HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

REDUCING DELAYED TRANSFERS OF CARE THROUGH WHOLE SYSTEMS PARTNERSHIP WORKING SINGLE ISSUE PANEL
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Executive Summary

1. The Reducing Delayed Transfers of Care Through Whole Systems Partnership Working Single Issue Panel was established in response to concerns about the number of people waiting in Cornwall’s hospital beds for longer term care placements.

2. The historically high hospitalisation rate in Cornwall together with the historically low spend per head of population on adult social care services have resulted in significant numbers of community hospital beds being used for patients to wait, sometimes for up to 20 weeks, for local authority funding of their continuing care needs.

3. The delays in the flow of people into long term placements throughout 2005/6 developed into a backlog of approximately 80 people occupying community beds, representing 20% of the total community hospital bed stock.

4. GPs play a pivotal role in the referral of vulnerable older people who find themselves needing additional care. The options available to the GP are to arrange:
   • Care at home by health and social care services
   • Admission to a local community hospital
   • Admission to an acute hospital

5. In most cases, admission to an acute hospital is not appropriate and GPs’ first choice will be a community hospital. However if a community bed is not available, admission to an acute hospital is chosen as a less desirable but safe alternative.

6. Such referral to an acute hospital has significant implications for the patient, their families and the health and social care community. For the patient, the environment can be disorientating and lead to a rapid decline in their physical and mental capacity to perform activities of daily living. For families and carers, the distances involved in travelling to Truro or Plymouth to visit their loved one can cause significant strain and often unaffordable expense. For the health and social care community, the situation represents inefficient use of resources.

7. The Panel’s work led it to conclude that:
   • Urgent action is needed to address the situation of those patients currently waiting in acute and community hospitals and that placements should be arranged to a care home or community hospitals closer to their homes;
   • In order to achieve a long term, sustainable solution, systems and procedures need to be reformed to ensure that clinicians and social care practitioners work in a way that is focused upon facilitating re-enablement and sustaining personal independence. Effective communication both within the health and social care community, and with patients and their families, will be important in ensuring that necessary changes to systems are understood and implemented.
   • Community hospitals’ role in ensuring localised access to services and support is vital and appropriate funding needs to be allocated to enable treatment to be diverted away from acute locations and provided closer to people’s homes.
   • The measures needed to bring about change need to be clearly identified and progress, both in terms of implementation and impact, needs to be monitored carefully.
Summary of recommendations

a) Acute referrals

<table>
<thead>
<tr>
<th>Recommendation</th>
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<tbody>
<tr>
<td>Due to the urgency attached to this aspect of the Panel’s findings, the Panel recommended to the Health and Adult Social Care Overview and Scrutiny Committee on 28 November 2006 and the Executive on 13 December 2006 that action be taken to secure funding to enable placements to be made in care homes and community hospitals for people currently waiting in acute hospitals and to progress the establishment of a single point of access for referrals.</td>
</tr>
</tbody>
</table>

In response to the concerns raised by the Panel, the Executive agreed that:

1. The Department for Adult Social Care (DASC) enable placements in care homes and community hospitals of people currently waiting in acute hospitals.

2. DASC and partners establish a single point of access offering simple, rapid referral to a range of services that provide an alternative to hospital admission or placement in a care home.

3. Robust monitoring arrangements be put in place to ensure that the above measures result in prevention of any delays from 1 February 2007.

4. £529k be made available to DASC for the remainder of 2006/07 in order to expedite the additional residential placements necessary.

b) System redesign

1. The Health and Adult Social Care Overview and Scrutiny Committee recommend that the Executive approve:

   a) The expansion of the Rapid Assessment Teams to provide seven day provision and a single point of access to intermediate care;

   b) Plans to redesign case management and anticipatory support of people with dementia as part of the Community Matron Scheme;

   c) The re-commissioning of the Homeward Bound Beds to increase support worker capacity to provide people with dementia, care in their own homes and extension of the scheme, subject to tender, beyond March 2007 if it delivers the required outcomes;

   d) The process of integration of health and social care therapists under a joint team leadership structure;

2. The Health and Adult Social Care Overview and Scrutiny Committee recommend that the Executive call for:

   a) a significant financial review of continuing NHS care and jointly funded long-term care arrangements including community equipment across the health and social care interface.
b) the development of a cost benefits analysis of developing jointly funded long-term care community teams.

3. Cornwall and Isles of Scilly PCT present written details of their Local Delivery Plan for 2007-8 to the Health and Adult Social Care Overview and Scrutiny Committee.

c) Community Hospitals

**Recommendation**

1. The additional levels of resources required to enable the expansion of Cornwall’s community hospital service be clearly set out within the Cornwall and Isles of Scilly PCT’s Local Delivery Plan.

d) Communication

**Recommendation**

1. Patient pathways be renewed to reflect the changes to systems and procedures so that clinicians and social care practitioners are clear about the actions they must take in facilitating access to re-enablement services and support.

