

Bursledon Care Home

Healthcare Impact Briefing Note

May 2025

Prepared on behalf of Colten Care Ltd

Bursledon Care Home

Quality management			
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Report ref:	Bursledon Care Home Healthcare Briefing Note v3.docx	Date of issue:	14/05/25

Revision history			
Rev	Date	Link	Status
0	17/04/25	ss\Bursledon Care Home Healthcare Briefing Note v0.docx	Draft for initial review
1	24/04/25	ss\Bursledon Care Home Healthcare Briefing Note v1.docx	Second round of comments
2	25/04/25	ss\Bursledon Care Home Healthcare Briefing Note v2.docx	Additional comments
3	14/05/25	Bursledon Care Home Healthcare Briefing Note v3.docx	Final comments

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1 Healthcare Impact Briefing Note

1.1 Introduction

- 1.1.1 The Savills Health and Social Impact Assessment team have been commissioned by Colten Care Limited (hereafter referred to as 'the Applicant') to address concerns that insufficient information has been provided to demonstrate that the proposed residential care community at Land Adjacent to 4 Brookfield Providence Hill, comprising a 68-bed care home (Use Class C2) and 3 x 2-bedroom close care cottages (Use Class C3 age restricted)¹, would not place undue pressure on healthcare services in the local area.
- 1.1.2 The purpose of this briefing note is to respond directly to Reason for Refusal 3 of permission F/24/97312.
- 1.1.3 The reality is that good quality residential care prevents, reduces and delays the need for clinical intervention and external referrals to primary and secondary care facilities. Residential care that provides nursing, such as the proposed development, directly improves NHS hospital bed availability as individuals can be discharged immediately to these facilities. Furthermore, the majority of future residents of the proposed development would be moving from the local area, and would already be registered with local GP facilities and would not result in any material increase in demand as existing patients. For those residents relocating to the area to be closer to family, there is sufficient capacity at local GP facilities to accommodate this.
- 1.1.4 The remainder of this briefing note outlines the following to substantiate the above position:
- information on the Applicant;
 - context on how the proposed care home would function;
 - existing primary healthcare capacity analysis; and
 - migration analysis.

1.2 The Applicant

- 1.2.1 The Applicant has 21 care homes across the South of England, specialising in residential, nursing, and dementia care. Seven of these homes are rated 'Outstanding' by the Care Quality Commission (CQC), which is the highest rating possible, and signifies exceptional performance, consistently exceeding expectations and achieving outstanding outcomes for people using the service. The remaining homes hold a 'Good' rating, which signifies that the service performs well and meets all the CQC's standards.

1.3 Context on how the proposed care home would function

- 1.3.1 Consistent with the Applicant's existing facilities, the proposed development would offer residents private nursing care 24 hours per day, seven days a week. Nurses are trained not only to manage complex medical needs, but to also proactively manage changes in condition. Prior to admission a full medical assessment and care plan is put in place for each resident. Such 24/7 care provision

¹ On the basis that no care would be delivered to the small number of cottages provided, these have been excluded from analysis in this briefing note.

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ensures that residents existing medical background and recent condition is known to the nursing team. As a result, any change in condition is recognised readily and residents receive the care they need immediately which could be vital in ensuring further complications do not arise. If care requires escalation to external healthcare professionals, this is done expediently with an informed 'handover' provided by Colten nurses.

