previous base was EBH may not want to stay at Campion permanently and may decide to move on to other jobs. However, could be mitigated via redeployment to other roles, also recruitment has been improved since the move to the new site Additional payment for travel for staff that have been re-located will continue however as new EBH won't be ready until at least 2024 this cost will remain regardless of this option.
Recommendation for option 5	**Progress in conjunction with Option 2 and 4**

Following the SWOT analysis for each option these were scored by members of the Community Hospital Steering Group which included: Associate Medical Director, AHP lead, nursing lead, operational managers x2, HR lead, finance lead.

Each option was scored against the following criteria:

Effectiveness				
QUALITY				
Outcomes	Cost efficacy	Patient Experience	Patient Safety	Equity of access

Efficiency				
SUSTAINABILITY				
Workforce capacity	Workforce capability	Estates	Operational	Financial

Feasibility			
SERVICE DELIVERY			
National Strategic fit	Local strategic fit	Timeline	Interdependencies with other programmes

Appendix 32A 2021-2022 Options appraisal summary 23 outlines the feedback from November 2021 and the scoring from November 2022 against the five options outlined in Table 16.

Table 17 Scoring and outcome from the engagement activities and SWOT analysis 14/11/22

	Suggestion	How it covers what came out of engagement exercise/ What this means	criteria	Yes	No	Outcome
Option 1	Retain the community hospital offer exactly as is now?	Bed numbers stay the same and beds return to new EBH site from Campion when works complete.	Patient Safety and Quality	33%	67%	Despite being deselected at the intial technical panel the Board requested on 12/21 and HOSC requested on 03/22 that this option was explored further. On further review including postcode analysis the steering group technical panel 14/11 advised it was deselected again
			Workforce delivery	33%	67%	
			National and local delivery	0%	100%	
			Affordability	17%	83%	
				21%	**79%**	
Option 2	Increase the number of community hospital beds.	Increase the beds, same locations, return to EBH and continue at Nicol	Patient Safety and Quality	17%	83%	Despite being deselected at the initial technical panel the Board requested on 12/21 and HOSC requested on 03/22 that this option was explored further. On further review the steering group technical panel 14/11 advised it was deselected again.
			Workforce delivery	17%	83%	
			National and local delivery	0%	100%	However, after further discussion at Board 01/23 it was agreed that this should be included for reasons outlined in the business case.
			Affordability	0%	100%	
				8%	**92%**	
Option 3	Keep the community hospital as is but change the type of services on offer: c. Diagnostics	Change the offer for instance Frailty Chair or Diagnostics	Patient Safety and Quality	83%	17%	This option will continue to be scoped through a different but interdependent business case
			Workforce delivery	33%	67%	
			National and local delivery	100%	0%	
			Affordability	17%	83%	
				58%	**42%**	

	Keep the community hospital as is but change the type of services on offer: a. Frailty Chair		Patient Safety and Quality Workforce delivery National and local delivery Affordability	83% 50% 100% 50% **71%**	17% 50% 0% 50% **29%**	This option will continue to be scoped through a different but interdependant business case
Option 4	Continue with a proportion of community hospital beds and invest in an 'own home' model/virtual ward to support and compliment this.	Reduce bed numbers and invest in alternatives as follows; •Increased Home Based Therapy Capacity by an additional 14 patients per month •Operationalise a Delirium pathway inclusive of short term overnight care •Increase the number of D2A beds commissioned in a care home by 3 beds •Increase access to CERT and Virtual Ward	Patient Safety and Quality Workforce delivery National and local delivery Affordability	100% 100% 100% 100% **100%**	0% 0% 0% 0% **0%**	This option went forward into the business case but only the investment in community alternatives
Option 5	Retain the community hospital offer but change the location	Change the location of the beds – the only viable location is a permanent move to Campion this would result in no return of inpatient beds to EBH	Patient Safety and Quality Workforce delivery National and local delivery Affordability	100% 67% 50% 83% **75%**	0% 33% 50% 17% **25%**	This option went forward into the business case

SWFT recommended that the following options were taken forward into a business case as they were deemed to provide the right capacity, were in line with the strategic direction of travel, affordable and clinically appropriate for the cohort of patients that require inpatient community support:

- Option 2: Increase the number of community hospital beds
- Option 4: Invest in community alternatives
- Option 5: Retain the community hospital offer but change the location

Following an internal review of SWFTs Strategic Review and proposed options (Appendix 1 Strategic Review of community hospital rehabilitation beds in South Warwickshire (2021-2023)) a report was provided to the ICB Board (Appendix 38 Pg76-82 South Warwickshire Place Community Hospital Bed Review ICB Paper 19 July 2023) that concluded the following:

- Based on the NHS England Strategic Service Change Assurance Process it is considered that the potential changes flowing from the Community Bed Review do constitute a significant service change, and although the engagement undertaken by SWFT as part of the Community Bed Review has been comprehensive, there is not yet sufficient information for the ICB to make a commissioning decision.
- It is therefore recommended that there is a need for further involvement of the public on the proposed options and the wider implications of the Community Bed Review.

The ICB Board approved proceeding with the development of a commissioning pre-consultation business case. As articulated in section 11.1 there was further work that was required to inform the PCBC. (Appendix 38 Pg76-82 South Warwickshire Place Community Hospital Bed Review ICB Paper 19 July 2023)

11.7 Review of the Options 2024

Following on from the recommendations at ICB Board in July 2023 further work commenced (outlined in 11.1) summarised below:

- Legal and specialist advice
- Review of Rehabilitation Services for the whole Coventry and Warwickshire population

The outcomes of the rehabilitation review have commenced but a decision was made due to the passage of time that has passed, to prioritise the work relating to the community hospital rehabilitation beds in South Warwickshire.

Between June and September 2024, the original long list was reviewed to ensure that nothing significant had changed impacting on the original appraisal, as well as further options considered (Appendix 23 Clinical Options Appraisal Summary, Appendix 31 Estates Commentary - August 2024 V1, Appendix 32 Financial Appraisal Community Beds options sent 3 Sept and Appendix 33 Option Appraisal - Use of second floor for beds Oct 2024 V1_).

Options evolved from key stakeholder discussions, including the ICS Clinical Care Forum (Appendix 22 – Clinical Forum Presentation). The proposed options were finally agreed based on significant new considerations and data relating to need and demand (refer to chapter 3 and 14):

- We are in a different situation re system financials since the previous work was undertaken with a projected £20 million deficit and a clear direction to 'live within our limits'.
- Due to parts of the EBH inpatient building having to be removed due to asbestos removal there is an overall change to the footprint of the building and a reduction in the number of beds this facility can house (12).
- The increased need for using beds flexibly at times of increased acute bed demand and access to emergency care should be a key consideration based on learning from winter bed pressures and Covid 19.
- Increase in community investment since the original community bed review.
- A new and approved Estates Infrastructure Strategy and Delivery Plan, requiring system support for any future proposals impacting estates.

Table 18 2024 New Identified Options for Consideration

A	Provide 35 community beds across three sites: EBH, Stratford Hospital and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision
B	Provide 35 community beds across two sites: Stratford Hospital and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision
C	Provide 35 community beds across two sites: EBH and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision
D	Provide 35 community beds at one purpose-built site at Stratford Hospital and continue to improve our care at home provision
E	Return the 16 beds to the EBH with no mention of the remaining 19 beds (received from Beds for Badger campaign group) The option with existing planning approval referred to as phase two in the Planning application 21/00004/FUL for all the reasons given in the planning statement to that application.
F	The options to include inpatient beds in the building currently under construction. This building's proportions are those of a modern hospital with all the advantages that makes it much more suitable than the retained building identified in your paper. The retained building could however be utilised for offices or community use.

Options C-F were rejected (Appendix 23 Clinical Options Appraisal Summary, Appendix 31 Estates Commentary - August 2024 V1, Appendix 32 Financial Appraisal Community Beds options sent 3 Sept and Appendix 33 Option Appraisal - Use of second floor for beds Oct 2024 V1_) using the same criteria as previously used.

Table 19 Rational for rejection of options C-F

C	Provide 35 community beds across two sites: EBH and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision		This option was rejected because it did not address the existing need to improve access to care for underserved populations based on current need. It is proposed that all 19 beds remain at Nicol and are not being considered. This is due to several contributing factors: • Need (postcode analysis) • Clinical expertise available that supports higher level of patient acuity

			• Specialises in end-of-life care • Recent investment into the building has made significant improvements. • Beds can be used flexibly at times of increased acute bed demand and has access to emergency care.
D	Provide 35 community beds at one purpose-built site at Stratford Hospital and continue to improve our care at home provision		Whilst redistributing the wards to one purpose-built site was initially considered, this option was ruled out due to the significant capital investment required. Not included within current estate plans or within capital budget.
E	Return the 16 beds to the EBH with no mention of the remaining 19 beds (received from Beds for Badger campaign group) The option with existing planning approval referred to as phase two in the Planning application 21/00004/FUL for all the reasons given in the planning statement to that application.		The construction of a new building in Shipston to house 16 community rehabilitation beds (Phase Two of the Ellen Badger site) is not feasible within the current financial framework. Due to significant capital constraints, alongside competing demands for resources across the ICB, securing the required funding for this construction project is highly unlikely and is beyond just a capital reprioritisation process. Additionally, the 'Home First' strategic approach and an analysis of patient needs across South Warwickshire indicate that the highest demand areas are Leamington, Kenilworth, and Stratford. As such, the construction of a new inpatient facility at Ellen Badger would not align with the priority areas identified, nor does it meet current funding limitations.
F	The options to include inpatient beds in the building currently under construction. This building's proportions are those of a modern hospital with all the advantages that makes it much more suitable than the retained building identified in your paper. The retained building could however be utilised for offices or community use.		The funding for the phase one building was secured from NHS England to support an out of hospital model of care which is why it was spent on this part of the development for community services and co-location with partners. It would not be possible to repurpose the funding to support inpatient care. However, for completeness we have still explored the option and the floor area available would not support the spatial requirements required for a viable inpatient unit. We concluded that a maximum of 10 beds could be accommodated, however this arrangement of beds would still present a range of safety, nursing and access challenges which would not be surmountable within the current structure. The practical changes needed to deliver the mechanical and engineering infrastructure requirements of an inpatient facility would also present with significant cost related risks

11.8 Final Shortlist Options 2024

The two viable options remaining as a result of the revalidation and review were:

A. Provide 35 community beds across three sites: EBH, Stratford Hospital and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision
B. Provide 35 community beds across two sites: Stratford Hospital and Leamington Spa Rehabilitation Hospital and continue to improve our care at home provision

11.9 Evaluation Criteria for 2024 options

For details on our approach to stakeholder engagement in the development of community hospital rehabilitation bed options, please refer to Chapter 7, Stakeholder Engagement. This chapter outlines who we consulted and how their feedback informed the options under consideration.

For a detailed breakdown of the expected patient outcomes and system-wide benefits that influenced the decision-making relating to the development of the options, refer to the Impact Framework in Chapter 9.

