JOINT COMMISSIONING BOARD	Agenda Item 15 Brighton & Hove City Council NHS Brighton & Hove

Subject:		**The Reconfiguration of Short Term Services**	
Date of Meeting:		**14 November 2011**	
Report of:		***Director of Adult Social Care/Lead Commissioner (Brighton and Hove City Council)*** ***Chief Operating Officer (NHS Brighton and Hove)***	
Contact Officer:	**Name:**	***Wendy Young***	**Tel:** 01273 574688
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Key Decision:	**Yes**	**Forward Plan No:** JCB21596	
Ward(s) affected:		**All**	

FOR GENERAL RELEASE

1. SUMMARY AND POLICY CONTEXT:

1.1 This paper describes the proposed model for the future of short term services.

The proposed changes to the service model will mean the pathway is more streamlined, will improve patient experience and outcomes, support the prevention of avoidable admissions to hospital and long term residential care and facilitate effective discharge. It will also be in line with the outcomes of the needs assessment and the preference expressed by people using these services. Previous briefings have been presented to the Joint Commissioning Board in April and July and an informal seminar to discuss the model was held with Non Executive Directors and Councillors in September.

This paper does not make recommendations on the delivery mechanism for implementing the new service model as we have sought formal legal advice on options and depending on the outcome of that advice recommendations will need to go through governance processes within the CCG and the local authority. It does describe the process for reaching agreement and it is expected that the Joint Commissioning Board will be asked to sign off the proposed mechanism in an extraordinary JCB in January.

2. RECOMMENDATIONS:

2.1.1 The Joint Commissioning Board is asked

- To support the proposed model for short term services
- To agree the process for reaching a definitive decision on the delivery mechanism for implementing the new service model.

3 RELEVANT BACKGROUND INFORMATION/CHRONOLOGY OF KEY EVENTS:

Background

3.1 Currently a range of short term services (bed based and home delivered) exist across the city. These services have developed in an ad hoc way and a new model is required which delivers greater clarity and efficiency and improves support to the system as a whole, supporting effective discharge and preventing avoidable admissions.

The original scope of this work included Intermediate Care (home and bed based) Transitional Care, Local Authority home care reablement service and Newhaven Rehabilitation Centre. As the review progressed it became apparent that the whole system of short term care needed to be looked at as it was felt that short term services could not be seen as separate from community urgent care services. For this reason, community urgent care services are now included within the scope of the review.

A further change is the exclusion from scope of the Local Authority home care reablement service. This is because the service also has responsibility for providing care to people who do not access services through short term service but are part of the mainstream care provided by the Local Authority.

A complete breakdown of services in and out of the scope of the project is attached at Appendix A.

The case for change

We have found throughout the course of the review that

- the current pattern of short-term services is a muddle for both public and professionals using the services
- pressure within the system to move people through quickly is such that it sometimes meets the needs of services rather than individual users i.e. referrers take the less complex route of referring into a 'bed' rather than putting together a package of care which may be more appropriate
- because there are many elements to the existing system patients are often subject to multiple assessments
- some people go directly into long-stay care without being given the opportunity for rehabilitation or reablement, especially from hospital
- it is often difficult to access to bed based services to support prevention of admission
- some services, in particular those aimed at preventing acute hospital admission are not used to maximum effect and operate in silos rather than providing joined up seamless care for patients
- the multiplicity of providers and contracts make governance and provider management complex
- although services have worked hard to maximise efficiency, there is significant variation in unit cost which is not necessarily linked to outcomes or dependency levels

- there is currently inequity in service provision with some elements of the service (e.g. transitional) being means tested whilst other services such as Intermediate Care (ICS) are provided free of charge
- National benchmarking data[1] suggests that cost of provision of bed and community places in Brighton and Hove are significantly higher than the national average
- This data also suggested that there is a greater reliance on bed based services in Brighton and Hove per 100,000 population compared to the national average.