2. Effective mechanisms be put in place to ensure that patients and the wider public understand the changes to health and social care services and systems.

e) Monitoring

**Recommendation**

1. An evaluation report be commissioned to review progress after six months in improving the efficiency of patient flows and that this report be presented to the Health and Adult Social Care Overview and Scrutiny Committee.
1. THE REDUCING DELAYED TRANSFERS OF CARE THROUGH WHOLE SYSTEMS PARTNERSHIP WORKING SINGLE ISSUE PANEL

1.1 The Reducing Delayed Transfers of Care Through Whole Systems Partnership Working Single Issue Panel was established by the Health and Adult Social Care Overview and Scrutiny Committee on 11 July 2006 in response to an identified need to address the number of people delayed in the local care system. The Panel was charged with:

- assessing how the hospital admission and discharge system works and its relationship to NHS and Adult Social Care Community Care services;
- receiving and evaluating proposals for systems reform having regard for available resources and investment options
- Making recommendations accordingly.

1.2 This report sets out the work undertaken by this Panel, its findings and recommendations to the Executive for approval by the Health and Adult Social Care Overview and Scrutiny Committee.

1.3 The Panel met formally on three occasions between September 2006 and January 2007. A wide range of fact funding visits to health and social care establishments were also carried out by Panel Members to identify how systems were truly working on the ground and to see the impact of these upon those people at the receiving end of local health and social care services. This research has included:

- Meetings with Rapid Assessment Teams (RATS)
- Observing a Decisions about Residential Care (DARC) meeting
- Visits to one of the Homeward Bound Units
- Discussions with the Integrated Discharge Team
- Visits to Acute and Community hospitals and a chance to meet patients awaiting a move to longer term care
- Attendance at a Delayed Transfers workshop with health and social care staff and local conferences on Long Term Conditions and GP Elderly Care, and Long Term Conditions and Medication Management
- Review and evaluation of workstreams aimed at achieving system reform
- Consideration of anonymised case studies to identify underlying reasons for blockages in systems
- Discussions with key officers representing Cornwall’s Health and Social Care Community and care providers.

1.4 Details of the Panel’s Terms of Reference, membership and meetings are included at Appendix 1.
2. BACKGROUND TO THE PANEL’S WORK

The Care System in Cornwall

Residential Care

2.1 Cornwall County Council’s performance, as measured by the Commission for Social Care Inspectorate (CSCI), is the maximum “very good” rating for the number of people supported by the Local Authority to enter residential care. For the year ending 2005, 73.35 per thousand elder people were supported financially by the Local Authority.

2.2 The Department of Adult Social Care (DASC) funds approximately thirteen new permanent placements in care homes each week. The precise number varies according to how many people exit the care system. The Department also supports between five and eight “step down” placements from Acute Hospital into a care home for either a period of assessment or for a programme of Intermediate Care lasting up to six weeks.

2.3 Each week between six and twelve people will transfer to a higher level of care home provision than had previously been funded. Also in any week up to forty people will receive a short stay in either a residential or nursing care home from the community or from hospital. It is also a legal requirement for the Department of Adult Social Care to take up funding once “self-funders” have reduced their financial resources to such an extent that they become eligible for DASC funding, referred to as “wealth depletion”. The DASC is required to make their funding a priority and this is effectively first call on the residential care budget.

The Budget for Residential Care - The Funding Arrangements for Nursing Care

Local and Central Care Planning

2.4 Each DASC General Manager meets on a weekly basis with their managerial health counterparts within the PCT to ensure that local joint care planning systems are in place and agree care plans and recommendations across the wide range of NHS and Social Care community services.

Determining Priorities for Funding

2.5 There is a weekly Adult Social Care and Health DARC (Decisions About Residential Care) meeting which captures all the previous weeks’ activity and allocates whatever resources become available for re-use in the coming week. The Local Authority is obliged to give priority to funding care for those who are “out of funds”, meeting the increased needs of those whose residential care placements are already funded by DASC and intervening to support people who are at home but cannot remain there because the risk is too great.

2.6 Whatever money remains unallocated after the above priorities have been addressed is then used to purchase permanent residential care for people who remain in a hospital bed whilst awaiting funding. Priority is given to people in Acute Hospitals, who have been assessed as needing a permanent placement in care. Government guidance clearly advises that no-one should have to make such a decision whilst in Acute Hospital. Generally people step down for assessment or Intermediate Care, unless previous care plans had already identified residential care as being “triggered” by an admission to hospital.
2.7 People in hospital have always been entitled to an assessment for fully funded NHS Continuing Health Care (CHC) prior to discharge from Acute Care. The recent landmark “Grogan” ruling, however, states that this assessment should precede decisions about funding for residential care by a local authority. Decisions regarding the funding of Continuing NHS Care are progressed via the same local and central planning systems. In the response to the Grogan judgement, however, Adult Social Care and Health have worked to agree changes necessary to the existing CHC decision making process.

2.8 Arrangements for the discharge of patients from acute hospital ongoing care are governed by the Reimbursement Act 2003. The DASC has a duty to assess and transfer a person who no longer needs acute health care out of acute hospital care. As stated previously, however, this decision must now be preceded by an assessment and decision about eligibility for continuing health care. If the Council is responsible for any delay, they are liable for a “fine” of £100 per person per day for the total duration of that delay.

2.9 Acute SITREPS (Situation Reports) are collated and agreed on a weekly basis and show how many people are:

(i) waiting for a social care assessment to start or be concluded
(ii) waiting for DASC/NHS funding for a residential or nursing home placement.
(iii) waiting to transfer to a care home placement.
(iv) waiting to transfer to further NHS care.