The South Warwickshire NHS Foundation Trust (SWFT) conducted a thorough and inclusive options appraisal process, adhering to the principles of the Treasury's Green Book guidance. The appraisal included multiple stages: initial stakeholder engagement, the creation of a longlist, subsequent shortlisting, and a final evaluation to identify the preferred option for future bed provision.

Key stakeholders collaboratively developed the evaluation criteria. Evidence for each criterion was rigorously scrutinized, using data and insights provided by local healthcare providers, publicly available resources, input from reference and working groups, and the professional judgment of experts involved in the process.

Key data sets (Appendix 39 List of Key Data Sets) relating to the evaluation criteria was provided during the process including information from both the Equality Impact Assessment (Appendix 9 Equality Impact Assessment) and Health and Equality Impact Assessment (HEAT) (Appendix 34 HEAT Analysis).

The following evaluation criteria was identified that incorporated the Hurdle criteria:

- Quality of care for all
- Access to care for all
- Affordability and value for money
- Workforce availability and sustainability
- Deliverability

Quality of care was assessed based on its projected impact on patient safety, outcomes, clinical effectiveness, and patient experience in 2023/24 and pre-2022 when the beds were temporarily relocated

to consider any negative or positive impacts on patient care. The evaluation drew on clinical audits and published national clinical standards to ensure alignment with best practices.

Access to care was analysed through an extensive travel time assessment, evaluating the population impact of relocating services based on the options presented. The analysis included:

- Current demand for community hospital rehabilitation beds in South Warwickshire.
- Anticipated future demand, factoring in commissioned 'Home First' services.
- Discharge data from existing community hospitals.

All noted that patients accessing community hospital rehabilitation beds will be internally transferred and therefore the impact noted would be on family and friends visiting and supporting recovery.

Affordability and value for money were evaluated in collaboration with the Finance Working Group, using financial models to assess the impact of proposed changes on capital and transition costs, income, expenditure, and system-wide financial deficits. The net present value (NPV) of each option was also considered.

The workforce criteria were reviewed with input from both the Finance Working Group and the Clinical Quality and Strategic Group . This assessment focused on the scale of workforce impact and the sustainability of staffing models.

Deliverability was examined by assessing the time required for implementation and the broader effects on other health and care policies. This included evaluating the movement of services, beds, facilities, and staff across sites.

11.10 Evaluation of final shortlisted options 2024

The final shortlisted options (2024) were evaluated through a structured process, including stakeholder feedback (see chapter 7 for further details) and clinical input via the Clinical Quality and Strategic Group. A detailed appraisal was conducted for each option (Appendix 23 Clinical Options Appraisal Summary, Appendix 31 Estates Commentary - August 2024 V1, Appendix 32 Financial Appraisal Community Beds options sent 3 Sept and Appendix 33 Option Appraisal - Use of second floor for beds Oct 2024 V1_), with the findings summarised below:

Table 20 Evaluation Criteria

	Quality of care for all	Access to care for all	Affordability and value for money	Workforce availability and sustainability	Deliverability
Option A: Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision					
Option B: Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital) and					

continue to improve our care at home provision					

The table above highlights the extent to which each option met/didn't meet the criteria.

	Does not meet criteria
	Meets criteria but issues associated
	Meets criteria well

Table 21 High level evaluation summary against the evaluation criterion

Evaluation Criterion	**Option A:** Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision	**Option B:** Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision
Quality of care for all	Both Option A and Option B are not expected to result in significant improvements in the already high levels of quality care currently being delivered. The high standards in patient safety, clinical outcomes, and patient experience will be maintained, but neither option presents a clear opportunity for substantial enhancement in these areas beyond what is already achieved. Shipston's isolated location may increase delays in transferring patients requiring urgent care or complex rehabilitation, potentially impacting outcomes. The continuation in community rehabilitation funding and the new Community Integrator Contract with SWFT as the lead provider was cited as improving quality of care for both options. Both qualitative and quantitative evidence has been gathered that whilst patients generally have a good experience whilst using community hospital, many patients should have been supported to continue their recovery and rehabilitation at home or in a care home rather than within the community hospital inpatient setting. At times of pressure there can be limited flexibility in terms of the capacity within the current inpatient units, and a distinct lack of alternative services in the community. Both options need to ensure resources and support is in the right place for frail or elderly patients who are the main patient group using the facilities. Option B facilitates the system's ambition to provide 'additional hospital bed occupancy' for more acute patients. Leamington and Stratford wards have the potential for additional beds whereas option A at EBH there would be no further capacity due to the space available than 12 beds maximum. Option A precludes access for more acute patients to be admitted to Shipston. The EBH site in Shipston is not equipped or suitable to handle patients with more severe or complex medical conditions. These patients may require more advanced care, such as that	

	provided by an acute hospital, which has the facilities and staff to manage critical health needs. As a result, Shipston would not be able to admit these types of patients, potentially necessitating their transfer to other hospitals that are better equipped to manage acute conditions.
Access to care for all	Relocating beds to Ellen Badger Hospital (EBH) in Shipston would improve access for local patients and visitors. However, its rural setting presents significant barriers in terms of public transport availability, affecting access for those without private vehicles. This would particularly impact patients and families from northern areas like Kenilworth and Leamington, where travel times would increase. Additionally, due to the distance and lack of proximity to acute hospitals, there could be challenges in accessing emergency or intensive rehabilitation services should a patient's condition deteriorate. Compared to both Campion Ward in Leamington, and Nicol in Stratford, which are both closer to larger acute facilities. We acknowledge that relocating the beds outside Shipston would also create access issues for family and friends living locally. However, data shows that only 15-16% of patients admitted have a Shipston, Kineton, or Wellesbourne postcode. While this group would experience an inconvenience in terms of travel, the majority of patients admitted to these beds come from areas further afield, where locating beds centrally—such as in Leamington or Stratford—might better serve the overall population's needs. Some patients have declined to transfer and have challenged services based on where they will receive their rehabilitation as it restricts family and friends visiting. Overall, the analysis shows that Option B is better for access as the proportion of the population accessing inpatient community hospital rehabilitation bed provision from Shipston is small and option B is more easily accessed by a greater proportion of the population in the north of South Warwickshire. When the population of Stratford that utilise inpatient community hospital rehabilitation bed provision is taken into account Option B is also better. An analysis of bed occupancy over the past two years indicates that on average 21 beds on Nicol and 29 beds on Campion are necessary. 35 beds are the subject of this PCBC. SWFT operationalise more due to demand and the opportunities to flex the beds as required to meet demand. SWFT fund the additional beds. Additionally, patient audits from 2021 and 2024 reveal that not all patients occupying these beds are admitted for community hospital rehabilitation. These beds are also being utilised to support acute patients when demand necessitates.
Affordability and value for money	All health system providers including SWFT across Coventry and Warwickshire are having to make efficiency savings that will contribute to the reduction of a forecasted system deficit. From an estate's perspective, option A will result in capital investment due to requiring modernisation and improvement to ensure the building meets modern day ward standards and can uphold infection prevention and control guidelines.

	The latest analyses completed to date show neither option to be substantially better from a revenue perspective than the other, but option A requires significant capital investment and additional revenue costs.	
	Costs associated with the running of three clinical sites incurring an additional annual revenue of £400,000 per annum including pay and non-pay costs. Capital costs associated with ward refurbishment to meet clinical ward standards as the building has been dormant for 2.5 years - £1.6m	Currently funded. No impact on revenue, no transitional costs or capital costs incurred as a result of the proposed changes. Potential legal challenge resulting in financial risk £635,000 due to a legacy fund for improvements to the health and wellbeing of Shipston residents having to be returned if there are no beds returning constituting it a hospital.".
Workforce	When assessing workforce, option A could potentially lose some of the existing workforce due to their current place of work having better public service networks. Option A would require an uplift in staffing as based across the 3 sites. The options have been thoroughly appraised by key stakeholders at SWFT and Option B was the preferred option from both a clinical and financial perspective due to clinical safety concerns and affordability. Option B also offered a more robust workforce given the co-location with other wards/clinical services and ease of access for the workforce. However, both options are considered to have a similar impact on the workforce in terms of overall numbers of staff changing place of work when travel from home is considered. The future workforce requirement is likely to be related to the future activity provided at each site and therefore we can make an assumption of the potential impact that there could be on the future workforce. .	
	Previous issues with recruitment and retention at the EBH site noted and covering staff sickness due to rurality and travel impact. Potentially need to recruit to the EBH site.	When assessing workforce, option B would retain the existing workforce on their current place of work than option A due to staff living near to their place of work.
Deliverability	Deliverability will require a series of logistical and procedural steps to ensure the successful implementation of this service change. First, the necessary refurbishments of the facilities need to be completed to meet modern healthcare standards. This includes both	No changes and the service would continue as is.

	physical infrastructure updates and ensuring compliance with infection prevention protocols. Secondly, the transfer of beds between sites will need to be carefully coordinated, including the approval of new patient allocation criteria. This process will define how patients are distributed based on their rehabilitation needs, proximity to the available beds, and access to acute care services. Lastly, careful consideration must be given to the transfer of staff and equipment, ensuring that patients requiring more intensive care can still access acute services when necessary. All of this must be done with minimal disruption to ongoing services and patient care. For Option A, a high-level implementation plan has been developed to outline the necessary steps to establish services across three sites, including infrastructure works and workforce requirements. This can be found in **Chapter 15: Implementation Plans** (Section 15.5). In contrast, Option B reflects the current service configuration and requires no formal implementation plan as it represents 'business as usual'.	

11.10.1 Addressing parity between options

Improved Provision in the Two-Site Option (Option B):

- The **two-site model** (Option B) provides enhanced resilience in responding to increasing patient acuity and operational demands. By concentrating services at two sites, resources, expertise, and equipment can be deployed more effectively to manage **higher-acuity patients**, which is an increasing trend in the region.
- **Ellen Badger Hospital (EBH):** While Option A includes EBH, it is more suitable for **lower-acuity patients** due to its size and infrastructure limitations. Patients requiring complex care, particularly

those from Shipston and nearby areas, may find EBH's clinical setting less appropriate compared to Stratford and Leamington.

2. Resilient and Flexible Workforce:

- Option B allows for a **more sustainable workforce model** by reducing fragmentation. Staffing fewer sites enables the recruitment and retention of **specialist clinical teams** who can deliver consistent, high-quality care. Option A, conversely, risks spreading workforce capacity too thinly across three sites, which could impact patient care and operational flexibility.

3. Impact on Patient Experience and Travel:

- While Option A prioritises **local access for Shipston residents**, the majority of demand for community beds comes from **central and northern South Warwickshire**, where population density and patient need are highest.
- Option B's consolidation improves accessibility for most patients and ensures that resources align with geographic demand. This trade-off reflects an **opportunity cost** in Option A, where a focus on rural provision may reduce efficiency and access for the wider patient cohort.

4. Opportunity Costs of Option A:

- Option A may require additional resources for workforce, operational overheads, and estate upgrades, diverting funds that could otherwise enhance patient care across the system. Option B, by contrast, optimises financial and workforce sustainability without compromising patient outcomes.

