report

meeting	**JOINT HEALTH SCRUTINY COMMITTEE**	
date	**11 July 2006**	agenda item number

REPORT OF THE HEAD OF OVERVIEW AND SCRUTINY

MODERNISING OLDER PEOPLE'S SERVICES

1 SUMMARY

At this meeting Members will have the opportunity to consider the further information provided by Rushcliffe PCT in response to a request made at the Committee's June meeting. Brian Brewster, the Chief Executive of Rushcliffe PCT, will be attending this meeting to clarify any necessary points for Members. David Pearson, Nottinghamshire County Council's Strategic Director of Adult Social Care and Health will also be attending and will be available to comment on the proposals from the point of view of the Adult Services Departments of both the City and County Councils. The information contained within the new submission from Rushcliffe PCT, together with that presented at this and previous meetings should then be used to inform the Committee's decision on what course of action to take in responding to the consultations.

Documents received from Rushcliffe PCT and other sources are attached as appendices to this report.

2 MATTERS FOR CONSIDERATION

Members are recommended to consider the further information provided by Rushcliffe PCT, together with the response of the Nottingham City PCT Patient and Public Involvement Forum and information gathered at previous meetings, in order to determine a response to the consultations.

Rushcliffe PCT has agreed to receive any response made by this Committee after the formal close of the consultations. They have requested that the Committee's response be forwarded to them by 14 July in order that it can be shared with their consultation 'scrutiny panel' alongside all other received responses.

3 BACKGROUND INFORMATION

3.1 Rushcliffe PCT is carrying out two consultations on behalf of the four conurbation PCTs and the Nottinghamshire Healthcare Trust on proposals to develop rehabilitation and mental health services for older people. Detailed information about the proposals has been considered by Members at previous meetings of this Committee. The Committee has been gathering information relating to the proposals over a number of meetings and, following the last meeting, remained concerned about a number of issues related to the proposals. In brief, Members' concerns included the following issues:

a) Funding Flows – how will savings made be reinvested, will these be sufficient to cover the increased cost of community based services and who will be responsible for managing these?
b) Engagement of Partners – has a joint agreement been reached with Adult Services on the proposals and have the concerns of all relevant partners, including housing organisations and the voluntary sector, been taken fully into account?
c) PFI – what impact has the PFI timetable had on the development of the proposals?
d) Management and Commissioning – who will be responsible for managing patient care packages?

Questions relating to these issues were sent to Rushcliffe PCT. The letter outlining the questions is attached as appendix A to this report and the PCT's response can be found at appendix B.

3.2 At the June meeting Members also expressed concern about the impact of the proposals on patients and carers – have the implications of having to travel greater distances to access services been taken into full account in drawing up the proposals? Do community based services have sufficient capacity to ensure that patient care does not suffer as a result of the proposals?

3.3 Since the June meeting further information has been received. The Nottingham City PCT Patient and Public Involvement Forum have provided their formal response to the consultations for Members' information. This is attached to this report as appendix C. The Adult Services Departments of the City and County Councils have also provided their formal response to the consultations, again for Members' information. This is attached as appendix D.

4 SUPPORTING INFORMATION

Appendix A	Letter from the Chair and Vice Chair of the Joint Committee requesting further information from Rushcliffe PCT;
Appendix B	Response of Rushcliffe PCT;
Appendix C	Formal response of the Nottingham City PCT PPI Forum to the consultations;
Appendix D	Formal response of the Adult Services Departments of the City and County Councils to the consultations.

5 LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING EXEMPT OR CONFIDENTIAL INFORMATION

None

6 PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

Rushcliffe PCT Consultation documents - "Improving inpatient and community rehabilitation for older people across Greater Nottingham" and "Improving mental health services for older people across Greater Nottingham". April 2006.

Reports to and minutes of the meetings of the Joint Committee dated 18th October 2005, 23 April 2006 and 13 June 2006.

Barbara Cast
Head of Overview and Scrutiny
Nottingham City Council

Contact Officer: **Nancy Watson**
Telephone number: 0115 915 9827
Email address: nancy.watson@nottinghamcity.gov.uk

29 June 2006

ELJ-GH/JHSC

APPENDIX A

Edward Llewellyn-Jones/Gill Haymes

Brian Brewster, Chief Executive
Rushcliffe PCT
Easthorpe House
165 Loughborough Road
Ruddington,
Nottinghamshire NG11 6LQ

16th June 2006

Dear Mr Brewster

IMPROVING HEALTH SERVICES FOR OLDER PEOPLE IN GREATER NOTTINGHAM

Thank you for your attendance and that of your colleagues at the meeting of the Joint Health Scrutiny Committee on 13th June.

