Agenda Item No 4

Warwickshire Shadow Health & Wellbeing Board

17 July 2012

'Discharge to Assess' Pathways

Integration / Alignment Status

1. Background

1.1 Against a background of a series of early service integration pilots in Warwickshire, senior leaders from Warwickshire County Council, South Warwickshire Foundation Trust, NHS Warwickshire PCT and South Warwickshire Clinical Commissioning group met to discuss the way forward towards integrated / aligned services for older people. This paper is a summary of a longer document, and outlines the approach that has been agreed. Project initiation is now underway.

2. Executive Summary - Our Shared Purpose

- We agreed that our shared purpose was to focus on developing and implementing a complete discharge to assess pathway as part of a vision to develop and deliver aligned care.
- We agreed that this process should be 'bottom-up' including patients and staff.
- We agreed that we must record what we are doing.
- We agreed that it would be South Warwickshire based at first with others kept in the loop as Phase One and then would be shared.

3. What we are aiming for and for whom:

4. System Drivers

4.1 The Dilnot Report (DoH, 2011a) highlighted the challenges health and social care face and made it clear that we as a nation face huge challenges in determining how we will fund the care and support that the most vulnerable and older and disabled people of our communities will need. It highlighted the challenges of determining what kind of assistance people should be entitled to expect and how we should all contribute to building a society which values all citizens and does not see supporting the most vulnerable as a burden. There are currently three million people over 80 in the UK, and this number is expected to almost double by 2030.

4.2 The National Health Service (NHS) reorganisation, catalysed by a change in Government in 2010 saw Andrew Lansley, Secretary of State for Health, designing a system to 'liberate the NHS' by broadly, developing clinically-led commissioning, reducing bureaucracy, strengthening regulation and reinforcing the use of marketisation (Dixon, 2012). As the architect of the redesign, Andrew Lansley presided over the development of the Health and Social Care Bill (DoH, 2011b). The Bill outlines what has been described as 'The Biggest Reorganisation in the History of the NHS', (Jowett, 2012). The Bill was finally given Royal Assent in early 2012, with huge opposition from many areas, most notably from the medical and nursing professionals from within the NHS (Buckman, 2012; Middleton, 2012). In addition to this political backdrop, the financial environment of health and social care had changed dramatically, with huge reductions in Social Care budgets (NSPCC and CIPFA, 2011) and also NHS budgets, (Appleby et al, 2009). The project described below is also delivered in the environment of the Quality, Innovation, Productivity and Prevention (QIPP) challenge which required all parts of the health service to rise to what has been described as the 'Nicholson Challenge' set by the Chief Executive of the NHS to deliver £20 billion of efficiency savings in the NHS, (Smith and Charlesworth, 2011).

4.3 At a recent Kings Fund summit on the care of frail older people (Cornwall, 2012) the key messages were:

- People in the UK are living longer, but many are living with one or more long-term medical conditions, and for a significant number, advancing age brings frailty. Although we have seen staggering improvements in medicine in the past 25 years, many of our health professionals were educated and trained for a different era.

- Successive governments have recognised the complexity of this problem and introduced policies and guidance for the care of older people. However, the great urgency is to turn the rhetoric of personalised care into the reality of everyday care and practice in relation to frail older people.

- Older people's services do not have high societal status and are not generally considered attractive options for professionals. The majority of staff providing the physical and emotional care for older people in hospital and at home have few qualifications, are on low pay and have poor working conditions.

- The quality of interactions and relationships between frail older people and professional caregivers is shaped by the team and the organisational 'climate' of care. Effective managers and staff working in a supportive organisational context could remedy many of the problems encountered by patients and carers in both their own homes and hospital.

- Actions can be taken at different levels of the system to deal with this issue, but we believe that the responsibility for quality of care and outcomes for patients is firmly located at the level of the team. The main purpose of decisions and actions taken at other levels of the system should be to enable frontline staff to do their work.

5.0 The 'initial' proposal

5.1 Each party has agreed to explore a series of shared Key Performance Indicators applied to shared simplified discharge pathways, subject to explicit entry and exit points and explicit accountability for the patient's journey and funding responsibility.

5.2 Pathway 1 (5 a day project) is in place. Our objective is to achieve a flow of 30 patients a week to CERT/IMC for South Warwickshire and a flow target will also be set for Reablement Services.

5.3 Pathway 2 is for patients who are likely to be not able to return home. This pathway is either funded by social care in the moving on beds (work is ongoing on the future model) or is funded by SWFT if the 'moving on' beds are unsuitable. At the end of 2-4 weeks the patient will either move into home based reablement or intermediate care services or will receive social care funding for their care or start self-funding their care. This is approximately 4 patients a week.

5.4 Pathway 3 is for patients who trigger in for full CHC assessment. It is proposed that health commissioners fund up to 4 weeks of nursing home care for CHC assessment to be completed. At the end of this time the patient will either be CHC funded, social care funded or self-funding and the transfer of responsibility will take place. This is approximately 6 patients a week.

5.5 The following principles will be applied:

- Clear and understandable pathways for all stakeholders, patients, carers and referrers
- A culture that takes responsibility for people that are referred
- A service that is timely –leading to best outcomes
- A service that is operationally and financially sustainable with risk and remuneration clearly identified/linked for organisations
- A system that is transparent
- A system that deliberately helps its constituent members with their challenges.

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