11.10.2 The Integrated Care Board (ICB) recommended preference

In considering the evidence local stakeholders required that the ICB determine a preference for Option B, noting that this is a preference. A final decision will be reached by the ICB once the public consultation has completed, and the results considered.

11.11 Conclusion

Both options A and B offer solutions for South Warwickshire's community hospital rehabilitation bed provision. However, Option B, which consolidates beds across two sites, emerged as the preferred option due to its superior performance in terms of affordability, workforce sustainability, and access to care. This preference aligns with the system's financial constraints and strategic goals.

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12. Economic and financial analysis of the options

This chapter presents a comprehensive economic and financial analysis of the proposed options for South Warwickshire's community hospital rehabilitation beds. We evaluate the cost implications and long-term sustainability, considering both direct financial impacts and wider socio-economic benefits. However, given that this case is based on an incumbent service and the proposed change for each option is limited in scope there is a limit to the implications that can be derived.

12.1 Introduction

The ICB faces significant capital constraints and must carefully prioritise investments to align with strategic goals, including the 'Home First' approach. Projects are evaluated based on demand, location, and alignment with regional healthcare needs. Current priorities focus on areas with the greatest patient demand and operational impact, meaning that new constructions or significant refurbishments, particularly outside of high-demand areas, face considerable funding challenges.

While the proposed changes to community hospital rehabilitation beds are not intended as a full-service reconfiguration, we acknowledge that they are identified as a major service reconfiguration within the context of the national process, primarily due to the change in geographical location. Additionally, some may view the changes as significant because of the classification of certain buildings and whether they will continue to be designated as hospitals.

However, it is important to emphasise that while the reconfiguration is classified as major, the scale of these changes is not as extensive as some other major reconfigurations. The focus is on redistributing beds and enhancing care-at-home services, with no reduction in the total number of community beds. These adjustments aim to optimise service delivery without fundamentally altering the overall healthcare model in South Warwickshire.

As such, the case should be treated in line with its materiality, recognising its significance but also proportionate to the scale of the changes being proposed ie the location of 35 community beds within South Warwickshire. The knock-on wider impact of socio-economic benefits of one location compared to another are therefore small, but still reflected within the case.

The case has potential capital costs as one option (Option A) requires refurbishment of capacity that is currently not in use and this is considered as part of the case.

Whereas the case aligns with HM Treasury guidelines part of these include the application of proportionality insofar as the effort employed should be related to the costs, benefits and risks involved to society as a result of the options being considered. Noting that the revenue cost of the options considered is between £5m and £6m, but that the impact is limited as the costs already being incurred by the service already being in place, the case will align to the guidelines but be relatively reduced in scope. If capital becomes a requirement at a later stage it is acknowledged that an appropriate capital business cases will be pursued. However, that it currently not the case.

On the same basis the long-term sustainability is assumed on the basis of the costs already being in SWFT's baseline service. Longer term consequences have been included, where relevant, in the related

sections rather than a separate assessment, therefore. In normal circumstances the options would be compared to a no change option, however, this isn't possible in this case.

The summary table of the costs of the two options is outlined below with further details of the case within the spread sheet appendices:

Table 22 Summary of the costs of the two options under consideration

	Option A			Option B		
Site	Beds	Revenue cost (£m)	Capital cost (£m)	Beds	Revenue cost (£m)	Capital cost (£m)
EBH (Shipston)	12	2.016	1.619	0	0.000	0.000
Leamington Spa (Campion Ward)	11	1.863	0.000	16	2.617	0.000
Stratford (Nicol Ward)	12	2.016	0.000	19	2.927	0.000
TOTAL	35	5.895	1.619	35	5.544	0.000

12.2 Capital Implications

12.2.1 Capital Requirements

In the event that Option A is selected, there would be a requirement for £1.6 million in capital funding specifically for the Shipston site. However, this funding is not currently secured and would necessitate a reprioritisation of existing capital projects. This reprioritisation could delay or even cancel other planned projects that also address high-priority needs within the ICB. Given the current financial constraints, any such funding decision would require careful consideration of the trade-offs involved, in alignment with the ICB's overall strategic and financial priorities. Full details are outlined within Appendix 31 Estates Commentary - August 2024 V1.

12.2.2 Funding Sources

Option B as outlined is the current state of the service. This option would need no additional capital or revenue funding as it is sourced within current costs of operations.

Option A, however, would require £1.6m additional capital. There is no additional external source of funding currently available for this to occur. The ICS and Provider have capital funding on an annual basis. To enable this option this would need to be prioritised above current anticipated projects and backlog maintenance. A full comparative prioritisation has yet to be undertaken on what would be impacted. This would become an immediate next step if option A was the final option chosen and would result in a delay or cancellation of other projected work.

12.3 Economic Case for HMT

12.3.1 Cost-Benefit Analysis (CBA)

Option B as outlined is the current state of the service. This option would need no additional capital or revenue funding as it is sourced within current costs of operations.

As outlined in table 10 above Option A would require £0.351m additional revenue. The cost pressure in option A relates to the fact that SWFT as a Provider would have to run 3 wards at 3 different sites. This means more staff to ensure adequate cover is consistently available on each site to ensure quality of care. There is also an additional £0.1m of costs for rent, rates, insurance, utilities that relate to having an additional site. These costs appear within Appendix 32 Financial Appraisal Community Beds options sent 3 Sept.

As an ICS there was a deficit plan set for the current financial year. This would add to the cost pressure and would need to see greater transformational savings elsewhere to cover the costs. Given the level of savings expected in future years this would further drive a difficult to achieve target.

12.3.2 Value for Money (VfM)

Given that the main differential between the two options is the location of some of the beds there is only marginal difference in benefits between the options. The main consideration of value for money is, therefore, a comparison of costs.

As this has already been covered in the section no further analysis has been undertaken.

This is not impacted upon by time period with the exception that all wards will at some stage need to be looked at for maintenance. Older wards that have not been recently refurbished are likely to need this at some stage so it is likely that additional costs will be incurred once this happens.

12.3.3 Sensitivity Analysis

It is not currently anticipated that key assumptions relating to demand, cost and inflation will significantly impact one option over the other. Risk factors remain as advised. However, as referred to in Chapter 8 a reduction in beds in Stratford and Leamington may have an impact during times of increased demand due to requiring an increased workforce to support the full capacity of the ward.

12.4 Wider Socio-Economic Impacts

12.4.1 Community Impact

Both options considered allow for the same number of beds overall. The expectation is that there will be an addition WTE and non pay costs of option A as three sites cost more than two. This will have a small impact on local employment and rates paid, but not necessarily on local business as non pay costs will be related to current purchasing of the hospital.

Given that the services will provide the same affective service to patients as that already in place the additional impact on health inequalities and vulnerable patients will be limited. Given that the service will be based on need for the beds rather than location of patients having a wider base of locations is not anticipated to have any impact on how close to home any individual patient will be.

12.4.2 Economic Multiplier Effects

Based on the impact assessment for Community it is not anticipated that either option will have much economic impact over the other on job creation or local economic growth. The limited benefit of an extra role will be negated by the fact that overall productivity will be the same in each case meaning that the productivity per role is reduced overall.

12.5 Compliance with HMT Green Book Guidelines

12.5.1 Strategic Fit

Lord Dazi's recent report into the state of the NHS includes a conclusion that too little a share of the budget is being spent in the community. These community beds support national and local principles of maintaining as a minimum community provision. This is expected to help long term sustainability of services in the NHS overall and maintain patient flows through the Acute hospitals.

12.5.2 Appraisal of Options

Whereas the case aligns with HM Treasury guidelines part of these include the application of proportionality insofar as the effort employed should be related to the costs, benefits and risks involved to society as a result of the options being considered. Noting that the revenue cost of the options considered is between £5m and £6m, but that the impact is limited as the costs are already being incurred by the service already being in place the case has aligned to the guidelines, but is relatively reduced in scope as the differential between options on a value for money and affordability front is cost alone.

12.5.3 Governance and Accountability

With the exception of the location the case has outlined that the costs are the main aspect of variability between the two options. This being the case the costs will continue to be monitored through the ongoing analysis of run rate costs and bottom line deliverability of the financial position. As this is Business as usual for the ICS there are no proposed additional ongoing governance requirements beyond the initial project delivery.

12.6 Conclusion

Given the differentiating factor between the two options is cost in terms of capital and revenue and that benefits have already been delivered as the service is already in place the economic and financial considerations of the case are solely the cost differential.

For option 1 there is a clear additional capital cost of £1.6m as well as revenue costs of £0.35m per annum with no additional impact on saving and no benefit to the quality of care. From a financial viewpoint option B can be concluded as the preferred option.

13. Workforce Modelling

In this chapter, we explore workforce modelling to assess the staffing requirements for implementing the proposed community hospital options. This includes forecasting the necessary skills mix, evaluating existing workforce capacity, and identifying training and recruitment strategies to ensure the effective delivery of services.

13.1 Introduction

SWFTs two community hospitals currently based at Stratford and Leamington offer inpatient specialist services for adult patients that require rehabilitation, reablement and recovery. This chapter will focus on the rehabilitation element of our service offer and will explore the impact of each option on workforce productivity, retention, and collaboration, as well as the potential to leverage recent workforce growth effectively.

This model of care is supported by NHSE. 'This framework is focused on step-down intermediate care – time-limited, short term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover'. *Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge,* NHSE, 2023.

SWFTs community beds provide for patients who no longer require treatment in an acute hospital but are not able to return home due to ongoing care needs which cannot be met by other D2A pathways and require 24 hour nursing care.

The patients may:

- Have had a severe illness
- Had a decline in their health after a long-term illness
- Need medical, physical or specialist rehabilitation
- May require a dedicated bed for end of life care

To meet these varied needs SWFTs ward teams are made up of a range of healthcare professionals including 24-hour nursing care and input from Physiotherapists and Occupational Therapists. Other specialist teams such as Speech and Language Therapy, Dietetics or Tissue Viability will review patients on request. It is noted by these teams that their activity has increased over the last 4 years due to the increasing complexity of patients that we are now caring for.

There is also a dedicated Integrated Discharge Team who review the patients daily to promote and expedite discharge working closely with Social Care and ICB colleagues. The team is seeing an increasing complexity of patients

Both hospitals have medical cover provided by local GPs Monday to Friday 0800-1830. If a patient requires review outside of these times the team will call the GP out of hour's service, 111 or 999 dependent on the patient need.

The community teams such as Urgent Community Response (UCR), Community Recovery Service (CRS), rapid response and Community Response Team (CRT) are also involved in patient care as a response to admissions prevention work.

13.2 Workforce Modelling

The Clinical Quality and Strategic Group undertook an in-depth options appraisal of the considered options discussed in Chapter 11 (Appendix 23 Clinical Options Appraisal Summary). This involved reviewing the options from the perspective of:

Quality of care for all
Access to care for all
Affordability
Workforce
Deliverability

The clinical group and other key stakeholders identified the following 2 options as viable from the long list:

Option A: Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision.