There are a number of matters on which members of the committee require fuller information before we can make a response to your consultations. It is our intention to consider the further information received from you, details set out below, at our next meeting which is on 11th July. Could we ask that you keep this date in your diary, 10.30am, in case there are still matters on which we need clarification. The committee will then respond to you formally immediately following that meeting. We understand that, although this falls outside your consultation period, this would be acceptable to you as we will undertake to forward the committee's responses before the meeting of your Board at which the results of the consultation will be considered.

The Joint Committee is considering all of the options available to it in responding as previously indicated in the report to the Committee. As part of the responses, the Joint Committee may make one or more recommendations and, should that be the case, it might be appropriate for the PCT to consider these prior to decisions being taken.

Members understand the overall vision for older persons' in-hospital rehabilitation and mental health provision and that the proposals are in line with the Government white paper, Our Health, Our Care, Our Say, in planning for shorter periods spent in hospital and more care provided in community or home based settings.

The Joint Committee is still not clear on what overall services will be provided in the future for patients, who will provide these and how they will be paid for. The Committee does not consider that these points should only be part of an implementation plan but that they should be clear in the proposals being consulted on. Without this patients and stakeholders cannot see how the process will work for them. Clarification of the following areas would assist in this understanding:-

o Funding

- A clear projection of the expected savings from reorganisation of hospital provision to fund community and home based care
- Whether this funding will cover the whole cost of community and home based care on an ongoing basis or for a defined period of years, bearing in mind that such care is likely to be longer term than hospital based care
- If it is not to cover whole costs, where will the shortfalls be met and, in view of hospital care being free to the patient, will there be an expectation that costs will be passed on to the patient in the long term (noted that current patients will not be expected to make payment)
- Who will manage the funding for community and home based care

o Management and commissioning

- Who will organise, commission and manage community and home based care
- Assuming an assessment of patients' needs will take place in the hospital, who will be responsible for the overall management of each patient's personal package of care

o PFI

- Further information on the PFI project at Highbury Hospital – what it encompasses, how it impacts on the reorganisation of hospital care for older people and how the reorganisation may impact on the PFI project
- The implications for the PFI project of any delay in the implementation of the reorganisation of services for older people

o Working with partners

- Clarification on whether a joint agreement has been reached with Adult Services Departments on the proposals
- Clarity on the financial viability of the proposals for all organisations likely to be affected
- Clarity on whether there is an understanding of the implications of the proposals by all organisations likely to be affected, including NHS, local authorities social services and housing services, voluntary and independent sector providers

- o Decision making
- Clarification as to which Trust Boards will be asked to consider the consultation findings and which boards will take any decisions on the proposals

The information on the above will assist members in determining the effect of these proposals on the health, well-being and experience of local patients and their carers and families.

On behalf of the committee, we would recommend that local authority housing departments or arms length housing organisations are consulted on the proposals as a matter of urgency.

Thank you for your assistance.

Yours sincerely

Edward Llewellyn-Jones
Chair of the Joint Health Scrutiny Committee

Gill Haymes
Vice-Chair of the Joint Committee

Consultation on older people's services

Rushcliffe PCT response to letter of 16 June 2006 from Joint Health Scrutiny Committee

Funding

<table>
<tr><th>Question from Joint Committee</th><th>Reply – Rushcliffe PCT</th></tr>
<tr><td>A clear projection of the expected savings from reorganisation of hospital provision to fund community and home based care</td><td>

Rehabilitation services

<table>
<tr><th colspan="2">Costs of existing service model</th><th colspan="2">Remodelled service</th></tr>
<tr><td rowspan="2">Existing inpatient rehabilitation wards at Highbury Hospital and Lings Bar Hospital (HH/LB)</td><td rowspan="2">£6.9 million pa</td><td>Inpatient rehabilitation wards at Lings Bar Hospital – 4 wards, 96 beds</td><td>£5.9 million pa</td></tr>
<tr><td>Investment in additional intermediate and community services</td><td>Between £0.5 million to £0.8 million pa</td></tr>
<tr><td>Total</td><td>£6.9million pa</td><td></td><td>£6.4 million pa*</td></tr>
</table>

*In addition, the PCTs have indicated a commitment to non-recurrent support to Social Services to facilitate timely discharges and respond to the accelerated turnover of patients. Initial projections have earmarked £100,000 for this.