The Hospital Assessment and Discharge System

Acute Hospital

Diagram: Total number of People Funded for Long Term Placement each month from April 2004 to April 2006 showing proportion that were from hospital waiting list

- Total number of others funded during that month (at risk, out of funds, temporary to permanent, acute hospital)
- Total number of patients funded during that month from community hospitals.
2.10 In reality no “fines” are paid within Cornwall, because the entire Reimbursement Grant received by the Local Authority between 2003 and 2006 was invested in a wide range of preventative services as agreed by the Executive of Cornwall County Council and the NHS Chief Officers. This included expenditure on mainstream NHS services, including therapy services and 12 community matrons.

2.11 The original Grant of £1.14M has been renewed for 2006 to 2008 and a new investment strategy has been agreed. The majority of Reimbursement Investment supports direct health and social care services designed to:

- Prevent admissions to long-term care
- Prevent admissions and emergency readmissions to hospital
- Facilitate discharge from hospital

2.12 The DASC had a theoretical option of spending the entire Reimbursement Grant on purchasing additional placements but (rightly) agreed with health partners to invest in the wide range of preventative and intermediate care services as recommended by the Intermediate Care Steering Group. The Reimbursement Grant would provide sufficient funds to place or support 75 each year.

2.13 The Reimbursement grant has been used for the past 3 years, and will continue for a further 2 years, to support a wide range of NHS and DASC initiatives aimed at preventing admission or facilitating timely discharge.

2.14 This investment, and the mainstream investment made by the Health Service and DASC, in alternatives to hospital have been managed, monitored and evaluated within the National Innovations Forum “Health of Older People” programme, which evaluated DASC investment in both EPIC advanced nurse practitioners (the forerunners of Community Matrons) and with professional Rapid Assessment Teams.

### Admissions Prevented, Discharges Facilitated and Bed Days Saved

<table>
<thead>
<tr>
<th></th>
<th>Admission Prevented No’s</th>
<th>Discharge Facilitated No’s</th>
<th>Bed Days Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acute Hospital</td>
<td>Community Hospital</td>
<td>Acute Hospital</td>
</tr>
<tr>
<td>RATS</td>
<td>400</td>
<td>646</td>
<td>634</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Matrons</td>
<td>226</td>
<td></td>
<td>63</td>
</tr>
<tr>
<td>Scheme 5 Therapy</td>
<td>44</td>
<td>115</td>
<td>94</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total for April 2005 to December 31 2005</td>
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</tbody>
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This equates to 76 FTE hospital beds saved in nine months.

### Community Hospitals

2.15 The national “SITREP” reporting system for people in non-acute hospital care began in April 2006. The Government will decide later this year whether it will introduce a Reimbursement system for Community and Mental Health hospitals as well as acute hospitals. The Community SITREP has not until now
captured activity in mental health units so there is a gap in this retrospective information.

2.16 Activity is collated and aggregated at District Council, Primary Care Trust and County level. This activity is then monitored in terms of timescales for start and completion of assessments, funding and placement. Historically, Community Hospital SITREPs have focused on any delays in assessment and funding.

2.17 The numbers on the Community Hospital SITREP and the Hospital Waiting List (HWL) of people waiting for NHS or Social Care funded residential or nursing home placements always vary from each other. This is because:
- Older people who are in CPT Mental Health Units are not yet the subject of SITREPs
- People in a hospital bed who develop a temporary illness are removed from the SITREP but not from the hospital waiting list.

Capacity/Flow Analysis

2.18 Cornwall historically has had a high hospitalisation rate compared to the national average and a significantly higher proportion of NHS spend on bed based care. The spend per head of population on adult social care is historically low. This has meant that for many years significant numbers of community hospital beds have been used as places for patients to wait for sometimes up to 20 weeks for local authority funding of their continuing care needs.

2.19 The health community has sought to reconfigure local services and community hospitals within existing budgets to provide greater therapeutic capacity through some bed reductions and reinvestment in services such as Falls Clinics, diagnostics and improved medical and nursing staff ratios. The aim has also been to bring NHS spend on beds more in line with other communities and to increase the emphasis on community home based support.

2.20 In November 2004 Central Cornwall PCT reduced the number of beds from 14 to 10 in Fowey Hospital as required by the Health & Safety Executive. During 2005, following a public consultation, the number of community beds at St Austell Hospital was reduced by 14. All of the savings from this reduction were invested into a number of new services locally to provide care that would have previously required admission, on an outpatient or day care basis instead. These services included a new Day Assessment and Treatment Centre, a haematology service, a falls service, respiratory clinics and Nurse Practitioner and Specialist GP clinics for Dermatology. At the same time Falmouth Hospital closed 7 beds in order to invest in extending the services provided at the Minor Injuries Unit and increase the level of specialist support for people who have had a stroke.

2.21 In May 2005 West of Cornwall PCT, following the formation of the public consultative group, the Helston Health Board, reduced the number of beds at Helston Hospital by 10 in order to reinvest the funding into day assessment and treatment services including physiotherapy and other rehabilitation, a blood transfusion service, and additional specialist staff for older people with mental health. Soon to be completed are specialist Audiology Outpatient facilities and a room for the local community staff of all disciplines from all agencies to meet and develop their working arrangements together.
2.22 These changes were approved by the Overview and Scrutiny Committee. Analysis is underway to evaluate the number of admissions prevented through these new services.

2.23 Community bed numbers have been temporarily reduced by a further 5% (22 beds) since the end of December 2005. A reduction of 8 beds took place in January 2006 at St Barnabas Hospital (North & East Cornwall PCT) for health and safety reasons. In February 2006, 10 beds at Poltair Hospital and 4 beds at Camborne-Redruth Hospital (West of Cornwall PCT) were closed as a result of recruitment difficulties and the cost pressures of using agency nurses.