Option B: Provide 35 community beds across the two sites (Leamington Spa Hospital and Stratford Hospital) and continue to improve our care at home provision.

The Clinical Group worked with workforce and finance leads to develop the following workforce modelling to support the 2 options:

Option A

Table 23 Workforce Modelling across all 3 sites

EBH (Shipston) 12 beds		
Job role	Band	WTE
Ward Manager	7	1
RN	6	2.6
RN	5	7.9
CSW	2	7.9
CSW	3	2.6
Physio	6	1.44
OT	6	0.96
Physio	7	0.40
OT	7	0.40
Therapy Assistant	3	1.20
Therapy Assistant Physio	3	1.20
Ward Clerk	2	0.6
Ward Co-ordinator	4	0.40
House Keeper	2	0.40
Activity coordinator	3	0.53
Medical Cover		
Total		29.53

Nicol (Stratford) 12 beds		
Job role	Band	WTE
Ward Manager	7	1
RN	6	2.6
RN	5	7.9
CSW	2	7.9
CSW	3	2.6
Physio	6	1.44
OT	6	0.96
Physio	7	0.40
OT	7	0.40
Therapy Assistant	3	1.20
Therapy Assistant Physio	3	1.20
Ward Clerk	2	0.6
Ward Co-ordinator	4	0.40
House Keeper	2	0.40
Activity coordinator	3	0.53
Medical Cover		
Total Pay		29.53

Campion (Leamington)12 beds		
Job role	Banding	WTE
Ward Manager	7	1
RN	6	2.6
RN	5	7.9
CSW	2	7.9
CSW	3	2.6
Physio	6	1.44
OT	6	0.96
Physio	7	0.40
OT	7	0.40
Therapy Assistant	2	1.20
Therapy Assistant Physio	3	1.20
Ward Clerk	2	0.6
Ward Co-ordinator	4	0.40
House Keeper	2	0.40
Activities coordinator	3	0.53
Medical Cover		
Pay Total		29.53

This modelling clearly demonstrates that deployment of the same workforce across all three sites to ensure consistent and equitable staffing coverage.

Option B

Table 24 Workforce Modelling across two sites

Campion 16 beds		
Job role	Band	WTE
Ward Manager	7	1.0
RN	6	2.6
RN	5	10.0
CSW	3	2.6
OT	7	0.5
Clinical Support Worker	2	18.4
Housekeeper	2	0.5
Ward Clerk	2	0.8
Activities coordinator	3	0.5
OT	6	1.2
Ward Coordinator	4	0.5
Therapy Assistant	3	1.2
Therapy Assistant	2	1.2
Physio	6	1.9
Physio	7	0.5
Medical Cover		
Total Pay		43.4

Nicol 19 beds		
Job role	Band	WTE
Ward Manager	7	1.0
RN	6	3.0
RN	5	9.6
CSW	3	5.5
CSW	2	15.5
Ward Co-ordinator	4	0.5
Activities coordinator	3	0.5
Ward Clerk	2	1.0
House Keeper	2	0.5
OT	7	0.5
OT	6	1.5
Physio	6	2.2
Physio	7	0.5
Therapy Assistant	3	1.2
Therapy Assistant	2	1.2
Medical Cover		
Total Pay		44.2

Option A would require an uplift in staffing as based across the 3 sites.

Option B, which consolidates community rehabilitation beds at two sites, is designed to maximise workforce productivity by concentrating staffing where demand is highest. This approach reduces the need for temporary staffing and enhances team cohesion, supported by recent workforce growth of 8.6%. In contrast, Option A, which spreads resources across three sites, requires additional staffing, particularly in rural areas, to cover shifts effectively and could increase the reliance on temporary staff.

Additionally, both options present opportunities to increase clinical placements for nursing and allied health professionals (AHPs) to enhance workforce recruitment and retention in the medium term. Providing high-quality placements is anticipated to strengthen recruitment pipelines and succession planning

The options have been thoroughly appraised by key stakeholders at SWFT and Option B was the preferred option from both a clinical and financial perspective due to clinical safety concerns and affordability.

13.3 Assessment of Workforce Needs

Over the past 2 years capacity at the acute sites has increased and are seeing higher acuity and complexity of patients. Patient acuity is measured at SWFT with the use of the Safer Nursing Care Tool (SNCT). The Safer Nursing Care Tool (Shelford Group, 2013) is the commonly used method to determine staffing levels

The Safer Nursing Care Tool (SNCT) is:

- An evidence-based tool that enables nurses to assess patient acuity and dependency. Data is collected and matched with present staffing multipliers to ensure that all areas reflect patient needs

- Staffing numbers recommended **do not refer to skill mix** and are provided to reflect patient care only
- Proposed staffing level numbers reflect on an analysis of actual patients on the ward at the time of data collection.
- Multipliers can be used to calculate nursing establishments in whole time equivalents (WTE) related to acuity and dependency measurement. The multipliers agreed for each level of patients on inpatient wards are:

Level 0	0.99* WTE nurse per bed
Level 1a	1.39* WTE nurse per bed
Level 1b	1.72* WTE nurse per bed
Level 2	1.97* WTE nurse per bed

The graphs below show the increasing acuity of patients over the last 3 years reflecting the changing landscape of healthcare.

Figure 18 Increasing acuity Nicol Ward 2022-2023

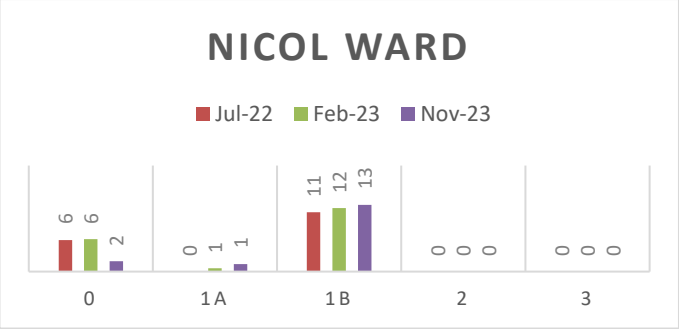
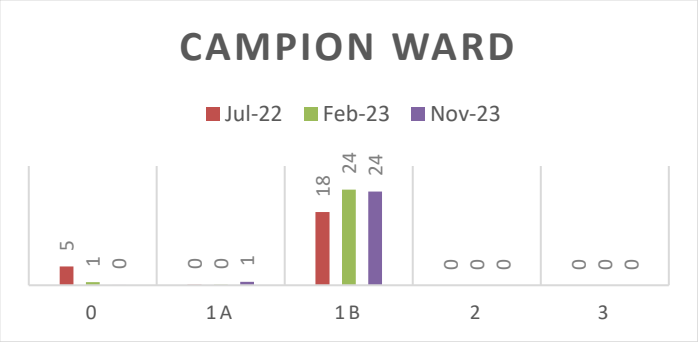


Figure 19 increasing acuity Campion Ward 2022-2023



This is in part due to the increasing activity of our community teams in developing and expanding our admission prevention strategies including Urgent Community Response (UCR), Community Recovery Service (CRS), Rapid Response, Community Response Team (CRT). In direct response to this there are increased numbers and acuity of patients in our community beds. SWFT has invested in the additional staffing required to support this increasing demand.

Given the higher acuity and patient complexity in community beds, targeted workforce strategies are in place, including a recruitment and retention lead nurse pilot program focusing on university partnerships and retention strategies. The potential to attract new recruits and reduce reliance on temporary staff is integral to meeting future workforce demands effectively.

13.4 Workforce Transformation Needs

The UCR team are based at Leamington and Stratford and are able to respond quickly to a deteriorating patient in these areas to prevent hospital admission. The timely access to patients at EBH would be delayed due to the rurality of the location.

The senior management team at SWFT are currently exploring options to provide Advanced Clinical Practitioner cover from UCR to support the medical team at Leamington with ward rounds and cover outside of GP working hours.

We have recently seen an increase in length of stay and in response have employed a ward coordinator to support the ward manager with discharge and maintaining flow from the acute to support operational pressures. Since in post we have seen a decreased in length of stay.

The workforce model emphasises transformation through the Multi-Disciplinary Team (MDT) approach, which is embedded in patient care across sites. Concentrating resources in Option B ensures each site has a full MDT, supporting coordinated, patient-centered care. Option B also aligns with the 'Home First' approach, enabling a flexible workforce structure that adapts to patient needs and enhances staff experience through greater teamwork and reduced travel burdens.

Throughout the development process, staff engagement was prioritised through surveys, focus groups, and feedback sessions to capture insights on operational efficiencies, team dynamics, and care delivery. Staff largely supported Option B due to its alignment with existing structures, minimal disruption, and positive impact on team morale and patient care quality.

13.5 Impact of Proposed Changes

13.5.1 Acuity of Patients

The patient acuity in the community wards is noticeably higher due to changes in the CRS pathway, the CRS team are taking on Medical Episode Complete (MEC) patients[5]. For higher-acuity patients, each site presents unique considerations. Ellen Badger Hospital (EBH) would need targeted support to manage patients with higher acuity due to its distance from centralised diagnostic and intervention services, which are more readily accessible at Stratford and Leamington. However, EBH may be more suitable for patients

[5] individuals whose current course of medical treatment, often called a "medical episode," has reached its conclusion. This term is typically used when a patient has completed the necessary care, interventions, or procedures related to a specific health issue or condition, and no further active treatment is required at that point.

In hospital settings, a "completed medical episode" could mean the patient has been stabilized, treated, and is ready for discharge or transfer to another level of care, such as rehabilitation or home care. It often indicates that the acute phase of care, such as surgery, emergency treatment, or hospitalization, is over, and the patient can transition out of that specific care setting.

requiring lower-acuity, rehabilitative care, and adjustments could be explored to meet clinical needs at this site. Option B's centralised approach allows resources to be allocated efficiently for higher-acuity patients, with streamlined access to diagnostics and interventions at Stratford and Leamington. By consolidating sites, the workforce can respond more effectively to acuity levels and maintain high-quality, responsive care.

13.5.2 Travel Analysis

The travel analysis for the proposed reconfiguration of community hospital beds in South Warwickshire (Appendix 8 Travel Analysis) highlights the potential accessibility impacts of each option. The analysis examined travel times by car and public transport, focusing on accessibility from different parts of South Warwickshire, particularly central, northern, and southern areas. Key findings reveal that:

- Ellen Badger Hospital (Shipston) has limited accessibility within 30–45 minutes by public transport, especially for central and northern populations. This may pose challenges for patient families and workforce who rely on public transport.
- Leamington Spa Rehabilitation Hospital provides broader accessibility within 30–45 minutes by both car and public transport, making it a more central option for the majority of South Warwickshire's population.

The analysis compared two options:

Option A (35 beds across three sites: Ellen Badger, Stratford, and Leamington Spa): This option would maintain bed access in rural Shipston; however, the travel analysis shows that access by public transport would remain limited, especially for central and northern residents. Family visits and staff commuting could face challenges due to the rural location.

Option B (35 beds across two sites: Stratford and Leamington Spa): With its stronger public transport links and central location, this option better aligns with travel convenience for a larger population in central and northern South Warwickshire. Option B mitigates travel limitations associated with Shipston, providing more consistent accessibility for patient' families, and staff.