- 1.3.2 The proposed development would work in partnership with external healthcare professionals including GP's. The highly trained in-house nurses would work in conjunction with the GPs to formulate processes for medical assessment and review. An example of this would be routine weekly scheduled reviews of non-urgent medical conditions to avoid the need to continually contact the GP. In relation to urgent medical reviews the nursing team will use a nationally recognised escalation tool, specifically RESTORE2, which give clear guidance on when a medical review is or is not needed. All nurses are trained in the use of this tool. These processes and arrangements ensure that the GPs time is used effectively.
- 1.3.3 It is considered that good quality healthcare within a social care setting prevents situations that lead to emergency hospital admissions, with good care homes having proportionally fewer admissions (QualityWatch, 2015). In the preceding 12 months across all 21 care homes owned by the Applicant that were operating, there have been only 188 hospital admissions, and of these the majority were as a result of a resident falling and needing additional investigations before returning back to the care home within 24 hours.
- 1.3.4 Taking the above into consideration, the reality is that the proposed development would contribute to/would provide:
 - **Increased hospital bed availability:** The provision of care homes provides elderly and vulnerable patients with more options for discharge from hospitals and reduces "bed-blocking", where hospital beds remain occupied by patients who no longer need acute care.
 - **Faster discharge rates:** Increased availability of care home placements leads to faster discharge processes. This directly reduces the time patients remain in the hospital, contributing to facilitating new NHS hospital admissions and reducing waiting times for hospital service. The Applicant has a robust 'end of life' strategy which educates the nursing team and allows for safe discharge of residents requiring end of life care. This will relieve the growing pressures on the local hospice and palliative care services.
 - **Reduced burden on A&E services:** Without sufficient care home support, more elderly individuals may turn to A&E departments for non-emergency health issues. The provision of in-house nursing care and triage mitigates this, reducing NHS wait times for patients needing emergency care. The nursing team are highly skilled at recognising early detection of infections which results in timely treatment and prevention of hospital admissions.
 - **Reduced pressures on the local medical teams:** The highly trained nurses will be capable of triaging any calls to the GP, using recognised tools such as the RESTORE2. This will relieve pressure on the administration teams in the GP practices as it will be a dedicated nurse that will call to discuss multiple patients as opposed to individual patients calling on their own behalf. There will be occasions when the nurse can provide a reassuring assessment to the patients who otherwise would have contacted their own GP.

- **Exceptional clinical risk management:** The proposed development will have a strategic and robust process for identifying clinical risk, which is industry-leading and highly commended by the CQC. This will include monthly review and analysis of specific clinical areas including falls, nutrition, pressure area care, medication errors, continence and infections. These will be benchmarked and rated as either urgent or non-urgent so that the nurses have clear guidance of the areas of clinical risk to focus on. The process is overseen by a regional team of highly skilled 'Admiral' nurses employed by the Applicant to ensure clinical excellence is delivered. This work contributes to the overall reduction of clinical incidents and therefore the reduced number of calls to the GP or emergency services for urgent medical review.
- **Decrease the number of GP surgery appointments needed:** The Applicant employs an in-house clinical skills trainer who provide the nurses with the clinical skills they need to provide exceptional nursing care. The skills that are trained in house include venepuncture, catheterisation and verification of death. If not provided by nurses at the proposed development, all these procedures would need to be completed by external nurses or doctors associated with the GP surgery. District nurses visit patients in their own homes and practice nurses hold clinics in the surgery to see patients. The proposed development will reduce the number of patients that would need to be seen directly by the GP surgery and therefore reduce the number of appointments needed. This will make it easier for local residents to access these services.
- **Clinical support:** The Applicant employs a team of four highly skilled and experienced 'Admiral' nurses. The primary role would be to visit the proposed development on regular basis to provide clinical support and expertise to the nursing team. This provides an additional level of clinical assessment for patients that will reduce the need to request medical reviews.
- **'Continued Clinical Development':** The Applicant has a renowned learning and development department which ensure that nurses and the care team are able to develop their knowledge and skills. Programs are developed for all levels such as the Registered Nurse Associate programme, which is run in conjunction with Solent University based in Southampton. The accredited course teaches carers how to undertake clinical procedures that ultimately support the nursing team. The Applicant's induction academy ensures that the great people recruited are given the skills they need from the start of their employment and this in turn increases staff retention. The nurses are led by the clinical leads who attend a leadership academy which develops their people management skills and ensures that high standards of care are maintained.

1.3.5 The National Audit Office (NAO) estimates that the NHS spends around £820m a year treating older patients in hospital who no longer need to be there, and at least a fifth of NHS costs are thought to be spent on end of life care (National Housing Federation, n.d.). The contribution of the proposed development to the above outcomes will result in a more efficient and cost-effective functioning of the NHS and will free up the NHS to deliver its services to those who need them most.

1.4 Existing primary healthcare capacity analysis

- 1.4.1 A target list size of 2,000 patients per GP, as defined in NHS England’s “Premises Principles of Best Practice Part 1 Procurement & Development”, is generally considered a benchmark for safe and acceptable patient care (British Medical Association, 2024).
- 1.4.2 There are three GP facilities within catchment of the proposed development. Table 1.1 shows these GP facilities, the number of FTE GPs and patients, and the resultant calculated patient to GP ratio. In total, there is capacity for an additional 6,222 patients.
- 1.4.3 While it is understood that there are different ways of calculating primary healthcare capacity using space standards, this is not appropriate in this instance as primary healthcare provision for residents of the proposed development would generally occur off-site. The results indicate that there is capacity at nearby GP facilities to provide this service for the 68 residents of the proposed development while maintaining safe and acceptable patient care for patients using the GP facility in-person.