2.24 The delays in the flow of people into long term placements throughout 2005/2006 developed into a backlog of approximately 80 people occupying community beds while they await their funding for up to 16 weeks. This represents over 20% of the total revised community hospital bed stock. Between 1993 and 2004 figures remained within 8% - 15% of total bedstock.

How the System Currently Functions

2.25 Many elderly and vulnerable people live at home coping with or without the support of neighbours, friends or relatives. They continue to live a relatively independent life without input from the local health or social care services. For these people, and those already receiving some care at home, deterioration in their ability to cope is often gradual but the decision to seek help is triggered when something temporary creates additional pressure and a crisis point is reached.

2.26 These crises arise if the person becomes more dependent or more difficult to care for as a result of illness or because the carer is ill, away or has extra demands upon their time, e.g. during school holidays. At such times the
person concerned becomes less able to manage than normal and may be very anxious. The additional pressure on the carer can be extremely stressful and they often are not aware of the ways in which they could receive extra support. At such times the person or their carer usually contacts their GP, the Out of Hours Urgent Primary Care Service or adult social care.

2.27 The options available to the GP to ensure the safety of their patient and the provision of appropriate care are to arrange:
- care at home by health and social care services
- admission to local community hospital
- admission to acute hospital.

2.28 For most elderly people in such circumstances admission to acute hospital is not required. However, many GPs continue to perceive care at home to be:
- limited by the inadequate availability of out of hours services such as RATs and night nursing
- limited to the provision of simple, low level care
- difficult and time consuming to arrange (even though there are many GP practices throughout Cornwall that include a case co-ordinator from adult social care.

2.29 As a result, for many GPs their first choice will be admission to a community hospital. If a community hospital bed is not available, admission to the acute hospital is often chosen as a less desirable but safe alternative. The disadvantages of this are shown in the table below:

<table>
<thead>
<tr>
<th>Disadvantage</th>
<th>Impact</th>
<th>Health &amp; Social Care</th>
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<tbody>
<tr>
<td>It will be further to travel</td>
<td>A long ambulance journey is traumatic and disorientating for elderly patients and can often lead to a rapid deterioration in their wellbeing.</td>
<td>The increased length of journey occupies the ambulance for longer so they are not available for other 999 calls.</td>
</tr>
<tr>
<td>On arrival at hospital the patient may spend some time on a trolley in A&amp;E, be transferred to Medical Admissions Unit and then, after a day or so, go to a specialist ward.</td>
<td>The moves from one place to another and the intensive medical investigation causes further distress and disorientation.</td>
<td>Admission to acute hospital is much more expensive than assessment and care at home or admission to community hospital. Usual input from community health and social care stops.</td>
</tr>
<tr>
<td>The staff in acute hospitals are specialist in acute care.</td>
<td>There is less focus on the need to establish a normal environment and re-establish/maintain a normal level of activity and mental stimulation. Often, pre-existing conditions are investigated even though they were being successfully managed at home. Whilst any simple acute illness such as infection etc will probably be treated successfully, the condition of the patient in terms of their physical and mental capacity to perform activities of daily living may decline rapidly. This is because:</td>
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<td></td>
<td></td>
<td>• The environment does not facilitate the exercise of</td>
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</table>
normal activities of daily living

- Normally those who require specialist acute inpatient care are not well enough to carry out these activities so the promotion of independence is not usually a key feature of acute care.

In addition, whilst in a declining condition, the elderly are vulnerable to acquiring other infections while in hospital.

The length of time spent in hospital is often longer than 10 days. By the time the patient is fit for discharge from acute care they are likely to be in need of considerable rehabilitation prior to returning home so rather than discharge home they will be transferred to a community hospital or step-down facility. The probability of successful rehabilitation to a previous level of independence is low and the likelihood that long term residential care is needed has increased considerably.

Meanwhile, the acute hospital has been caring for someone who did not require the expensive, high tech service that they are there to provide. The bed that they have used has then not been available to others. When this situation is multiplied the result is a shortage of beds for the hospital care provision that is costing both health and the local authority far more than it needs to.

2.30 If a community hospital bed had been available at the time of admission the likely scenario would have been direct admission to the ward, a short stay in hospital for treatment of any temporary acute illness and assessment of current care needs. During this time, normal activity and the maintenance of independence is encouraged. A rapid return home will be arranged, with a temporary increased support package if necessary. When the person has recovered their potential for independent living a reassessment of their care needs should be carried out and adjustments made to accommodate any change to their needs or the circumstances of their carer.

2.31 This approach results in lower overall stay in hospital, better health, wellbeing and independence outcomes for patients and clearly reduces the probability of the crises leading to the patient needing long term placement in a care home. If demand and capacity are in balance, this “virtuous circle” can be achieved.

2.32 The numbers of occasions when there are no beds available for direct admission have become more and more frequent so more people have been admitted to acute hospital as an alternative. The financial consequences to the NHS are significant when people who could have been cared for in a community hospital are admitted needlessly to an acute hospital bed generating a Payment by Results (PBR) payment of at least £2000 per admission.