Note: The remodelled service would be subject to approval through the established commissioning process including utilisation of the balance between old and new model. As an indication, if the investment of between £0.5 to £0.8 million is used to commission additional intermediate care at home services, initial planning assumptions are that this would support approximately an additional 300 to 500 older people a year.

(See page 8 of the PCT's further information provided for the Joint Health Committee meeting on 13 June 2006).

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Mental health services

The proposals focus on a reduction in fully-funded NHS continuing care beds, provided by Nottinghamshire Healthcare Trust (reducing from 71 beds to 45 beds). Running alongside this, the PCTs will cease to fund new placements in the two Independent Sector homes, and will retract NHS funding for Mellers Court, which together will release approximately £3.8 million by 2009.

The historical investment in continuing care beds for older people with mental health problems has been £6.9 million pa to support a maximum of 181 patients at any one time.

<table>
<tr><th colspan="2">Costs of existing service model</th><th colspan="2">Remodelled service</th></tr>
<tr><td>Provision of 181 continuing care beds</td><td>£6.9 million pa</td><td>Provision of 45 continuing care beds</td><td>£3.0 million pa</td></tr>
<tr><td>Community health services</td><td>£1.9 million pa</td><td>Community mental health services</td><td>£4.2 million pa</td></tr>
<tr><td>Total</td><td>£8.8 million pa</td><td></td><td>£7.2 million pa*</td></tr>
</table>

*In addition, the PCTs have indicated a commitment to non-recurrent support to Social Services, over a period to be agreed, to manage the transition to the new model. Initial projections have earmarked £300,000 for this.

Note: The remodelled service would be subject to approval through the established commissioning process including utilisation of the balance between old and new model. As an indication, initial planning assumptions show that an additional 1,200 older people a year could benefit from the shift of investment into community mental health services.
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<td>Whether this funding will cover the whole cost of community and home based care on an ongoing basis or for a defined period of years, bearing in</td>
<td>
Rehabilitation services

See above.
The investment in additional intermediate and community support services would be
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mind that such care is likely to be longer term than hospital based care	recurrent. Financial support to Social Services would be on a transitional basis, over a period to be jointly agreed, to address any increase in demand as lengths of stay begin to shorten. *(See page 8 of the PCT's further information provided for the Joint Health Committee meeting on 13 June 2006).* The same throughput will be achieved in the remodelled inpatient service, with the result that <u>there will be no additional care packages for Social Services to fund.</u> The same number of older people will be ready for discharge each week as are ready now. *(See page 6 of the PCT's further information provided for the Joint Health Committee meeting on 13 June 2006 and page 15 of the original consultation document).* The proposals do not change the overall model of care in the community nor the associated funding responsibilities. As is the case now, older people would continue to be discharged from the inpatient wards (in the same numbers, and the same ratio) each week as follows: • home with no support • home with joint packages (eg home care and primary care) • care home placement (either self-funded or funded by Social Services, with free nursing care funded by the NHS if appropriate) **Mental health services** The proposals do not change existing funding arrangements – they reflect implementation of agreed continuing care policies and criteria, which determine responsibilities between health and social services for funding individual packages of care. The PCTs are mindful that this may impact on social services funding of long term care placements. In recognition of this, the PCTs are committed to transitional support for both Social Services Departments in order that they can build their responsibilities into their planning and financial cycles – the rate and duration of support will be jointly determined and agreed, based on evidence from Social Services of the impact. (PCT expenditure across Greater Nottingham on individual continuing care cases

	over all care groups has increased by £4.7 million since 2001). The substantial additional NHS investment into community mental health services will be in line with the agreed Joint Strategic Framework and the model of care therein. *(See page 10 of the PCT's further information provided for the Joint Health Committee meeting on 13 June 2006 and the original consultation document).* The expectation is that the increased capacity and capability of community services to support older people with mental health problems will have a positive impact on social services – helping achieve the target of supporting more older people to live at home, and in time to reduce the over-reliance on long-term care. Without this investment in additional community mental health services for older people, there is little or no prospect of halting any rise in the growth of long-term care placements.
If it is not to cover whole costs, where will the shortfalls be met and, in view of hospital care being free to the patient, will there be an expectation that costs will be passed on to the patient in the long term (noted that current patients will not be expected to make payment)	**Rehabilitation services** See above. There will be no fundamental change to funding arrangements and responsibilities. Intermediate care is a time-limited service (often lasting about 4 to 6 weeks) to facilitate a smooth transfer back to home. It is free at the point of delivery and so older people discharged to that service would not incur a charge. As outlined in the further information to the Joint Committee of 13 June, in terms of local health services, there is a wide range of support available to older people in the community, and this will continue: ▪ new community matrons, caring for very vulnerable older people – across Greater Nottingham there are already 17 community matrons in post. By 2008, 2000 patients will be cared for by 41 community matrons ▪ community-based specialist falls services ▪ increased investment in the Integrated Community Equipment Service ▪ intermediate care services, developed jointly and which now have the capacity to provide over 1600 care episodes a year If older people are transferred home with a social care package, or placed in long-