Evidence Base for Proposed Model

A national evaluation[2] of the costs and outcomes of intermediate care for older people concluded that

- Cost effectiveness and patient outcomes were improved through increased focus on prevention of admission rather than facilitating discharge
- There are larger short term gains in quality of life and functional outcomes for patients in residential settings with greatest need
- The fragmentation and poor integration with other services impacts negatively on the effectiveness of ICS
- Better integration between health and social services boosts effectiveness of ICS and patient outcomes
- Patient feedback indicated a more positive response to services provided at home rather than in residential settings

The review of the Community Rapid Response Service (CRRS) in August 2011 concluded that service model was working but that stronger links with other short term services would further strengthen the service and improve patient outcomes. The review recommended that other rapid response services were integrated with the CRRS and highlighted the need for more robust medical support and leadership within short term services and the need to strengthen the relationship with the acute elderly care service at BSUH.

The proposed model also takes account of the feedback received from staff and users about the current system. Staff have reported that the system is confusing, complex and difficult to navigate with multiple points of access and provision of care scattered across the city. Service users have reported similar levels of confusion with the system and a strong desire to have an increased number of services provided within community settings where possible

A local clinician led needs assessment which was carried out early 2011 in conjunction with front line staff indicated that 50% of patients in short term beds could be more appropriately cared for at home with appropriate community support and that their actual medical needs were relatively low.

Sussex Community Trust carried out an analysis of the acuity of patients in all the bedded intermediate care facilities in July. The findings from this analysis were

[1] *comparison data based on NHS Benchmarking 2010 and PSSRU research 2005 in Unit Costs of Health and Social Care 2010*

[2] Intermediate care for Older People – University of Birmingham /University of Leicester

similar to those of the PCT audit. For example one of the findings was that 79% of the patients at Knoll House were medically fit for discharge.

Service model

The proposed service model has three main elements

- integrated bed and community based short term services
- an integrated rapid response service
- medical support

A diagram of the model is included in Appendix B. The new model addresses the following agreed principles:

- an increased focus on the prevention of admission rather than supporting patients being discharged from hospital
- that the system will be responsive and able to facilitate urgent referrals to prevent avoidable admissions
- patient care will be seamless and allow for more tailored and flexible support as patients needs change. For example a patient will be able to move from a bed to the community based service without reassessment or change of care manager.
- Clear and logical distinctions between means tested and free NHS services when it is clear which services individual patients require

Accessing short term services

There will be a single streamlined point of access which will operate across both the integrated bed/community service and the rapid response service which facilitates prompt and effective referral into the system, reducing confusion and duplication. This referral process will support patients coming via community services or from hospital. A key feature of the referral process will be that patients will only need to be assessed once. Once the referral has been made patients will either receive their care from the integrated bed and community short term service or the integrated rapid response service.

Integrated bed and community short term service

This aspect of the service takes in the functionality of the existing service provided by the
Newhaven Rehabilitation Centre, the intermediate care service and transitional beds.

There will be further development of community services and reduced reliance on bed based services in line with patient preference. Extrapolation of the needs assessment audit suggests that the total bed stock within the city could be reduced from 105 to around 60 with the equivalent capacity being reprovided in a community setting.

Plans have already been agreed to reduce the current bed stock within the scope of the review from 105 to 76 by the end of March 2012 with the conversion of the 13 transitional beds at Glentworth and Sycamore Court back to long term nursing home beds and the closure of the16 of the beds at the Newhaven Rehabilitation Centre This is the first stage in reducing the bed based provision and will be an early opportunity to measure the impact of shifting capacity from bed based to community based care.

The service model also proposes a reduction in number of sites from which the bed based service is delivered to increase efficiency and effectiveness – ideally to one site with a maximum of three sites across the city.

To remove the current inequity in the system it is proposed that for all patients accessing the service there will be an agreed initial free period of assessment whilst the needs of the patient are determined. Patients will be able to access these services for a maximum of 6 weeks in line with existing guidance at which point they will be reassessed to determine whether their primary need is health or social care.

Integrated Rapid Response Service

The integrated rapid response service will incorporate the functions of the existing community rapid response service, the Roving GP service, the out of hours district nursing service and the Age Concern Crisis Rapid Response service.