2.33 The numbers of people per month waiting for a DASC funded placement from an acute hospital bed is as follows:

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<thead>
<tr>
<th></th>
<th>2005</th>
<th></th>
<th>2006</th>
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<tr>
<td></td>
<td>Apr</td>
<td>May</td>
<td>Jun</td>
</tr>
<tr>
<td>People</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Bed</td>
<td>9</td>
<td>9</td>
<td>5</td>
</tr>
</tbody>
</table>
2.34 These patients often then need to be transferred to step-down care or a community hospital bed after their stay in the acute hospital, so they then occupy a community bed or a social care funded temporary placement as well as having already occupied an acute bed. These resources are then not available to take people for direct admission.

2.35 The inevitable consequence for many following this journey, is that their condition will have deteriorated to such an extent that they cannot be successfully rehabilitated and so will need a long term care placement. During 2006, it has become too common for people to have to wait 3 to 4 months for funding – during which time they stayed in community hospitals.

2.36 Aside from the fact that a hospital is not designed to be lived in for long periods of time, so those waiting do not experience a good quality of life for those three or four months. It also means that the bed they are occupying will not be available for a direct admission so more patients may be admitted to an acute hospital.

2.37 Therefore:

- The number of patients waiting in a community hospital for placement has steadily increased.
- The number of unnecessary admissions of elderly people to acute hospital has increased.
- The number of times there is no bed for direct admissions to community hospital may be increasing.
- The pressures on joint NHS and DASC discharge planning systems means that there are delays in discharging people home quickly and this has an impact on how many people might deteriorate and require long term care when other parts of the system would have produced a better outcome.

2.38 This steadily deteriorating situation offers no benefit for any of the parties involved. It represents a significant level of avoidable expenditure, for both health and social care, which provides no value. The cost for the Local Authority and the Local NHS is already unaffordable, is growing and will continue to do so unless action is taken to break the cycle.

2.39 The cost for the individuals concerned in terms of loss of quality of life, independence and wellbeing is counter to the responsibilities of both health and social care to enable people to maintain independent living as set out in NHS targets and the CPA assessment for the Local Authority. It is too high for our community to ignore.

2.40 Between November 2004 and March 2005 a total of 102 extra placements over and above what could be funded were made by DASC to eradicate Hospital Waiting List pressures. This cost DASC £1.3m full year effect initially and is projected to cost £690,000 in 2006/07.

2.41 It has been noted that the rate of admissions to care in Cornwall is assessed to be either good or very good at around 70 per 10,000 population (it is neither too high nor too low). However, the continued use of community hospitals as places to wait for Adult Social Care funding for placement masks the true demand and resource allocation needs to provide for ongoing continuing care in a residential or nursing home setting.
3. THE PANEL’S FINDINGS AND RECOMMENDATIONS

a) Acute referrals

3.1 A clear priority from the Panel’s work was the need to reduce the referrals of vulnerable older people to acute hospitals. The Panel’s work in visiting Grenville Ward at Royal Cornwall Hospital Trust provided the opportunity to meet with patients and their families and to discuss the impact of their stay in hospital.

3.2 It was evident in many cases that patients’ ability to remain independent had deteriorated significantly – in one example a patient had entered hospital following a fall. Prior to her admission she had simply needed help at home in preparing hot meals. However, following her 28 weeks in an acute ward, her faculties had diminished and she now requires a nursing home placement.

3.3 The impact of admission to an acute setting was also seen to have a significant impact for families and carers. The Panel met with a number of family members, many of whom were themselves elderly and frail, and learnt that many were travelling long distances in order to be able to visit their loved ones. One example involved a lady in her 80s, with health problems herself, travelling across Cornwall each day by bus in order to see her husband at Royal Cornwall Hospital Treliske. Another elderly relative left home at 10.00am every day in order reach the 2.00pm ward opening time by public transport.

3.4 The Panel was left in no doubt that referral to an acute setting should only take place where absolutely necessary on clinical grounds. Wherever possible every effort should be made to ensure that patients are referred to a community hospital closer to their home or that measures are provided to help them to receive care within their home. Immediate action was considered to be necessary to address the situation of those patients currently waiting in acute hospitals and to make appropriate placements to a care home or community hospitals closer to their homes.

3.5 However, to achieve a long term, sustainable solution, the Panel recognised that systems and procedures need to be reformed.

Recommendation

Due to the urgency attached to this aspect of the Panel’s findings, the Panel recommended to the Health and Adult Social Care Overview and Scrutiny Committee on 28 November 2006 and the Executive on 13 December 2006 that action be taken to secure funding to enable placements to be made in care homes and community hospitals for people currently waiting in acute hospitals and to progress the establishment of a single point of access for referrals.

In response to the concerns raised by the Panel, the Executive agreed that:

1. The Department for Adult Social Care (DASC) enable placements in care homes and community hospitals of people currently waiting in acute hospitals.
2. DASC and partners establish a single point of access offering simple, rapid referral to a range of services that provide an alternative to hospital admission or placement in a care home.

3. Robust monitoring arrangements be put in place to ensure that the above measures result in prevention of any delays from 1 February 2007.

4. £529k be made available to DASC for the remainder of 2006/07 in order to expedite the additional residential placements necessary.

b) System redesign

3.6 Taking action to make placements for those patients currently delayed in acute beds addresses the current situation but does nothing to prevent those beds simply being refilled and the situation perpetuating. It is therefore vital that the provision of additional funding is accompanied by system reform within health and social care services so that it will be the exception rather than the rule that any patient will be delayed in an acute or community hospital bed as a result of waiting for public funding by the Local Authority for care home placement.