The travel analysis highlights distinct accessibility impacts for each option. Option A retains bed access in Shipston, benefiting rural residents who may face longer travel times to centralised sites. In contrast, Option B centralises services at Stratford and Leamington, making these beds more accessible to patients from northern and central South Warwickshire. Each option thus supports different population needs, with mitigations such as patient transport services in place to address specific accessibility challenges..

While Option B would reduce accessibility for rural areas such as Shipston, where demand for community beds has remained stable, mitigations are available:

- Patient Transport Services: SWFT arranges transport from acute care to community beds, ensuring that patients without private transport have support.
- Public Transport Options: Services like IndieGo PLUS and Shipston Link connect Shipston with surrounding areas, helping to alleviate access issues for patients and visitors.

- Car Parking and Facilities: At Leamington Spa, parking is available with options for discounted rates for frequent visitors, and nearby public transport options connect the hospital to surrounding areas

The staff travel survey highlighted a reliance on car travel, particularly in rural areas. Moving community beds to more central locations in **Option B** could reduce commuting challenges for staff and support a more resilient staffing model with easier access to both sites.

Overall, **Option B** better aligns with population density and travel convenience for the majority of South Warwickshire, supporting equitable access to rehabilitation services. This option addresses the accessibility challenges for underserved groups by centralising beds in locations with strong public transport links, while also providing mitigations for rural populations in Shipston. It also aligns with the Trust's Green plan of encouraging the use of public transport.

13.5.3 Access to diagnostics and end of life provision

Stratford hospital has access to the newly built diagnostic hub and end of life provision. Access to diagnostic services varies by location. Stratford Hospital, with its new diagnostic hub, offers immediate access to diagnostics. Stratford also supports end-of-life care services, supporting patients with higher acuity needs. At EBH, distance from diagnostic services would require additional planning for timely patient transfers when needed. Both configurations are being evaluated for their ability to support patient care in alignment with clinical needs.

13.5.4 Emergency Planning

The Emergency Preparedness Resilience Response forum have raised concerns regarding the rurality of EBH in case of major incident and additional beds being required to create capacity at the acute hospital. Each option presents distinct capacities for emergency response. Campion and Nicol sites, located centrally, have greater potential to support surge capacity due to their bed availability and proximity to SWFT's operational resources. EBH's location may require alternative strategies for emergency preparedness, focusing on maintaining its primary role within the community..

13.5.5. Workforce Recruitment

Currently SWFT have minimal vacancies at Campion and Nicol. SWFT are engaged with positive recruitment to these areas and vacancies are filled quickly.

Due to the rurality of EBH it has been difficult to recruit to positions there in the past. Campion is situated in the Royal Leamington Spa Rehabilitation Hospital. It therefore has support from other wards to provide short term cover for sickness or absence proving more resilience from a service continuity perspective. Due to the close proximity Campion and Nicol also provide staffing cross cover where required.

Option B helps mitigate the recruitment challenges associated with rural locations by focusing staffing at two central sites, Campion and Nicol, where recruitment and retention have historically been stronger. With a stable workforce structure in place, recruitment efforts are further supported by flexible scheduling and targeted recruitment initiatives, including the recruitment and retention lead nurse role.

The majority of staff at Campion and Nicol live local to the hospitals so would have attrition of staff if we are asking them to move to EBH which would impact on service delivery across the 3 sites in South

Warwickshire. The teams are well established now at Nicol and Campion. Workforce recruitment and retention factors vary by site. EBH's rural location presents unique recruitment challenges, and retaining staff who live near Campion and Nicol may require focused transition planning. Campion's proximity to other wards also provides flexibility for short-term coverage, supporting service continuity. Both configurations would require tailored workforce support strategies to ensure sustained staff engagement and morale.

Maintaining & developing the rehabilitation ward at Stratford/Leamington sites is consistent with the central rehab hospital location for the county. It is important to note that we are reviewing rehabilitation bed provision for South Warwickshire and it has been shown that only 4% of Shipston residents utilise the community beds. It is clear that the residents of South Warwickshire that utilise the beds would be negatively impacted by the move to EBH. Both Campion and Nicol are centrally located and closest to the population who use the services as demonstrated by the heat maps.

13.6 Training & Development Needs

The consolidation under Option B supports consistent training and professional development, enhancing team cohesion and making training resources more accessible. In Option A, additional strategies may be required to support professional development at rural sites like EBH, including potential investments in digital training solutions. Both options uphold the commitment to rehabilitation training as a core component for all staff.

13.7 Conclusion

The workforce model presented demonstrates a clear, adaptable approach to staffing across both options, emphasising patient-centered care, productivity, and team cohesion. Option B's focus on two sites allows SWFT to maximise productivity by concentrating workforce resources, promoting consistent access to MDT services, and reducing reliance on temporary staffing. The alignment with the MDT approach enhances collaborative decision-making and supports staff experience and morale, contributing to workforce stability. Both options prioritise strategic workforce planning to meet current and future demands, with targeted retention and recruitment efforts in place to ensure ongoing service quality.

14. Demand and capacity modelling

This chapter outlines the demand and capacity modelling approach used to determine the required number of community rehabilitation beds that formed part of the strategic review conducted by SWFT. By analysing patient demographics, referral patterns, and projected service utilisation, we provide evidence-based estimates for capacity needs that align with expected demand.

14.1 Predicting Future Demand and Capacity

14.1.1 Introduction to Future Community Bed Needs

See Appendix 39 List of Key Data Sets. Chapter 3 addresses our transformation aspirations and future demand and challenges surrounding local health needs and the potential impact on community bed requirements in South Warwickshire.

South Warwickshire's ageing population is driving an increased need for rehabilitation services, particularly among those aged 65 and above. Community-based support initiatives like the Community Rehabilitation Service (CRS) have enhanced home care capabilities, which mitigate some demand on bed-based rehabilitation but underscore the need for strategic allocation of community beds to meet core patient needs.

14.1.2 Impact of Demographic and Service Trends on Community Beds

South Warwickshire's ageing population is anticipated to increase demand for community rehabilitation services, particularly among residents over 64, who represent a significant portion of community bed users. Current data indicates approximately 500 admissions per year, with the highest demand concentrated in central and northern South Warwickshire.

To address these needs effectively, community support initiatives such as the Community Rehabilitation Service (CRS) have been implemented, helping to reduce dependency on bed-based rehabilitation by providing care options that promote patient independence at home.

Demand projections further highlight the influence of key population health trends, including an increase in frailty and the need for rehabilitation following surgery or acute episodes. Future community bed requirements will focus on balancing these needs through strategic bed allocation across South Warwickshire, ensuring accessibility, efficiency, and alignment with community-based support systems.

14.2 Supporting Increased Health Service Demand with Community Rehab Beds

14.2.1 Community Beds in practice

Community rehabilitation beds play a critical role in supporting acute hospital flow by admitting patients who are medical episode complete (MEC) but still require 24-hour nursing care. This allows the acute hospital to focus on patients needing acute care while ensuring smooth transitions for those in recovery. Community beds also admit step-up patients from the community, reducing the need for acute admissions and promoting capacity across the system.

At the Leamington and Stratford sites, community wards have sufficient bed capacity to flexibly respond to acute demand surges, ensuring continuity during periods of high operational pressure. In contrast, the footprint at Ellen Badger Hospital (EBH) may limit its ability to accommodate similar demand surges, which the Emergency Preparedness Resilience and Response (EPRR) team has noted as a concern.

14.2.2 Role of Community Beds in Supporting Acute Flow

Community hospital beds are integral to the Integrated Care System (ICS) by facilitating step-down support and expediting discharge. The Integrated Discharge Team works closely with local authorities, community teams, and the ICB to maintain efficient patient flow.

Capacity and Alternative Support Models

The Integrated Care Board (ICB) funds a baseline of 35 community rehabilitation beds across South Warwickshire: 19 beds at Nicol Ward, Stratford Hospital and 16 beds that were originally at Ellen Badger Hospital (EBH) but are temporarily relocated to Campion Ward, Leamington Spa. These 35 beds meet the usual community rehabilitation demand.

However, during times of increased patient need, SWFT has the flexibility to temporarily increase capacity. When demand surges, Campion can expand beyond the 16 relocated beds to accommodate additional patients (between 25-29), and Nicol can expand to accommodating an additional 2 beds, further ensuring continuity of care without requiring permanent funding for these extra beds.

This setup allows the system to balance regular, funded bed capacity with the ability to scale up temporarily during high-demand periods, making efficient use of resources while still meeting patient needs. Looking to the future, we are also exploring options such as remote technology to further enhance flexibility in patient care.

14.3 Demand and Capacity Modelling: Evaluating Bed Allocation Across Sites

To effectively discuss demand and capacity modelling with regard to **Option A** Provide 35 community beds across three sites (EBH, Nicol Ward and Campion Ward) and continue to improve care at home (maximum of 12 beds at EBH) and **Option B** Provide 35 community beds across two sites (Nicol Ward and Campion Ward) and continue to improve care at home, it is important to compare the efficiency, flexibility, and impact of each option on patient care and operational flow.

Key Considerations in Demand and Capacity Modelling:

1. Patient Distribution and Demographics

- **Option A** distributes the beds across three sites, which could provide more geographic access to patient's families and friends, potentially benefiting patients in rural areas with fewer healthcare options. However, very few patients are admitted who reside in Shipston, therefore utilisation of resources may be inefficient, leading to underused capacity.

- **Option B** consolidates the beds into two sites where the majority of patients are being admitted. This could lead to more effective bed use since the sites are closer to where the bulk of the demand is coming from, improving operational efficiency and better matching demand to capacity.

2. Geographic Considerations and Patient Proximity

- In **Option A**, workforce and patient's carers from Shipston may face longer travel distances to other hospitals if the hospital beds are not reinstated, potentially impacting patient satisfaction and outcomes or issues with recruitment and retention.
- **Option B** might require workforce and patient's carers from rural areas to travel farther. However, this may be offset by the fact that the two more central sites will have higher occupancy and bed availability.

3. Flexibility in Bed Allocation

- The current ability to flex beds during high-demand periods is key to managing capacity, especially during peak times or crises. **Option B**, which concentrates beds in two high-demand areas, might offer greater operational flexibility. This allows staff and resources to be focused, reducing logistical challenges and ensuring that critical areas can scale up or down as needed.
- **Option A** may offer flexibility in terms of geographic distribution, but its impact may be limited if one of the sites isn't contributing significantly to patient throughput and cannot flex the beds due to it's rurality. The fewer patients admitted to the underused site could lead to inefficiencies in staff deployment and resource management.

4. Impact on Acute Flow and Bed Utilisation

- Rehabilitation beds are critical for freeing up acute hospital beds, ensuring that patients requiring acute care are not held up by those needing post-acute care. **Option B**'s focus on two busy sites may streamline the flow of patients from the acute hospital, ensuring quicker transfers and reduced bottlenecks.
- In **Option A**, the less-utilised site may not be as effective in relieving acute hospital pressure. While it could serve as a backup or overflow site, its current low admission rates may prevent it from significantly impacting acute flow.