It will be medically led and have a target response time of 2 hours and support patients for a maximum length of stay of 72 hours. Its primary objective will be to prevent acute admission to hospital by providing rapid assessment and intervention but it will also expedite the rapid discharge of patients from the emergency department at BSUH.

The service will provide a rapid multi disciplinary assessment for patients referred from the community with an urgent care need. It will carry out urgent GP homes visits to patients who would otherwise be admitted to hospital because a patients' own GP is unable to carry out a visit. It will identify where patients require ongoing support beyond 72 hours and works with partner agencies to put in place those services. It will provide a short term hospital at home service for patients requiring intensive support to keep them out of hospital or following discharge from hospital and it will provide out of hours nursing care for patients on the district nursing case load.

The service will operate for 7 days a week for 24 hours a day. It will not hold a caseload and will work with other providers to discharge patients as soon as they are referred to the service.

Medical support

There will be clearer and more consistent arrangements for the provision of medical cover and support for both services typified by effective clinical governance structures, leadership to drive and direct the services and the breaking down of barriers between services through rotation of posts and joint education.

It is expected that the provider of the integrated bed based service will assume responsibility for medical cover arrangements for patients in beds, for example, through enhanced nurse practitioner roles. Patients own GPs will assume medical cover for patients who are supported at home, with additional support from the urgent care GP if dependency levels require it, supplemented by appropriate access to specialist advice and support. This is in line with feedback received from clinicians regarding the optimum medical support for the new service.

Expert advice and support will be provided across both elements of the service by increased community geriatrician capacity, for example through participating in multi-disciplinary team meetings in bed based services, by providing telephone advice, through domiciliary visits to assess patients in the service or through more comprehensive acute assessment at the Rapid Access Clinic for Older People (RACOP). It is expected this role will be undertaken by a limited cohort of care of the elderly consultants to provide seamless care across the urgent care pathway that spans both acute and community.

We will clarify clinical governance arrangements for each component of the service and work with acute elderly care service to strengthen the links it has with both the existing short term and rapid response and the model in the future. For example we will be developing an accreditation scheme for health practitioners working in the CRRS and roving GP service so they can attain recognised qualifications in providing acute elderly care in the community.

Key Interfaces

It is expected that all aspects of the short term service will work closely with key interface services such as the integrated primary care community teams, in house reablement services, end of life and dementia services. These interfaces and how they will function will be described in more detailed in the detailed service specifications.

Outcomes

Overall we expect that the changes proposed will improve patients' experience of short term care:

- patients will have less assessments and will have dealings with fewer teams
- they are more likely to be cared for in their own homes and are less likely to be admitted to hospital unnecessarily
- with increased specialist care available in the community we would expect fewer patients to be readmitted following hospital discharge
- and the system will be less confusing for patients and their carers and families

In terms of benefits to the local health economy we will be expecting to generate some financial savings by:

- providing services in a more integrated way and reducing management costs
- and by shifting the balance of care in favour of home based care and strengthening community support arrangements

RISKS AND ISSUES

There are some challenges in implementing the new model.

There is a current lack of appropriate estate within the city in order to deliver the optimum model of bed based services from a single location within the city. We also have a number of sites within the city some of which are owned by current providers and are unlikely to be fit for purpose in terms of size. Options may need to include adapting and enhancing existing sites or partnerships with independent sector providers who are developing new sites within the city. Whatever the ultimate configuration it is likely that there will be a phased process to implementing the service model.

There are also risks that need to be effectively mitigated and monitored with reducing the number of beds, given the system's historical reliance on beds. The learning gleaned from the reprovision of the 16 beds at NRC will inform the development of the service specification and we will develop a range of metrics to measure impact on the wider system. These changes will be happening in the context a wider systems plan which should mitigate the impact of fewer beds in the system such as the development of integrated discharge teams at BSUH, the implementation of new integrated primary care team to support patients with long term condition and investments in capacity such as carers support.

Effective delivery of this new service model is dependent on significant culture change for staff working within the services as well as those services which interface with the services such as acute provision. This will require leadership, careful management and a comprehensive change management programme to support the implementation of the new model.