3.7 It has been agreed that no patients in the Royal Cornwall Hospitals Trust will be assessed as needing a placement in a care home. This decision is an important one for the individual and their family and an acute hospital is not the right place to make this decision. People requiring longer for the assessment process will transfer back home with an appropriate care package or to a community hospital.

3.8 All patients waiting in hospital beds for public funding of their placement will be moved, releasing around 100 community hospital beds that are currently occupied by people no longer requiring NHS inpatient care.

3.9 Against a backdrop of a growing older population with predictable rises in the number with long-term conditions such as dementia, Cornwall faces a considerable challenge to redesign services to avoid unnecessary hospitalisation, or institutionalisation.

3.10 It is vital that the health and social care community is able to stabilise and contain the rise in demand for long-term care home placements over the next three years. This requires a number of whole health and social care system reforms to create the capacity in the community to support people to remain within their own homes and within their community.

3.11 Shifting the balance of resource allocation in favour of anticipatory and proactive care in proportion to spend on crisis intervention is crucial. The areas for systems changes set out below will ensure that hospital does not become the default position for inadequate home support systems, non-joined up care processes and poor identification of vulnerable people within our population.

i) Integrated systems for identification of vulnerable people at risk of avoidable hospital admission or care home placement

Case Management
3.12 Cornwall has made significant progress in shifting health care closer to home and in improving the management of long-term conditions based on an anticipatory care model. This is being achieved through the introduction of Community Matrons, case managing the fifty most vulnerable patients in each practice at risk of repeated emergency hospital admission.

3.13 Providing intensive patient and carer education on self-management, coordinating support services and medication management, the rate of unplanned admissions has almost halved in their patient caseloads. Since October 2006 there are now 40 Community Matrons in Cornwall achieving cover of 80% of practices. Recently, historical hospital admission data provided on a monthly basis by the information department to the Community Matrons has provided a high level of accuracy in identifying the most at risk patients suitable for case management.

Immediate Planning Priorities

3.14 There is further opportunity in commissioning plans for mental health services for older people in 2007/8 to explore expanding integrated case management support to people with dementia through extending the community matron role with support worker capacity.

ii) Creating a single point of access and increasing capacity within the intermediate care services to provide intensive and sustained care and support to people in their own homes

Rapid Assessment Teams

3.15 A number of joint initiatives were introduced in 2003 using the Reimbursement Grant to increase capacity within the community to provide viable alternatives to acute hospital admission. This includes establishment of six multi-agency Rapid Assessment Teams (RATs), one per District Council area made up of therapists, social workers/care coordinators, rehabilitation care assistants, community and mental health nurses. Providing intensive intervention services to vulnerable people with urgent rehabilitation needs, they commission and deliver up to two weeks of non-means tested care.

3.16 In the same year, two Acute Care at Home teams were introduced in Central and West Cornwall providing home-based care for people with acute medical intervention needs requiring intravenous drugs and frequent medical monitoring. These services have been instrumental in moving the rate of unplanned admissions into hospital from a position of 9% growth in 2003, reducing to 5% growth in 2004 and to 1% growth in 2005/6. National data for quarters 1 and 2 of this year demonstrate 13% reduction in emergency bed days and 18% reduction in emergency admissions compared to the same periods last year.

Homeward Bound Contract

3.17 The Homeward Bound Units (HBUs) were started in 1999 and were one of the first innovative partnership developments creating intermediate care services for people requiring short-term physical rehabilitation to enable them to continue to live at home. Over time, new services have been developed to keep pace with the ethos of care outside of hospital and this has meant that a significant number of people who once would have accessed Homeward Bound Units now return home with a package of care provided by the very successful and well established RATs based in each Borough/District Council area.
3.18 HBUs are configured to provide physical rehabilitation and have been staffed accordingly. They were not designed to provide care for very physically frail people or those with mental health needs.

3.19 The outcome of the comprehensive review has led to the decision to change the Homeward Bound bed-based service. The money previously spent on HBU beds will be maintained and reinvested in an innovative and comprehensive range of services based in the community. There will be a particular focus upon people with mental health conditions like dementia. These services will be arranged by the RATs.

Integrated Health and Social Care Therapy Services for People with Long-Term Conditions

3.20 This project is well underway to integrate health and social care occupational therapists and physiotherapists under one team leadership structure from April 2007. The benefits from integration will include the delivery of therapy and adaptation as part of a care pathway for adults with long-term conditions and rehabilitation needs. Reducing bureaucracy and providing opportunity for multi-skilling and integration will create greater capacity to deliver more therapeutic interventions within communities.

Immediate Planning Priorities

3.21 The delivery of these projects in reducing reliance on acute secondary care beds provides assurance and should give commissioners confidence that shifting resources from hospital to the community setting is cost- and care-effective and improves the quality of life for people with complex long-term illnesses. However, there are a number of significant gaps in community capacity and Cornwall continues to have a relatively high incidence of hospitalisation despite its recent successes.

Seven-Day Access to Intermediate Care

3.22 The most significant gap in capacity is the need to extend the availability of the RATs during the week and at weekends and to operate a Single Point of Access to intermediate care.

3.23 Establishing a Single Point of Access within the seven-day provision of the RATs service will provide clinicians with a single referral point to the full range of services available to provide assessment and care for those with urgent health and/or social care needs. It will also provide GPs referring patients for non-elective admission to acute hospital with suitable alternatives to be considered where appropriate. Projected activity savings through expansion of RATs with the Single Point of Access demonstrate financial benefits to the health and social care community in terms of Payment by Results and emergency care home placements.