5. Operational Efficiency

- **Option B** focuses on the two sites of greatest need, potentially improving the cost-efficiency of running the service, with reduced overhead from a third underused location. Consolidating the beds might lead to more consistent bed occupancy and improved resource allocation (staff, equipment, etc.).
- **Option A**, with a third site, may incur additional operational costs (staffing, utilities, etc.) without proportional patient need, making it less efficient overall.

6. Response to Population Growth and Ageing

- With the South Warwickshire area seeing an increase in the elderly population and those with long-term conditions, **Option B** is likely to be more responsive to growing demand, especially since most of this demand is centered around the two main sites.
- **Option A** could ensure wider geographical coverage but may be slower to respond to increased demand if one site remains underutilised, creating a bottleneck at the other two sites.

14.4 Conclusion

Option B, which focuses on two sites with greatest need, seems to align better with demand and capacity needs. It optimises resource allocation, ensures more efficient bed utilisation, and supports the acute hospital by providing quicker access to rehabilitation services. However, careful consideration should be given to the impact on accessibility for patients and carers from the rural areas in **Option A**. If these patients can still access care through other community-based services or if travel is not significantly burdensome, Option B may be the more effective model moving forward.

15. Implementation plans

In this chapter we describe the phased implementation plans for rolling out the selected options. This chapter focuses on the key activities, timelines, and milestones necessary to ensure a smooth transition from current service models to the enhanced community hospital rehabilitation services.

15.1 Overview of implementation

Our goal is to make a decision about the new model of care by 2025/26. This chapter provides an overview of the activities and sequencing required to deliver the changes outlined in Chapter 11, ensuring services are transitioned smoothly while maintaining clinical safety.

Although no decisions have been made yet, as we are still in the pre-consultation phase, we have developed a high-level implementation plan to outline how the transition would unfold after a final decision is made. Once the public consultation concludes and a decision is reached, we will proceed with detailed planning to ensure a smooth and effective implementation of the chosen option.

The implementation process will be led by clinical teams, with a commitment to supporting SWFT in meeting the timelines and coordinating the necessary activities for a seamless transition. Notably, there are no commercial implications, as SWFT will continue to serve as the provider of community hospital beds in South Warwickshire and will maintain its leadership of the Community Integrator contract..

15.2 How the proposed changes will impact on others

The proposed changes will affect multiple stakeholders, including patients, healthcare providers, and commissioners. SWFT will need to coordinate its clinical and operational teams to ensure minimal disruption to services during the transition period. Collaborative efforts with other health and social care providers will be essential to maintain integrated patient care pathways.

Local communities may see changes in the location of care, particularly in rural areas, which could impact travel times for some patients and carers. However, the continued improvements in care-at-home provision will help mitigate these challenges by allowing more patients to receive rehabilitation services at home.

15.3 How the proposed changes may affect current or future commissioning of services

The proposed changes are not expected to significantly impact the commissioning of services, as SWFT will continue to provide community hospital rehabilitation beds totalling 35 core beds under their existing contract. However, commissioning arrangements may need to be adjusted to reflect the reconfiguration of bed locations and increased reliance on care-at-home models. These adjustments will be made in collaboration with commissioners to ensure that services remain aligned with patient needs and system-wide priorities.

15.4 Analysis of travelling times and distances

The proposed changes will primarily impact family and friends of patients rather than the patients themselves. Most patients - 87%, are transferred from acute hospitals using arranged patient transport services, minimising travel concerns for patients during the discharge process.

However, for family members and friends, there may be some inconvenience due to increased travel distances. We have qualitative feedback of some patients declining discharge to community hospitals due

to the location. Public transport options and parking facilities are available at all sites, and care-at-home services will be enhanced to provide alternatives for those affected by distance.

For a full breakdown of travel implications, including public transport schedules, car parking availability, and mitigation strategies, please refer to Appendix 8 Travel Analysis.

15.5 Implementation plan timeline and approach

To ensure clarity and transparency, this section outlines the timeline for decision-making and the high-level implementation plan should either Option emerge as the favoured option during the public consultation process.

The implementation plan will be further developed once a decision is made, with more detailed timelines and milestones created to support the transition. Currently, the high-level plan consists of several key workstreams, which are focused on integrating the community hospital rehabilitation bed review with the broader Infrastructure Delivery Plan. The infrastructure planning will include any necessary refurbishments, particularly under Option A, where Ellen Badger Hospital may require facility upgrades.

The following two options will guide the programme:

- Option A: Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital, and Stratford Hospital).
- Option B: Provide 35 community beds across two sites (Leamington Spa Hospital and Stratford Hospital).

A robust programme plan, led by SWFT, will oversee the coordination of clinical requirements, estates planning, and operational changes. The workstreams will include:

- Clinical workstream: Focused on ensuring the continuity of patient care during the transition, supported by clinical staff training and pathway adjustments.
- Estates workstream: Overseeing the physical refurbishment of facilities, especially at Ellen Badger Hospital, if Option A is selected.
- Operational workstream: Responsible for managing the logistics of relocating beds and ensuring that all services are fully operational in the new configuration.

The programme plan will be regularly reviewed and updated to ensure progress is in line with the established timelines and that all necessary steps are taken to support a successful transition to the new models of care.

15.5.1 Decision-Making Timeline

The following timeline reflects the key milestones for decision-making and approval of the selected option:

Figure 20 Decision making timeline

Milestone	Date	Details
Public Consultation Launch	06/01/25	Formal public consultation period begins to gather stakeholder feedback.
Consultation Period Ends	14/02/25	Public consultation closes. Analysis of feedback commences.
ICB Board Decision	19/03/25	Final decision on the preferred option by the Coventry and Warwickshire ICB.
Notification of decision to HOSC	19/03/25	Final decision on the preferred option communicated to HOSC by the Coventry and Warwickshire ICB
Final Decision Announcement	19/03/25	Public communication of the approved option and next steps.

15.5.2 High-Level Timeline for Implementation of Option A

A high-level implementation plan has been included for Option A to outline the steps required to establish services across three sites, as this option involves changes to the current configuration. In contrast, Option B does not require a formal implementation plan as it reflects the current 'business as usual' model with community rehabilitation beds continuing to be provided across two sites.

If Option A (three-site model) is selected, the following high-level implementation plan provides an overview of key activities, milestones, and expected timelines:

Table 25 High-level timeline for Option A

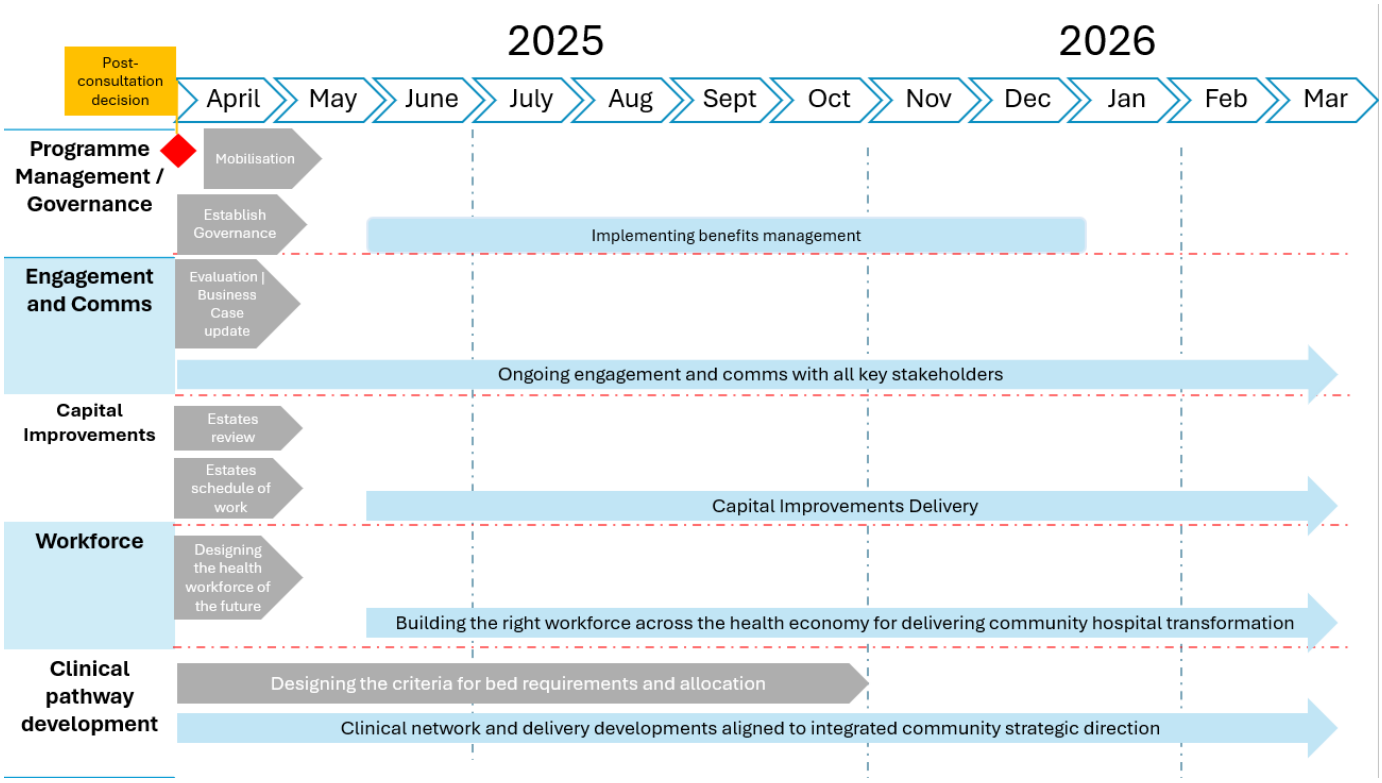
Phase	Activities	Timeline
Phase 1: Preparation	• Establish programme management and governance • Confirm bed distribution across 3 sites. • Explore funding caveats for capital works and revenue costs. • Establish workforce and operational plans for all three sites. • Finalise construction requirements at EBH.	Month 1-3
Phase 2: Site Readiness	• Begin staff consultation processes regarding changes to roles and locations. • Commence infrastructure works at Ellen Badger Site. • Ensure IT, estates, and clinical pathways are aligned.	Month 4-18
Phase 3: Operational Testing	• Conduct operational testing at EBH for low-acuity patients. • Monitor and address initial staffing challenges. • Prepare for phased bed reduction at Stratford and Leamington.	Month 18-24

Phase	Activities	Timeline
	• Complete phased **bed reductions** at Stratford and Leamington to accommodate the rebalanced bed model. • Ellen Badger Hospital becomes fully operational.	
Phase 4: Full Implementation	• Workforce recruitment (as required) • Monitor impact on patient flow, outcomes, and workforce.. • Monitor bed usage and patient outcomes. • Evaluate workforce and operational performance.	Month 24-32

Notes and Assumptions:

1. **Funding Caveat:** While Option A has been assessed as viable and implementable, its delivery is contingent on securing the necessary capital and revenue funding. This funding is not currently prioritised within existing financial plans; however, we remain committed to identifying appropriate funding sources to support implementation. We recognise the importance of this option and have factored its feasibility into our planning, ensuring it is a credible and deliverable alternative, subject to securing the required investment.
2. **Staff Consultation:** Formal staff consultations will commence during Phase 2 to ensure workforce changes are managed effectively and in line with employment regulations.
3. **Phased Bed Reductions:** Phase 4 includes a reduction in beds at Stratford and Leamington to ensure a balanced service model across all three sites.