	term care, they will be subject to a financial assessment by Social Services – as is the case now. To reiterate the above point – the assumption is that the same number of people will be discharged each week, with the same destinations, as occur now. **Mental health services** Existing patients admitted before April 2005 will have protected rights if the proposals are approved, which mean the NHS will continue to meet their care costs. Since April 2005, all patients are being assessed, within a systematic approach, to determine their continuing care needs – as is the case with all other care goups. If they meet the criteria for 'level 3', their care is fully-funded by the NHS. If they do not meet the criteria, the multi-professional team determines the appropriate package of care, which might be jointly funded depending on the individual level of need. If the package includes social care, older people have to undergo a financial assessment to establish the level of any personal contribution eg home care charges. As highlighted in the consultation document and the further information provided to the Committee, it is not equitable that some older people continue to have their care fully-funded by the NHS when they are not entitled to that, when there are others in the community who are not able to access the specialist health services they need because resources are not targeted fairly.
Who will manage the funding for community and home based care	**Rehabilitation services** See above. Funding arrangements will continue to be jointly managed, depending on the needs of individual patients. For example, the PCTs will continue to fund primary and community health services, as they do now, such as community nursing and rehabilitation services. The PCTs will also fund additional capacity in intermediate care and community services. Social Services will continue to manage the funding of social care. However, the

	PCTs commit to provide transitional financial support to Social Services to address the impact of any additional demand on their budgets as a result of the proposed changes. **Mental health services** See above. Funding arrangements will continue to be jointly managed, depending on the needs of individual patients. The PCTs have committed to shifting almost £3million over the next 3 to 4 years into community-based services. The PCTs will continue to fund specialist health services and Nottinghamshire Healthcare Trust will continue to provide them. The precise allocation of the reinvestment has yet to be agreed but the PCTs will wish to see allocation reflect the priorities previously agreed in the Joint Strategic Framework. This will include, for example, increasing the number of community psychiatric nurses, therapists and psychologists. It is also likely to include the establishment of 'generic support' roles to work at the interface between health and social services and support the targets to increase the number of older people supported to live at home and the number of intensive home care packages.

Management and commissioning

Question from Joint Committee	Reply – Rushcliffe PCT
Who will organise, commission and manage community and home based care	**Rehabilitation services** See above. The proposals make no changes to the organisation, commissioning or management of community and home-based care, except for the funding by the PCTs of additional intermediate care and community services and the transitional funding to SSDs. **Mental health services** See above. The proposals make no changes to the organisation, commissioning

	or management of community and home-based care, except for the funding by the PCTs of additional community mental health services and the transitional funding to SSDs.
Assuming an assessment of patients' needs will take place in the hospital, who will be responsible for the overall management of each patient's personal package of care	**Rehabilitation services** There will be no change to the current arrangements. As is the case now, responsibility for overall management will depend on the individual patient's needs. For example, in some cases it might be a community matron, in others it might be a social worker. To reiterate the earlier point, the planning assumption is that the same number of older people will be discharged as are now. It is also worth reflecting that the activity across the inpatient rehabilitation wards at HH/LB account for about 1% of all admissions and discharges across Greater Nottingham in any one year. **Mental health services** For existing patients in the continuing care wards admitted before 2005, the NHS will be responsible for the continued overall management of each patient's package of care. For all other patients, now and in the future, the normal arrangements will apply ie responsibility will depend on the individual patient's needs. For example, in some cases it might be a CPN, in others it might be a social worker.

