Stockport **NHS**
Primary Care Trust

COMMITTEE	Health Scrutiny
DATE	10th October 2006
REPORT OF	Director of Clinical Services
REPORT TITLE	Modernising Older People's Non-Acute Services

Executive Summary

1. The strategic business case reviews Older People's non-acute services in Stockport and develops proposals for service reconfiguration and modernisation ensuring that best value and contestability is achieved. The business case outlines an overview of existing service provision, considers why services need to change, and outlines the strategic case for a new service model on which the PCT intend to consult.

2. The strategic case seeks *formal support* from commissioning bodies in the PCT and SMBC for the proposed changes in **service provision** and proposed improvements in **commissioning.** This document will be followed by a formal consultation period to ensure full sign up to these important changes in services. The procurement of high quality providers and stimulation of the 'market locally to rise to the challenge of this vision will be a key task of commissioners in moving forward in the implementation of this during 2007. It is envisaged that the full model will be in place, through a phased implementation, by 2008-9.

3. The PCT is very aware of the significant challenges involved in delivering reform of this scale, in closing Cherry Tree hospital and investing in new community based alternatives. The PCT is committed to work with partner organisations closely to ensure that there is a successful, well managed and safe implementation of this new model. The new model of care must provide better quality care for patients.

4. The changes outlined in this paper will take a minimum of 2 years to bring about and pacing each step of this change will be a key consideration in development of an implementation plan and in particular with our chosen partner(s) for delivery.

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5. Commissioning resources from both Stockport PCT and Stockport MBC will be managed and co-ordinated to ensure that there is a smooth transition, agreed resourcing envelopes which are fair and equitable over the medium term, recognising health and social care responsibilities.

6. Around £11.7m is currently invested in Older People's non-acute services in Stockport, £9.8m invested by Stockport PCT, and £1.9m invested by SMBC in intermediate care services. Both organisations also invest considerable sums in other Older People's services such as acute care, primary care, community services, home care, residential care and nursing care.

7. The case for change in service delivery in Stockport is considerable and it is important to note that modernisation work in already underway in Stockport. Examples include changes to respite care, the development of a model for single point of access for Intermediate Care, implementation of a district wide service for Active Case Management, appointment of a Falls co-ordinator, plans to introduce 24-hour nursing support, IV Therapy service, and the appointment of a Parkinson's Disease Specialist Nurse.

8. A range of Older people's non-acute services are provided by Stockport PCT, the NHS Foundation Trust, Stockport MBC and the voluntary sector including:

   - Cherry Tree Hospital, Wards 2 and 4 (Rehabilitation), Ward 3 (Continuing Care Assessment)
   - The Meadows, Bluebell ward (Continuing Care and Palliative Care)
   - Stepping Hill Hospital, Wards A10 and A11 (Rehabilitation), and day hospital
   - Rehab at home services
   - Intermediate care beds – step up / step down
   - RRATH's (Rapid Rehab at Home Service)
   - Services provided by voluntary sector

9. Around 270 places are supported in the system, the bulk of these (82%) being bed based places. The Independent sector also provides around 2,300 Care Home beds which are skewed towards residential care beds.

10. The analysis of why the service needs modernising and reconfiguring around a new model makes a case for change which is based around the following main areas:

    - Over-provision of bed based places in the system
    - Lack of capacity in community support places
    - Delays and blockages within the system including 61 delayed transfers of care confirmed by 7th July 2006 point prevalence study
    - Lack of high volume alternatives to hospital care with step-up and step-down capacity provided at limited levels and compromised by delayed transfers of care
    - Long lengths of stay within the system
    - Low investment in admission avoidance, preventative, and health improvement initiatives.

11. Evidence from the recent point prevalence study and SITREP reports indicate that up to 20-30 delays to transfer of care reported each week. It is difficult to be precise about the exact numbers of people this

equates to as many patients are delayed for a few weeks at a time and appear on many of the weekly reports. Many of the delayed transfers of care are on the Cherry Tree Hospital site which raises questions about the viability of this site should a new model of care be introduced with less reliance on a bed-based system.