Table 1.1: Local healthcare facilities within catchment of the proposed development

Practice code	Name	Distance (miles)	Number of patients	FTE GPs	Patients per GP	Additional capacity
J82051	Hamble Valley Health PCN (previously Blackthorn Health Centre)	1.3	18,412	10.2	1,813	1,904
J82622	Ladies Walk Practice (Living Well Partnership)	1.7	46,760	25.5	1,831	4,318
J82622	Botley Surgery (Living Well Partnership)	2.3	Part of Living Well Partnership			
J82622	Harefield Practice (Living Well Partnership)	2.3	Part of Living Well Partnership			
J82622	St Lukes Surgery (Living Well Partnership)	2.4	Part of Living Well Partnership			
J82128	Old Fire Station Surgery	2.5	8,613	4.1	2,097	0
J82622	Weston Lane Surgery (Living Well Partnership)	2.5	Part of Living Well Partnership			
J82622	West End Surgery (Living Well Partnership)	2.6	Part of Living Well Partnership			
Total						6,222

Source: NHS Digital (NHS Digital, 2025)

1.5 Migration analysis

- 1.5.1 Residents moving to care homes come through hospital referrals or the community. Analysis undertaken as part of the UnPiCD study (Ciminata, et al., 2024) concludes based on records from the Scottish Care-Home Census (SCHC) that 57% of residents come from hospital and the remaining 43% come from the community. The Applicant has provided primary data for two nearby care homes (Bourne View in Poole and Wellington Grange in Chichester) which broadly supports this. Specifically, the data across the two care homes shows that 43% of residents are

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seeking care as they are awaiting hospital discharge or surgery, while the remaining 57% are seeking care due to increased care needs, carer respite or due to lifestyle/loneliness.

- 1.5.2 As previously stated, residents admitted directly from hospital would contribute to increased hospital bed availability, improving capacity and providing cost savings to the NHS through reducing “bed-blocking”, where hospital beds remain occupied by patients who no longer need acute care.
- 1.5.3 Most residents moving into a care home (from hospital or the community) come from the same local authority or nearby areas. This is often due to familiarity with the area, proximity to family and friends and hospital discharge referral pathways where NHS/social care teams typically aim to place individuals in local facilities. Using primary data provided by the Applicant, which provides the postcode of new residents being discharged from hospital before they moved into care, it can be established that 73% of these residents across the two care homes (Bourne View in Poole and Wellington Grange in Chichester) are moving from within a 5 mile radius or 15-minute drive time. This analysis is shown in Figure 1 (Bourne View) and Figure 2 (Wellington Grange), overleaf.
- 1.5.4 The exceptions to this, where residents move to a care home from outside of the local area, generally occur where:
 - residents have specific health needs that require specialised care that is not available locally (not the case for the proposed development, which is not a specialised facility);
 - when no local placements are available due to a lack of capacity (which the proposed development would seek to improve); and
 - to move closer to family or friends.
- 1.5.5 On this basis, it is reasonable to assume that the vast majority of future residents would be from within the NHS Hampshire and Isle of Wight Integrated Care Board (ICB) boundary, would not be considered “net additional” to the area, and would not create additional demand for local NHS services. As outlined in Section 1.3, the reality is that moving into care can reduce demand for NHS services by in-house nursing staff delivering the majority of care needs.

1.6 Conclusion

- 1.6.1 This briefing note provides information on the Applicant, who provides no less than a good to outstanding quality of nursing care at all of its existing facilities. This would be the case at the proposed development, which would provide 24/7 nursing care that ensures that residents get the care they need immediately. The resultant key benefits of such care provision include increased hospital bed availability, and reduced burden on A&E services and local primary care teams.
- 1.6.2 While the majority of residents moving to the proposed development would come from the same local authority or nearby areas, it is acknowledged that a small proportion of residents would be moving from further afield due to a potential lack of capacity elsewhere or to move closer to family. However, it is established that local GP facilities have capacity for an additional 6,222 patients, which is more than sufficient to meet the needs of the 68 residents of the proposed development via scheduled weekly rounds or urgent consultations.

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- 1.6.3 Overall, the content of this briefing note directly responds to Reason for Refusal 3 of permission F/24/97312, providing a range of information to demonstrate that the proposed residential care community would not place undue pressure on healthcare services in the local area.

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