Review of Long-Term Care Funding Flows and Community Provision

3.24 The capacity of the health and social care community to provide people with complex long-term care needs affordable care in their own homes is severely challenged. The baseline budget for continuing health care has not been reviewed for several years and is £2 million over-committed. New National Eligibility Criteria for Continuing Health Care introduced this year puts additional pressure on the Primary Care Trust budget. It is not unusual for people to require care packages that cost £2000 per week and patient choice to receive their care at home rightly challenges the least costly option of long-term placement in a care home. The provision of
substantially more care to people in their own homes has equal pressure on the community equipment budget that has become over-committed year on year.

3.25 Creating the capacity to support people over the long-term with ongoing complex health and social needs to remain in their own home and to avoid hospitalisation or a care home placement is the final and most important plank of the transformational systems reform that needs to take place.

3.26 More cost-effective commissioning of home care assistants to support the work of professionally qualified practitioners will be necessary. Previous attempts to train rehabilitation care assistants have foundered due to a reluctance on the part of therapy practitioners to depend upon their services.

3.27 There is a need to explore some of the resource in the DASC uplift on care home placements and spend by health on high-cost spot purchased packages of continuing health care to pool resources and jointly commission a more affordable way and workforce that could directly provide community based high quality health and social care long-term support services. The community nursing and therapy teams would be key to delivering a new system of care delivery supported by support workers capable of providing home care, night sitting services and respite over the long term.

3.28 An imaginative use of assistive technology and the policies of District Councils to provide innovative extra care housing solutions will also be an important part of the overall picture.

**iii) Strengthening and integrating health and social care discharge planning and rehabilitation from the point of hospital admission**

Integrated Discharge Team

3.29 A multi-agency discharge team has recently been established at the Royal Cornwall Hospitals Trust (RCHT) funded by the Reimbursement Grant and the RCHT. Made up of nurses, social workers and patient flow coordinators this team will work closely with the intermediate care coordinators Single Point of Access. The team exists to support wards in developing effective discharge plans, ensuring timely assessment of continuing care needs, facilitating discharge home with intermediate care support for vulnerable patients and identifying and facilitating timely transfer of those patients who will benefit from rehabilitation in a community hospital setting. There are similar arrangements at Derriford Hospital, Plymouth.

3.30 The necessary system reforms outlined above will have funding implications for health and adult social care services. It is essential that these costs are appropriately budgeted for and incorporated specifically into the Local Delivery Plan (LDP).
Recommendation

1. The Health and Adult Social Care Overview and Scrutiny Committee recommend that the Executive approve:
   a) The expansion of the Rapid Assessment Teams to provide seven day provision and a single point of access to intermediate care;
   b) Plans to redesign case management and anticipatory support of people with dementia as part of the Community Matron Scheme;
   c) The re-commissioning of the Homeward Bound Beds to increase support worker capacity to provide people with dementia, care in their own homes and extension of the scheme, subject to tender, beyond March 2007 if it delivers the required outcomes;
   d) The process of integration of health and social care therapists under a joint team leadership structure;

2. The Health and Adult Social Care Overview and Scrutiny Committee recommend that the Executive call for:
   a) a significant financial review of continuing NHS care and jointly funded long-term care arrangements including community equipment across the health and social care interface.
   b) the development of a cost benefits analysis of developing jointly funded long-term care community teams.

3. Cornwall and Isles of Scilly PCT present written details of their Local Delivery Plan for 2007-8 to the Health and Adult Social Care Overview and Scrutiny Committee.

c) Community Hospitals

3.31 The pivotal role played by community hospitals in ensuring patients’ localised access to services and support was recognised by the Panel. Information was reviewed concerning the community hospital capital bid that has recently been submitted to the Department of Health which places key importance to three community hospitals in providing additional diagnostic and treatment services to the County’s communities.

3.32 Whilst applauding the key elements of the bid, the Panel was concerned of the impact if the bid was to be unsuccessful and the requested £100M capital (over three years) was not forthcoming from the Department of Health. Community hospitals are highly regarded by local people and offer the potential to divert treatment away from the existing acute hospital locations, bringing those services far closer to people’s homes. It was felt essential that the PCT’s Local Delivery Plan (LDP) process very clearly sets out the additional levels of resources that the expansion of the community hospital service requires.
Recommendation
1. The additional levels of resources required to enable the expansion of Cornwall’s community hospital service be clearly set out within the Cornwall and Isles of Scilly PCT’s Local Delivery Plan.

d) Communication

3.33 Crucial to the success of redesigning systems and services is good communication – both within the health and social care community and with patients and the public. The role played by GPs in making referrals is key and robust measures need to be put in place to ensure that clinicians are aware of the need for changes in their traditional referral patterns and specifically understand and support the changes in systems and procedures – in particular the new single point of access arrangements.

3.34 Public awareness is also important to enable patients and their families to understand the services and choices which should be made available to them. Local people also need to understand that the changing role of community hospitals and Trusts have an important part to play in making sure that changes are communicated proactively and effectively.

Recommendation
1. Patient pathways be renewed to reflect the changes to systems and procedures so that clinicians and social care practitioners are clear about the actions they must take in facilitating access to re-enablement services and support.