Figure 21 High-level implementation plan


2025
2026
Post-consultation decision
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Programme Management / Governance
Mobilisation
Establish Governance
Implementing benefits management
Engagement and Comms
Evaluation | Business Case update
Ongoing engagement and comms with all key stakeholders
Capital Improvements
Estates review
Estates schedule of work
Capital Improvements Delivery
Workforce
Designing the health workforce of the future
Building the right workforce across the health economy for delivering community hospital transformation
Clinical pathway development
Designing the criteria for bed requirements and allocation
Clinical network and delivery developments aligned to integrated community strategic direction

16. Plans for consultation

This chapter outlines the plan for public consultation, includes the context of the consultation, how the consultation will be run and the involvement activities to be carried out to make sure all local residents have an opportunity to share their views.

A communication and involvement plan (Appendix 40 Coventry and Warwickshire Consultation Plan) draft consultation document and survey sit alongside this document and will be updated pending the outcome of NHSE assurance process and subsequent governance.

The consultation plan has been developed and will be further refined by a consultation reference group. This will include patient representatives, voluntary sector organisations, clinicians and Healthwatch to guide the process

16.1 Consultation commitments

During this consultation, we are committed to ensuring:

Clarity about decisions

We will be clear in our documentation and in discussions with local people about:

- Why is change necessary?
- How is this a change from current arrangements?
- What are the potential benefits e.g., improved outcomes, service, efficiency, sustainability?
- What are the implications and disadvantages for patients and local residents e.g. number of people involved, access to services, issues for carers and family?

Clear and accessible supporting information to enable people to take a view

We will publish an easily accessible library of background information that will include details on:

- Background and case for change
- Clinical evidence and relevant national guidance
- How the new service model would work in practice
- Equality
- Benefits for workforce
- Implications for staff
- Benefits for the system and implications for partners and cross-border issues
- Resource and financial issues e.g., costs, investment, savings

Clarity of proposals

We will include in the accessible library full details on how we have arrived at the current proposals, including:

- What the options were and how we assessed them
- How people have been involved in this process

Effective opportunities for people to have a say

We will make our consultation process fair and effective by providing:

- A reasonable and proportionate period to access and respond to the information
- Accessible channels and methods for feedback, including digital
- Good access to information and further information
- Demonstrable “listening” and two-way discussion
- Ensuring it is a view seeking exercise, not a vote/referendum

We will be proportionate in our efforts

We will ensure that our consultation is proportionate by:

- reaching out to South Warwickshire geography, demography, and diversity
- seeking fair representation across patients, carers and the public, groups, and organisations
- include the views of equality groups potentially impacted by the proposals and their specific needs informed by the Equality Impact Assessment (EIA) (Appendix 9 Equality Impact Assessment Version 10).

16.2 Legal duties

16.2.1 Why we need to involve people

There are a range of legal and regulatory requirements to involve people in NHS change.

Sections 242, 13Q and 14Z45 of the NHS Act 2006 (as amended) require NHS organisations to involve and consult patients and the public in:

- The planning and provision of services.
- The development and consideration of proposals for changes in the way services are provided.
- Decisions to be made by NHS organisations that affect the operation of services.

Section 23(1) of The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 (as amended) require NHS organisations to consult relevant Overview and Scrutiny Committees (OSC) on any proposals for a substantial development of the health service in the area of the Local Authority, or a substantial variation in the provision of services.

At its meeting on Wednesday 18 September 2024, Warwickshire Overview and Scrutiny Committee committed to endorse the approach to formal consultation due to the service change proposed being considered substantial and therefore warranting public consultation. This enabled the ICB to fulfil its duty to notify the Secretary of State.

16.2.2 The NHS Constitution

The NHS Constitution gives the following rights and pledges to patients:

> *“You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”*

"The NHS commits to provide convenient, easy access to services within the waiting times set out in the Handbook to the NHS Constitution (pledge)"

"The NHS commits to make decisions in a clear and transparent way, so that patients and the public can understand how services are planned and delivered (pledge)"

"You have the right to receive care and treatment that is appropriate to you, meets your needs and reflects your preferences."

16.2.3 Equality and diversity

Information will be provided in different formats and languages if requested, and support available for all to have their say.. As part of the engagement activity, respondents will be asked to provide demographic information covering the following nine protected groups under the Equality Act 2010. Collecting and reporting this data will support decision makers in meeting their duties under section 149 of that Act (The Public Sector Equality Duty).

These are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership (in employment only)
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

16.2.4 Gunning Principles and best practice

When we consult people about changes to public services, it's important we make sure we adhere to the following principles. By doing so, we meet our legal duties about informing and involving people, and ensure our consultation is easy to take part in.

The Gunning Principles say that we must:

- Involve people when our proposals are at a formative stage. This means a final decision has not been made. We can still change the proposals based on what people have to say.
- Make sure we provide enough information, in ways that are easy to understand, so that people can understand what is being proposed, and how any changes might affect them.
- Allow people time to get involved. i.e. enough time to peruse information, attend events, answer surveys and otherwise share views.
- Listen to what people say and take their views into consideration before making any final decisions.

16.3 Consultation objectives

The primary objectives of the consultation plan are as follows:

- To inform the public about the proposed changes to the location of community beds in South Warwickshire.
- To provide staff, stakeholders, and the community with an opportunity to express their views, concerns, and suggestions regarding the proposed changes.
- To ensure compliance with all relevant legislation. These include the duties on NHS bodies to make arrangements to involve the public and are all set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022:
    - section 13Q for NHS England
    - section 14Z45 for integrated care boards
    - section 242(1B) for NHS trusts and NHS foundation trusts.

As part of this public consultation we will also develop the consultation mandate. This will include:

- A description of the purpose of the consultation.
- What the ICB wishes to achieve through consultation.
- The specific areas where we need to understand the potential impact of the proposals.
- How the ICB will respond to inform their decision, and respond to the feedback.
- The proposal(s):
    - Description of the proposal.
    - Benefits of proposals.
    - Within the proposal highlight the need to understand the impact on service users, patients, carers, staff and public.
    - Set out clearly what can be influenced, what can't.
    - Set out clearly the interdependencies with other transformation projects.
    - Include all changes needed to implement the proposals.
    - Set out funding/financial implications.
    - How the proposals were developed
    - Ongoing engagement and involvement
    - How the engagement and involvement has influenced proposals.

Show how the proposal meets financial and clinical objectives

16.4 The proposals

Our proposals, which are a relocation of beds, not a reduction are:

- Option A: Provide 35 community beds across three sites (Ellen Badger Hospital, Leamington Spa Hospital, and Stratford Hospital) and enhance care-at-home services.
- Option B: Provide 35 community beds across two sites (Leamington Spa Hospital and Stratford Hospital) and enhance care-at-home services.

16.5 Pre-Consultation engagement

SWFT, with support from Healthwatch Warwickshire, gathered input from 193 survey respondents and conducted 27 face-to-face interviews with patients. This activity took place in 2021. This engagement helped us to understand patient concerns around travel distances and the quality of care provided in community settings and to develop a viable long list of proposals.

We are committed to:

- Being open in communicating about the proposals, and using a range of ways to provide information.
- Actively engaging with people who might be affected by the changes.
- Reaching out to people whose life circumstances could mean the impact of change is greater.
- Providing a range of opportunities for people to share their views and experiences.
- Considering what matters most to people, and taking views into account during the decision making process.

During the consultation period, engagement will be overseen by the consultation reference group to ensure we are listening to a range of people and organisations. If we are missing key groups of people, or not hearing from sufficiently diverse groups of people, we will adjust our activities accordingly.

16.5.1 Stakeholders

Our work to map stakeholders has been an ongoing process throughout this programme of involvement activity.

16.6 Our involvement approach

NHS Coventry and Warwickshire ICB is the accountable body for the consultation. The services impacted by the proposals are provided by South Warwickshire University NHS Foundation Trust. The consultation plan (Appendix 40 Consultation Plan) will be informed by a consultation reference group. This will include patient representatives, voluntary sector organisations, clinicians and our Healthwatch organisations to guide the process.

Communication strategy

- We will develop a comprehensive communication plan to ensure all relevant information is accessible to the public.
- Utilise a variety of communication channels, including local newspapers, websites, social media, public meetings, video content and information sessions.

Public meetings and events

- Organise public meetings in accessible locations and online to present the proposals and answer questions.
- Host information sessions to provide in-depth information on the proposed changes and potential relocation of community beds.

Consultation materials

- Create clear and concise consultation materials, including leaflets, brochures, audio/video and online resources.
-

Feedback mechanisms

- Establish multiple feedback mechanisms, such as online surveys, written submissions, and a dedicated consultation email address.
- Encourage stakeholders to provide feedback through various platforms, making it convenient for them to participate.

Analysis and reporting

- Thoroughly analyse all feedback received during the consultation period.
- Compile a report for decision makers summarising the feedback and outlining any adjustments to the proposals based on stakeholder input.

Decision making

- Consultation findings will inform the final decision-making process.
- Decision-makers will consider the tests of the NHS England assurance process to reach a final decision.

Timeline

- Establish a clear timeline for the consultation process, including key milestones and deadlines.
- Ensure transparency by regularly updating stakeholders and the public on progress.

Evaluation

After the consultation, evaluate the process to identify areas of improvement for future consultations.
Share the results of the consultation, including any decisions made, with the public and with staff working in affected services.

Legal Compliance

- Continuously review and ensure compliance with all relevant legislation as noted above and including the 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires NHS bodies to have regard to 'all likely effects' of their decisions in relation to three areas:
    - health and wellbeing for people, including its effects in relation to inequalities.
    - quality of health services for all individuals, including the effects of inequalities in relation to the benefits that people can obtain from those services.
    - the sustainable use of NHS resources.

Subject to NHSE assurance approval, the consultation is due to launch on 6 January 2025 and will run for six weeks. During this time there will be a number of ways for people to get involved.

16.6.1 Face-to-face discussion sessions.

There will be four face-to-face discussions in different locations:

- Shipston
- Stratford
- Leamington
- Warwick

These locations have been chosen as the proposals could affect people living in these areas and the services that they use. We also want to ensure we hear from a range of people who are likely to have different experiences of the services proposed to change.

The sessions will take place in accessible community spaces, within easy reach of public transport routes. Each session will last about one hour 30 minutes.

During the session, the ICB and facilitators will share information about the proposals and how we think the changes might affect people and the services they use. People will have the chance to ask questions, share their views and talk about how they think the changes could affect their lives.