DELIVERY MECHANISM

A range of options for securing delivery of the short term services model were discussed at the informal seminar in September. These have been developed further in the light of discussions with procurement advisors and we have sought formal legal advice on whether any of these options can be implemented without the need for a formal competitive tender process The options currently include:

- A management board made up of existing provider and commissioner representatives with a key role in driving greater co-ordination and co-operation of services on these – but separate contracts and specifications continuing with existing providers
- A full competitive tender exercise which could then enable the generation of two further options for delivery:
    - One main contract with a lead provider responsible for delivering against a single revised service specification either providing all

services themselves or subcontracting elements of the service to other providers.
    - A formal joint venture with existing providers with one contract and revised service specification

It is proposed there are three stages to reaching a definitive decision on the ultimate delivery mechanism once full legal advice has been received:

- the establishment of a sub group of the JCB including , commissioners, members and non executive directors to recommend a joint approach
- Recommendations to then go for ratification within current CCG and local authority governance structures (IDGC (Integrated Delivery and Governance Committee) for the CCG and CMM for the local authority) in early January
- Sign of off the recommended approach at an extraordinary Joint Commissioning Board in January

4 CONSULTATION AND COMMUNITY ENGAGEMENT

4.1 Extensive patient, public and wider stakeholder feedback has informed both the development of the core principles for the future model for short term services and the draft model developed, including:

- a questionnaire to the Health User Bank to seek views on current services and the future model
- Detailed table top discussions at two CCG locality meetings to inform the development of the service specification
- The engagement of two clinical leads i.e. local GPs to lead on development of the service model with primary care colleagues
- The needs assessment audit conducted by a multidisciplinary group of health and social care professionals (GP; Social Worker, Physiotherapist; Public Health Consultant; Nurse).
- The establishment of a wide stakeholder reference group including representatives from patient groups, service providers and wider stakeholders to seek feedback throughout the development of the model and to help shape the principles.
- A stakeholder event on 17th May 2011 which included front line staff from provider organisations, primary care, patient representatives and the voluntary and community sector
- A letter outlining the work and consultation presented to the Health Overview and Scrutiny Committee on the 15th June
- An informal seminar with members and Non Executive directors in September where detailed discussions around the model and the options for procurement were discussed with commissioners of the future service and clinical representatives.

This model has been taken to several other key meetings for support including the CCG Clinical Operations Group and Board, has been presented previously to the Joint Commissioning Board.

5 FINANCIAL & OTHER IMPLICATIONS:

5.1 The estimated current cost of the services that are included within the scope of this review, jointly funded by Brighton and Hove City Council and the PCT, is approximately £ 10847k.

In addition to this, there are services which whilst considered key to the success of this review, would not be directly affected by any of the proposals. These include the Independence at Home Team and the Integrated Community Advice and Support Team (ICAST). The estimated cost of these services is £3,350k.

The aim of the review is to deliver an improved and more streamlined service which would provide increased value for money and reduced unit costs whilst enhancing outcomes and the customer experience. It would also be a platform to develop joint working and would be expected to deliver efficiencies and savings to both organisations.

It is likely that the level of efficiency savings will be dependent on the model of delivery selected which will be influenced by the decision of whether to modify existing services with the introduction of a management board or to embark on a full competitive tender exercise. Should the tender route be selected, it is likely to provide greater flexibility and therefore a greater level of efficiency savings than the creation of a management board with existing providers. The detailed financial implications will be developed as the delivery options are explored further and will be reflected in the budget strategies for 2012/13 and 2013/14. This would include the impact of the loss of income to the Authority as a result of no longer charging for the first 6 weeks for transitional beds, estimated at £50kpa, should this proposal be implemented in due course."