12. In considering future strategic direction a range of criteria were considered including securing an appropriate number of bed-based places in future, providing an appropriate balance between bed and community based places, ability to avoid unnecessary hospital admissions, supporting the Independent sector, optimising the patient experience, and delivering financial value.

13. The future model that meets the needs of patients most effectively and provides for a more integrated and co-ordinated set of services is that which entails significant service modernisation and a fundamental shift towards a more community focused model.

14. Each element of reform in this model has been developed in response to a gap in services, lack of choice and poor integration across the system. Investment and reform is envisaged at the assessment and preventive end of care as well as the choices for rehabilitation.

15. The new service model will include:

    a. Admission Avoidance Assessment Team – a single point of access to a multi-disciplinary assessment team that can plan/implement care packages accessing specialist support and diagnostics. The core team will be the intermediate care assessment team being able to draw on a wider range of skills and expertise including consultant in Older Peoples Medicine, Specialists.

    b. Intermediate Care/Rehabilitation Service
        - Home based providing intensive intermediate/rehabilitation care to service users who can safely be managed at home. Increasing capacity from 40-90 through additional capacity and reduced length of stay.
        - Bed based service providing intensive intermediate care/rehabilitation to service users who can not be safely managed at home. Consolidating the current capacity onto one site.

    c. Post acute intensive rehabilitation service – for service users requiring a period of rehabilitation who are not medically fit for discharge. A specification needs to be developed for this service.

    d. Nursing home support team

    e. 25 beds at The Meadows for service users who meet the eligibility criteria for fully funded continuing health care.

f. Investment in partnership with voluntary and charitable bodies focusing on support to older people together with more preventive and health improvement programmes is a key feature of the infrastructure planned for this model.

g. Day hospital

In total these services will provide a minimum of 280 places which will allow for choice within the system and the flexibility to achieve additional capacity to meet future growth the forecast number of over 65's in Stockport. (Further defined in Appendix A).

16. This overall improvement in services will not be achieved without the full engagement of our partners. It has been crucial for the PCT to engage with Stockport MBC, Stockport NHS Foundation Trust and a range of stakeholders and patient groups. Formal public consultation on this model is planned to take place later in 2006.

17. The additional community based capacity provided through this new direction is central to achieving the shift in service model away from hospital beds towards community based support and most effectively supports aspirations to provide more care in people's own homes where possible, promoting independence and healthy living.

18. It is believed that the options which significantly modernise services are also most likely to deliver the best value service. The rationale behind this conclusion being that these options eradicate the current wasted resource in blocked beds, and re-provided services on a community basis which is traditionally lower cost than equivalent hospital based services.

19. In terms of a longer term strategic commissioning direction the PCT is committed to work with partners in seeking to strengthen further the infrastructure for Stockport's Older People, for example through the provision of Extra Care Housing schemes, and the development of Nursing Home capacity. There is significant interest in Stockport in exploring these options further.

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Appendix A

Strategic Vision of Elements of the New Service Model

Element of Service	Description	Access/Eligibility Criteria	Capacity	Outcome
Admission Avoidance Assessment Team *(A)*	Range of professionals working on a multi-disciplinary basis to provide rapid assessment and diversion into an appropriate place of care. This would include access into intermediate care, specialist medical/ nursing services. Professionals: – Community consultant in older people's medicine – GPSI's – Nurses, therapists – Social worker – Medicines management/ pharmacy support – Mental Health Practitioner Undertake assessment, signposting and onward referrals i.e. to specialist services, diagnostics, ICAT'S, falls, ACM, respite support ensuring that the appropriate support package is in place.	Anyone in a community placement/own home who has an acute exacerbation or chronic condition that does not require acute hospital care. Access to the service through single contact number. Referrals accepted from Primary/community based services	Approx 20% of admissions for >65yrs are suitable for an alternative to an acute hospital bed, be that either management at home or use of intermediate care facility. (as judged by Utilisation management report 2003)	Avoidance of hospital admission.
Intermediate Care/Rehabilitation Home Based Service *(B)*	The core team will be the intermediate care assessment team pulling in the support from enhanced team. Intensive rehabilitation/support service provided in persons own home. Utilised as a step up service for those who can be safely managed	▪ Step up – patients in their own home requiring up to 6 week intensive support/rehabilitation ▪ Step down – patients in their own home requiring up to 6 week intensive	90 places Support between 770-900.	Increase in number of service users cared for at home. Avoidance of hospital admission.