2. Effective mechanisms be put in place to ensure that patients and the wider public understand the changes to health and social care services and systems.

e) Monitoring

3.35 The work involved in bringing about the level of system reform needed cannot be underestimated and success will be dependent upon close collaboration right across the health and social care community.

3.36 Close monitoring will be essential to ensure that the system reforms are taking place and having the desired effect of maintaining a focus upon re-enablement. A detailed evaluation should be carried out in six months’ time to review the progress made and reported to the Health and Adult Social Care Overview and Scrutiny Committee.

Recommendation
1. An evaluation report be commissioned to review progress after six months in improving the efficiency of patient flows and that this report be presented to the Health and Adult Social Care Overview and Scrutiny Committee.
Appendix 1

WORKING IN PARTNERSHIP TO REDUCE DELAYED TRANSFERS OF CARE FROM COMMUNITY AND ACUTE HEALTHCARE

Purpose of this panel / anticipated value of its work:

In the light of the paper submitted to this Committee today to:

1. Assess how the hospital admission and discharge system works and its relationship to: NHS and DASC Community Care Services including Domiciliary Care, Intermediate Care, Acute Care at Home, Community Nursing and Care Home Services.

2. Receive and evaluate proposals for systems reform having regard for available resources and investment options.

3. Make recommendation accordingly.

Key objectives:

1. To determine what the critical issues impacting on the flow of patients across the system are.

2. To assess the impact of proposals to reform the way in which Health and Social Care is delivered within this area.

3. To confirm and support proposals for specific investment to address critical issues and to agree the preconditions necessary within the system for this investment to be made.

4. To ensure the risks associated with proposals and ensure that these risks are properly agreed and managed.

5. To receive regular reports on how commitments made by key partners are being progressed.

6. To receive information about finance, activity and outcomes against the situation as a baseline and enable performance against plan to be measured.

7. To elicit the views of service users, carers and their representatives (including Forum reps and Age Concern) on the current experience and to establish what the current pathways to independence and care should be. To establish how quality of life can be improved as a result of reform and what measures might be available to capture this.

Scope of the work:

1. All social care services covered by the Portfolio for Adults.
Terms of Reference prepared by:

Mike Faulds
Acting Assistant Director, Community Care, Department of Adult Social Care

Jenny Bowden
Head of Service Improvement (Unscheduled Care) NHS

Terms of Reference agreed by HASCOSC:
To be considered 11 June 2006

Meetings:
Public unless discussing items of a personal or confidential nature.

Panel Structure:
5 CC and 2 DC Members

Panel Chair:
TBA

Co-opted member /s
TBA

Portfolio Holder
Nigel Walker
Portfolio Holder Adults

Lead Officer for Cornwall County Council:
Mike Faulds
Acting Assistant Director, Community Care, Department of Adult Social Care

Lead Officer for Cornwall Health Community:
Jenny Bowden
Head of Service (Unscheduled Care) NHS
BACKGROUND:

A background paper is presented to the Committee to consider the flow of people through the local care system. It describes the impact of the current delays to transfers of care from health to long-term placements in social care and explains why the status quo is not affordable for health, for the Local Authority or the people of Cornwall.

The first part of the report provides some background information on how the local care system works. It goes on to explain the flow of people through our various care services, making clear the increasingly negative impact of the problems with the current system.

It provides an overview of the changes being implemented through health and the DASC to prolong independent living and reduce demand for long-term residential and nursing home placements, in turn improving care outcomes for those who are reliant upon the care system.

Finally, it brings in to clear focus the need to reduce the number of people delayed in the system, it recommends action to reduce waste and the counterproductive impacts that are a current feature, illustrating the potential benefits of doing this for the older people of Cornwall, the Local Authority and the local Health Service.

The report recommends that the Single Issue Panel will consider a co-ordinated multi-agency approach to establish improved systems and processes to enable both adult social care and the local health service to provide the right care for older and vulnerable adults, in the right place, at the right time.

The impact of this will be the prevention of unnecessary deterioration to the health, independence and well being of older and vulnerable adults who need a rapid but temporary increase in the intensity of their care and support and a review of their ongoing care needs.

The panel will be asked to review the financial plans of the local authority in relation to adult social care in the light of this paper with a view to achieving the co-ordinated system change to arrest the increasing growth in the cost of long term care per head of our population of older people. It will need to link with the Single Issue Panel considering the DASC savings plan. And in doing so consider the currently unfunded social care costs arising from the Learning Disability Investigation and the subsequent savings arising in overall Health Budgets.

SPECIFIC QUESTIONS FOR THE PANEL TO ADDRESS:

1. How does the system work and how much activity occurs currently?

2. What are the major issues impacting on outcomes and quality of life for older people?

3. What should a proper pathway look like and what outcomes do older people need and want to maintain or regain independence within the community?

4. What are the major cost pressures currently and what will happen if nothing changes?
5. What has to change and what is currently being proposed or developed to support whole systems change in this area?

6. How will demographic factors impact on demand for services and how can this be managed?

7. How this initiative relates to other major work programmes such as the implementation of the IPC Housing Strategy for Older People, the work of the Older People’s Partnership Board, the Local Area agreements and the work towards establishing user engagement in service delivery?

8. How should the Local Authority and the local NHS approach the integration of health and social care?

KEY DOCUMENTS / BACKGROUND DATA / RESEARCH

1. IPC Housing Strategy
2. SITREP Date
3. Current Budgeting Information
4. National Innovations Forum Activity Date