Finance Officer Consulted: Michelle Herrington, Principal Accountant, Brighton and Hove City Council, Date: 02/11/11

Finance Officer Consulted: Debra Crisp, Deputy Director of Finance, NHS Brighton and Hove, Date 02/11/11

Legal Implications:

5.2 JCB is the responsible body for the monitoring of and making decisions concerning the commissioning and delivery of social care and health services within the s75 joint working arrangement and therefore to make the decisions required by the recommendations in this report. The service re- configuration and proposed delivery options addresses the need to ensure ongoing value for money in terms of public expenditure and delivery of statutory services based on patient led principles. Wide consultation has taken place in compliance with Article 6 ECHR (Human Rights Act 1989) and all decisions for provision of care for individuals will continue to require Human Rights act implications are taken into account.

Lawyer Consulted: Sandra O'Brien Date: 01/11/11

Equalities Implications:

5.3 The reconfiguration of short term services is a key element of the Urgent Care Commissioning Plan which has been subject to a full equalities impact assessment. The new model for short term services will improve equity, creating a new more streamlined, efficient, tailored and effective service which improves patient outcome and experience.

Sustainability Implications:

5.4 The reconfiguration of short term services will develop a new sustainable model of care which will make a positive ongoing contribution to preventing inappropriate admissions and facilitating effective discharge. Tendering and procurement processes will address sustainability implications which will be a key factor in the decision regarding procurement.

Crime & Disorder Implications:

5.5 There are no crime and disorder implications arising from this work.

Risk and Opportunity Management Implications:

5.6 A detailed risk log has been developed. Each risk has mitigating actions and is monitored and reviewed by the Project Steering Group. Risks to the procurement process will be identified and actions developed to mitigate these. The incremental implementation of the new service model following successful procurement will ensure the ongoing safety of patients.

Public Health Implications:

5.7 The new service will have an increased focused on prevention and therefore will aim to avoid and reduce the severity of patient illness, improving both patient outcomes in addition to being more efficient. The inclusion of the development of a new integrated rapid response service ensures that patients who do require a more urgent intervention receive this in a timely and more effective way, improving outcomes and reducing the need for long term care.

Corporate / Citywide Implications:

5.8 The reconfiguration of short term services will have a positive impact on all wards of the city, reducing inequalities and improving patient outcomes and experience.

6. EVALUATION OF ANY ALTERNATIVE OPTION(S):

6.1 During the process of developing the draft model, a range of possible options have been considered, including maintaining the current split between transitional (means tested) and free NHS services. However this approach would maintain the current inequities in the system and fail to resolve the current complexity for staff and patients. The model presented meets the ambitions of staff and patients and is intended to reduce these inequities with clear, logical

and fair distinctions between means tested and free services and is in line with legal guidance on this.

7. REASONS FOR REPORT RECOMMENDATIONS

7.1 Joint Commissioning Board is requested to support the overall aim to reconfigure short term services. The new model will increase equity, efficiency and improve patient outcomes and experience. It is intended to deliver a more streamlined model for the future, greater responsiveness and flexibility and meet patient and staff expectations.

SUPPORTING DOCUMENTATION

Appendices:

1. Appendix A -. Summary of existing services
2. Appendix B - Model for new integrated short term rapid response service

Documents in Members' Rooms

1. None

Background Documents

1. None

Appendix A Existing short term services, providers and costs

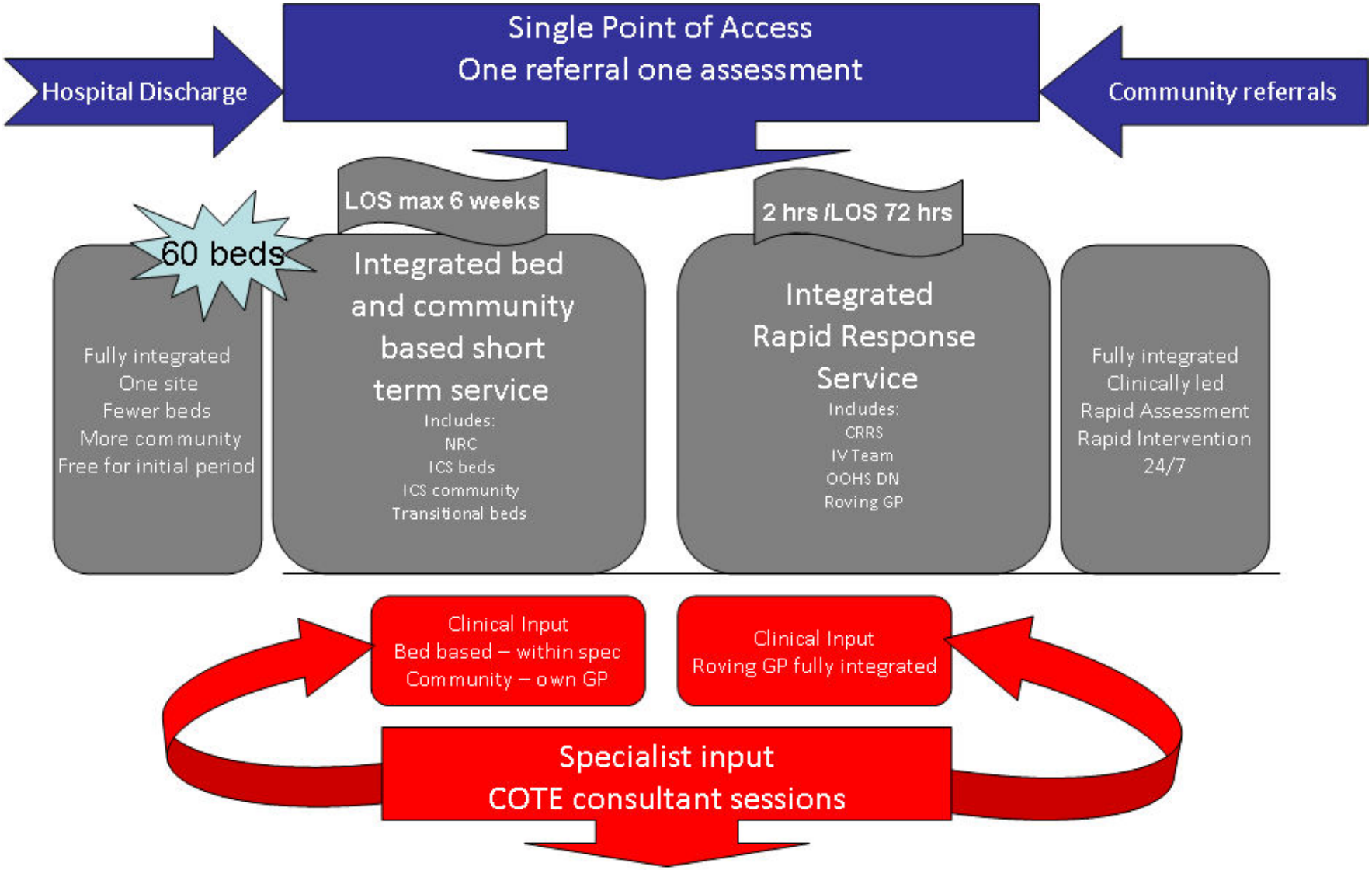
Services in Scope

Service	Provider	Cost £k	Cost £k	Total
		CCG	BHCC	
Community Rapid Response Service	SCT			
Roving GP service (including provision of medical cover for community beds)	SEH			
Out of hours district nursing service	SEH			
IV service	SCT			
Community geriatricians	BSUH			
Newhaven Rehabilitation Centre	SCT			
Knoll House	SCT/BHCC			
ICS Community	SCT/BHCC			
Craven Vale IC beds	BHCC/SCT			
Craven Vale Transitional beds	BHCC			
Highgrove	Victoria Nursing Homes			
Age Concern -CRISIS	Age Concern			
Sycamore Court Grant	Sycamore Court			
Total		**9382**	**1465**	**10847**
2012/13 efficiency savings		**-515**	**-140**	**-655**
Grand Total		**8867**	**1325**	**10192**

Services out of scope

Independence at Home	BHCC		
ICAST	SPFT		
Total		**0**	**3,353**

Appendix B



Acute Hospital Care/Rapid Acute Assessment (RACOP)