Element of Service	Description	Access/Eligibility Criteria	Capacity	Outcome
	at home or step down to support early discharge. Maximum length of stay = 42 days Average length of stay = 35 days Working to discharge policies that will support a reduction in length of stay. Workforce: Dedicated team of SW/nurses/therapist providing input into service. Care workers – Assistant Practitioners	support/rehabilitation. Admission through Admission's Avoidance Team. Exit routes: ▪ Mainstream services - Health & social care ▪ Specialist services ▪ ACM ▪ Falls services Referrals accepted from - Hospital discharge services - Community/primary care services		Early discharge – decrease in length of stay.
Intermediate Care/ Rehabilitation Bed Based Service *(B)*	Intensive rehabilitation/ support service provided to people where the risk of providing a home based service is too high. i.e. require immediate access to support; unsafe to be left overnight – IV Therapy, acute exacerbation of a chronic condition Can be utilised as a step up and step down service to avoid hospital admission and support early discharge. ▪ Length of stay as home based service. ▪ Discharge policies as home based service.	As home based service except the risk of providing care at home is too high.	62 includes (11 flats) Supports approximately 533-620 patients per annum.	As home based service.

Element of Service	Description	Access/Eligibility Criteria	Capacity	Outcome
	▪ Economies of scale if this is provided on 1 site – could be a mix of individual bed places/flats ▪ Workforce – Dedicate team of SW/nurses/therapist providing input into service. Core workers Assistant Practitioners. Medical input from Hospital Avoidance Service.			
Post acute intensive rehabilitation *(C)*	Step down from acute phase – patients not medically stable for discharge programme but require rehabilitation. Average length of stay = tbd	Transfer from acute hospital ward. Exit Routes: ▪ Transfer to Intermediate Care/Rehab. Home or bed based service. When medically fit for discharge. ▪ Mainstream services	52 places with variable LoS dependant on complexity / case mix	Avoidance of readmission for same episode of care. Reduction in patient safety incidents involving transfers of care. Reduction in emergency bed days.
Nursing Home Support Team *(D)*	Provide education and professional support to care homes. Develop policies, procedure, standard – clinical guidelines. Providing support to patients at end of life. Incentive scheme for accredited providers.	All care homes wishing to seek accreditation.	40-50 places which are homes / beds for rest of life	Increased choice. Not blocked purchased. Reduction in delayed transfers of care.
Continuing Health Care Beds *(E)*		Service users who meet the eligibility criteria for NHS funded continuing health care (GM criteria – awaiting national framework)	25 places with variable loS assessed regularly against NHS continuing	

Element of Service	Description	Access/Eligibility Criteria	Capacity	Outcome
			care criteria	
Voluntary Sector *(F)*	Range of local services provided for older people in need of support not traditionally provided by statutory organisations. Services to be provided: - Placement service – advocacy - Well check screening - Home after hospital – follow up visiting service - Befriending, home shopping support	All older people requiring additional support. Access: - Self referral - Carer referral - Statutory organisations	Additional services to provide approx 1000 extra assessments for wellcheck. Additional support for respite / carers support, befriending support	Increase in number of older people cared for at home.
Day Hospital (G)	Diagnostic and treatment service for older people with complex and competing needs especially mental health needs and where medical cover and close supervision may be needed e.g. first dose iv therapy blood transfusion	Being cared for in the community. Treatment/investigation is part of an ongoing treatment plan. Admission not normally required for investigation/treatment but home or health circumstances cannot be met in out patient provision.	To be determined	Admission avoidance for investigation or treatment. Equity of access for people with mental health needs.

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