PFI

Question from Joint Committee	**Reply – Rushcliffe PCT**
Further information on the PFI project at Highbury Hospital – what it encompasses, how it impacts on the	**Rehabilitation and mental health services** See summary attached of the PFI scheme of the HH site and the three phases of

reorganisation of hospital care for older people and how the reorganisation may impact on the PFI project	development (please note that the timeframe has since slipped by several months). The interaction of the two consultations is the estates reconfiguration of the HH site. This is being undertaken within a commercial framework (PFI) and not through public sector capital funding. The key details for older people's services are as follows: <u>Phase One</u> ▪ redevelopment of Hastings ward for older people with mental health problems. Completed May 2006 - the services have moved into custom-designed accommodation – the new Silver Birch ward. <u>Phase Two</u> ▪ build new adult mental health wards – work in progress, due for completion Autumn 2007 ▪ refurbishment of Hastings ward – on hold pending outcome of consultation <u>Phase Three</u> ▪ refurbishment of Carlton and Lady Middleton wards ▪ transfer of older people's inpatient rehabilitation services to the refurbished Hastings, Carlton and Lady Middleton wards Work is programmed to start on the redevelopment of the rehabilitation wards in December 2007. However, if the PCTs wish to withdraw rehabilitation services from the HH site, it is recommended they give notice by August 2006 to allow sufficient time for revised plans to be drawn up and approved for alternative use. Nottinghamshire Healthcare Trust has indicated it would welcome the opportunity to utilise the space vacated by rehabilitation services as it would allow the Trust to rationalise its estates and concentrate more services on the HH site. This would

	include the provision of an additional ward at HH for older people with mental health problems, if the proposals to centre those services at the HH site are approved.
The implications for the PFI project of any delay in the implementation of the reorganisation of services for older people	As outlined above, the PCTs need to give notice, in good time, of their intention to withdraw rehabilitation services from the site, otherwise substantial financial penalties will be incurred. The impact of re-phrasing, or variation, post completion is not available at present on the basis this would be detailed through application of the relevant clauses within the PFI contract. The nature of the deal would result in variations to revenue flows payable of the life of the contract (up to 2034). It is the long term revenue impact that is driving the need for early determination of site configuration so that the phased work can proceed in line with contracted timelines.

Working with partners

Question from Joint Committee	**Reply – Rushcliffe PCT**
Clarification on whether a joint agreement has been reached with Adult Services Departments on the proposals	As outlined in the further information provided for the Committee's June meeting, the PCTs and both SSDs have been meeting for many months, at both officer and Chief Officer level. The PCTs have made a commitment to continue to work with both Adult Services Departments to understand the likely impact for them, which includes the development of a joint performance management framework to monitor the impact of any changes, which will include joint targets and measures. The PCTs have also confirmed commitment to provide transitional financial support. The PCT intention has been to incorporate this detail in a joint implementation plan subject to the outcome of the consultation process on the proposed service changes. It would be inappropriate to agree on the outcome prior to conclusion of the consultation on the service changes as that would be contrary to good practice on consultation.

Clarity on the financial viability of the proposals for all organisations likely to be affected	The consultation documents have been circulated to all key partners. The 3-month consultation period allows time for all organisations to submit details to the PCT of any likely impact for them, so that we can take that into account. So far, the only organisations to indicate it will have an impact are both Social Services Departments – this has been through ongoing dialogue as indicated above. At the time of writing, no formal response has been received from either Social Services Department.
Clarity on whether there is an understanding of the implications of the proposals by all organisations likely to be affected, including NHS, local authorities social services and housing services, voluntary and independent sector providers	The consultation documents have been circulated widely – including to health partners, social services, local authorities, the voluntary sector, organisations that represent older people etc. All local authorities were sent the consultation documents in early April. However, in response to the Joint Health Committee's letter of 16 June , Rushcliffe PCT has written again to Chief Executives of the following local authorities, bringing to their attention the Committee's recommendation that housing departments are consulted on the proposals and reminding them that the consultation period runs to 2 July: ▪ Ashfield District Council ▪ Broxtowe Borough Council ▪ Gedling Borough Council ▪ Nottingham City Council ▪ Rushclifffe Borough Council The PCT has also written to arms length housing management organisations, as recommended by the Committee, ie to: ▪ Ashfield Homes ▪ Nottingham City Homes ▪ Rushcliffe Homes The multi-agency working groups that have been meeting for many months include representatives from key partners and so they have helped shape the proposals and understand the implications.

	Subject to any objections from the Joint Committee, the responses to the Committee's consultation process (included in the papers for its 13 June meeting and others tabled on the day) will be tabulated with other documents for consideration at the close the formal consultation period.