People will be able to register for sessions in advance, so that: numbers can be monitored; the ICB can check it's hearing from a diverse range of people; and so contingencies can be made if more people register than the venue can accommodate.

16.6.2 Online discussion sessions

There will be 4 online sessions using Microsoft Teams.

1. **Seldom heard groups** (including deprived backgrounds, ethnic minorities), and those in rural locations.

   Why: These groups often face barriers to accessing healthcare or may be disproportionately impacted by service changes. Engaging them ensures equitable representation and captures insights from those who are often underrepresented in decision-making.

2. **Patients receiving community rehabilitation services, people aged 80+, and people with lived experience of complex conditions**

   Why: These individuals are likely frequent users of community beds and will be directly affected by the reduction. Their feedback will highlight the potential impacts on continuity of care, recovery outcomes, and quality of life.

3. **Palliative and end-of-life care patients, carers, and people with long-term conditions**

   Why: Reducing community beds could have significant implications for patients nearing end-of-life, their families, and carers who rely on these services for support. Their input is essential to understand the emotional and practical impacts.

4. **Health and care service providers, people within an 8-mile radius, and people not currently using services but likely to be impacted**

   Why: Service providers offer operational perspectives, while residents within the vicinity and those not currently using services can provide insights into future needs, including how service reductions might influence healthcare access in the long term.

The sessions should be independently facilitated, and people from the ICB - including clinical leads - will be available to answer questions.

People will need to register in advance to join the online sessions, but there will not be a maximum number of participants.

Recordings and transcriptions of the online sessions will be available during the consultation period.

16.6.3 Self-selection survey

A self-selection survey provides an easily accessible way for people to give their views. This should be made available both online and on paper with a free post for ease of return.

A self-selection survey allows a consultation to tap into the voices of those who are highly engaged, passionate, or affected by the proposals. These individuals often have strong opinions and insights into specific issues which are important to them. They can provide in-depth qualitative data, surfacing topics or concerns that are driving the public consultation debate.

This group will help ensure that key issues, emotions, or arguments that are circulating within communities, groups, or specific segments of the population who are most activated by the consultation debate are captured.

Access to the survey should be a key feature of publicity and promotion, making sure that anyone who wants to take part is able to do so.

Setting questions and analysis

An independent organisation with expertise in complex survey design and registered with relevant professional bodies will lead on developing survey questions and carry out the analysis in order to ensure independence from the NHS organisations leading the consultation. This is an important aspect of ensuring public confidence in the question setting and analysis.

16.6.4 Voluntary and Community Sector Organisation - led discussions

Using the voluntary sector collaborative and WCAVA we will explore the possibility of funding the voluntary sector to run additional sessions focussing on those groups and communities which face barriers to accessing services. This could be, for example, those who have a language or cultural barrier, access barriers due to income, immigration status or poverty.

VCSE groups and orgs are invited to capture feedback and insights through activity which best suits their audience – this might be through existing activities, or a festive event.

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16.6.5 Other ways to get involved

Dedicated pages on the ICB's website (happyhealthylives.uk) will share information about the project and its development and information related to the formal public consultation can be shared when it is launched.

The ICB website will include documentation about the proposals and ways for people to give comments (as well as linking to the survey).

Email: during the consultation period, people can email an address which will be regularly monitored by ICB staff.

Social media: during the consultation period, people will be able to ask questions and talk to us on our social media pages:

- Facebook: Coventry and Warwickshire ICB
- LinkedIn

Telephone interviews will be offered to support those who may need it to ensure that they are able to understand the information contained within the documents and to ensure that all participants in the consultation have enough information and are able to give informed feedback in a telephone call. If translation is required then this can be arranged.

16.7 Audience

The population of Coventry and Warwickshire is 1.12m and covers two Local Authorities (Coventry City Council, and Warwickshire County Council), and five Districts and Boroughs. It is served by three acute hospitals, two community services providers, and one mental health Trust, as well as 19 Primary Care Networks and 119 General Practices.

We want to hear from:

- Groups that are harder to reach, including those from deprived backgrounds or ethnic minorities
- Patients receiving community rehabilitation services
- People aged 80+
- People within an 8-mile radius of the Leamington Spa and Stratford sites
- Shipston, Leamington and Stratford residents
- People with lived experience of complex conditions like neurological disorders, major trauma, and strokes
- Palliative and end-of-life care
- Carers
- People with long term conditions
- People who might not currently use services, but whose circumstances, characteristics, or health conditions mean they could be more significantly impacted
- Health and care service providers
- Community Hospital workforce
- Organisations representing the groups that would support patients receiving community rehabilitation services

16.8 Channels

The ICB has existing channels of communication – website, newsletters and social media– which can be used to promote this activity and to ensure that all those who wish to take part are able to access relevant information and have the opportunity to be involved.

Promotion channels identified are:

- Information provision:
    - Media releases to local media
    - Staff newsletters
    - Videos/podcasts
    - Voluntary sector newsletters/emails/social media
    - System briefings for MPs, other partners and councils a week before we go live
- Involvement:
    - Facebook
    - Website:
    - LinkedIn

Resources and materials needed

To use the channels to communicate about the public consultation, the following resources will need to be developed and disseminated.

- Narrative to recruit to the focus groups and expression of interest form.
- Focus group toolkit for VCSOs running their own focus groups via the microgrant scheme, to include focus group guide, participant consent form, facilitator script and focus group reporting template
- Presentation to be used within the focus group
- Briefing/ invitation note for participants, so they know what to expect from the session
- Demographic form
- Event feedback survey
- Post-event email thanking participants for their valuable contributions and explaining next steps

16.9 Accessibility

It is important that everyone who wants to contribute has the opportunity to do so. Accessibility of information and access to the events and surveys is key to ensuring that the involvement exercise hears all voices. Steps are being taken to ensure the digitally excluded can be involved, for example through opportunities to take part in a phone interview.

All information produced to support this involvement will be written in language that can be easily understood. Technical phrases and acronyms will be avoided. Information will be produced in other formats as required, to reflect the needs of the population. This might include, but is not limited to:

- Easy read
- Different languages
- Large print

- Accessible electronic formats
- Audio interpreters at public events

All materials will be presented in line with accessibility guidelines.

16.10 Key messages

- We're finding out what's important to people when accessing community rehabilitation beds in South Warwickshire.
- We'd like to understand how people feel about some of the discussions around how these services can be delivered.
- What people tell us will help us as we decide whether to make some of these changes permanent or provide the service differently again, in the future.
- We want to make sure that our future model of care has the needs of our patients, carers, staff and the public, at its heart.

16.11 Timescale for consultation

Table 26 Timescales for consultation

PHASE ONE- Consultation preparation	**DATES**
Draft consultation plan	18th November 2024
PHASE TWO - Pre-consultation Activities	
Board approval for consultation launch	6th January 2025 (extraordinary meeting dependent upon NHSE approval)
Liaison with HOSC	22nd January 2025
Draft Stakeholder briefing	December 2024
Prepare for discussions sessions and speakers/subject experts	December 2024
Prepare press and media updates	January 2025
Briefing and preparation with key spokespeople	December 2024-January 2025
PHASE THREE - Consultation	
Publish consultation materials via website and distribution	6th January 2025 (dependent upon NHSE approval)

Formal launch and media programme	6th January 2025 (dependent upon NHSE approval)
Ongoing stakeholder briefings and updates	January-February 2025
Individual stakeholder discussions and meetings	January-February 2025 (dates yet to be confirmed)
Programme of workshops	January-February 2025 (dates yet to be confirmed)
Sessions with targeted groups	January-February 2025 (dates yet to be confirmed)
Feedback via survey, letters, notes from meetings and workshops	February-March 2025
PHASE FOUR - Decision making	
Feedback collated and prepared for analysis.	March 2025
Independent analysis and outcome report	March 2025
Outcome report for consideration	March 2025
Engagement and discussions with stakeholders	March 2025
Decision-making process and post-consultation business case	March 2025

16.12 Consultation Analysis, reporting and decision-making

Prior to the ICB making their final decisions on the future of community beds, several key activities must take place. These include:

- **Analysis of the consultation**: during this phase responses to consultation will be analysed and a report produced containing the findings from this analysis. This report will be provided to the Health Overview and Scrutiny Committee and made available to the public.
- **Updating the Integrated Impact Assessment**: the ICB will continue to review and update the Integrated Impact Assessment in parallel to the consultation process, in line with the ICB's statutory responsibility to ensure equality across protected characteristic groups, to promote health and reduce health inequalities. The views of local individuals, groups and organisations will form a

valuable part in ensuring that all potential impacts of the proposed change - positive, negative or neutral – are fully identified to inform the final decision.

- **Ongoing development of the business case**: elements of the pre-consultation business case will be further developed to ensure that the clinical and financial case for the options are fully explored, confirming workforce availability and affordability and assessing any relevant risks. This will involve further clinical and non-clinical review of the proposed options, drawing upon external advice and opinion as may be deemed necessary. Further clinical review will be particularly important where any alternative service models are suggested and need to be considered against the criteria previously applied to the options proposed. All additional information will be included in a final Decision Making Report.
- **High-level implementation and evaluation planning**: while no changes can or will occur until after the ICB make their decision, some high-level implementation planning will take place, given that the 'do nothing' option has been discounted. Early implementation planning will enable the programme to mobile any redistribution of the 35 beds at the earliest opportunity and to realise the promised health and efficiency gains as soon as possible. Implementation and evaluation planning cannot and will not be completed in detail until the outcome of the consultation is known and a decision is taken to go ahead with a particular solution.

16.13 Conclusion

In developing the consultation plan for the proposed reconfiguration of community rehabilitation beds in South Warwickshire, we are committed to ensuring a transparent, inclusive, and accessible process for all stakeholders. This chapter has outlined a detailed approach to engagement that prioritises clarity, thoroughness, and equity, ensuring that every resident, patient, and healthcare partner has an opportunity to participate meaningfully in shaping the future of local healthcare services.

The consultation plan includes structured communication and involvement efforts, supported by clear documentation and a variety of engagement activities, such as public meetings, online sessions, and surveys. Additionally, our adherence to legal duties and consultation best practices, including the Gunning Principles, underscores our commitment to a legally compliant and robust consultation process. Our collaboration with a consultation reference group, comprising patient representatives, voluntary sector partners, clinicians, and Healthwatch, provides essential oversight and ensures that diverse perspectives are represented.

The consultation will seek to capture the views, concerns, and suggestions of stakeholders across South Warwickshire, particularly those from communities who may be more impacted by these changes. We will use a dual-survey approach, stakeholder mapping, and targeted engagement to ensure fair representation. Feedback gathered will directly inform the decision-making process, and a thorough analysis of responses will guide the final recommendations.

We remain dedicated to delivering a consultation that not only meets regulatory requirements but also reflects our commitment to inclusive, patient-centered care. As we move forward, our aim is to provide a future model of care that is accessible, equitable, and responsive to the evolving needs of our community, while maintaining high-quality, sustainable healthcare services.

17. Appendices