Decision making

Question from Joint Committee	**Reply – Rushcliffe PCT**
Clarification as to which Trust Boards will be asked to consider the consultation findings and which boards will take any decisions on the proposals	Rushcliffe PCT is running the consultation process on behalf of the four Greater Nottingham PCTs and Nottinghamshire Healthcare Trust. However, <u>all</u> relevant Boards are considering the proposals, as follows: Broxtowe & Hucknall PCT Gedling PCT Newark & Sherwood PCT Nottingham City PCT Rushcliffe PCT Nottingham University Hospitals Trust Nottinghamshire Healthcare Trust A report of the consultation feedback, including conclusions of the above Boards, will then be reported to Rushcliffe PCT Board on 26 July. The report will be taken in open session and all documentation will be available to other PCT Boards if required. It is inappropriate to prejudge the outcome of the Boards' consideration of the consultation at this time. Any proposals to progress towards implementation will be submitted to each Board for approval. Those papers would include detailed implementation proposals in the form of a business case and be subject to the established commissioning process to be enacted into service delivery. Implementation proposals will also be available to the Joint Health Committee if required.

Highbury Hospital
PFI Scheme

- Works started December 2004.
- Programme of works to take 4 years to complete.
- A Private Finance Initiative scheme in partnership with James Walker (Leith) Ltd.
- Refurbishment of elderly Medical Rehabilitation Services wards with 72 in-patient beds and new outpatient areas (managed by Rushcliffe PCT).
- New build Adult Mental Health wards and PICU unit—total of 42 beds. New Adult Mental Health therapy areas.
- New build Mental Health Service for Older People ward of 22 beds.
- New kitchen, laundry, office accommodation, hall, reception and other facilities.
- New car parks and landscaped areas.

Phases of Development

Phase One - Dec 04 – Feb 06

- Demolish Strelley Ward.
- Build New Mental Health Services for Older People ward.
- New kitchen and laundry built.
- Some temporary accommodation provided.
- Hastings patients move to new building as does kitchen and laundry.

Phase Two – Sep 05 – Apr 07

- More temporary accommodation provided for offices, hall, bank and therapy areas.
- Demolish admin/therapy building.
- Build Adult Mental Health wards.
- Hastings Ward refurbished.

Phase Three – Apr 07 – Jan 09

- Carlton and Lady Middleton patients move to new building.
- Carlton and Lady Middleton refurbished.
- Linby, Willoughby and Nuthall ward patients move to Hastings, Lady Middleton and Carlton refurbished wards.
- Temporary accommodation for main entrance and reception.
- New car park in front of AMH new building comes into use.
- Demolish central H block.
- New block built.
- Therapy services, reception, offices, etc. move in new building.

Site Plan

View of Reception

View of Entrance

Highbury Hospital

Some information about the hospital redevelopment in conjunction with James Walker (Leith) Ltd.

Capital Planning Unit

Nottinghamshire Healthcare NHS Trust

Response of Nottingham City PCT's PPI Forum to the Consultation on the Modernisation of Older People's Services.

The following comments relate to both parts of the proposal; the changes to the Mental Health and Rehabilitation Services. The issues overlap and we have found it helpful to see the impact of the changes as a whole. Despite early involvement with Rushcliffe PCT over the proposals, it has been disappointing to find how little impact the working group has had on the final proposal; many of the points below have been made consistently throughout the last months.

The following comments were discussed in depth and agreed by forum members at their meeting on 19th June 2006. They have also taken into account views of people unable to attend. The interviews with patients at both sites also influence these comments.

Our chief concern is that vulnerable people will be exposed to risk if there are major changes in the health services that do not take full account of the provision in the community. We are also concerned that lack of a policy over transport is a major, not a small, issue for patients and their carers.

1. In interviewing patients at Highbury Vale and Lings Bar, the feeling that this period of adjustment to a trauma, such as a fall, was highly valued came across strongly. While for some the physical rehabilitation, such as physiotherapy, was highly valued, many people appeared to need a time for emotional, as well as physical, readjustment. There were also people who were not receiving much physical support but who were clearly in need of care and respite. **There does not appear to be a strategy for meeting the needs of people who are not clearly in the two categories covered by the proposal.**
2. These interviews did not lead to the impression that people were kept on these wards because of the slowness of the rehabilitation. Many people were waiting for equipment or for their future housing to be sorted out or for their carers to recover strength or for Social Services to sort out future housing and/or care. It seems unlikely that anything suggested in the proposals will have an impact on the wider community to make early discharge a reality. **Giving people the time they need and then making sensitive arrangements with them for the future is surely a matter of good practice in joint working and does not need a policy change.** There is a real danger that there will be fewer beds but that people will be in them for just as long so that the overall impact will be a cutting back of this support.
3. A cut back in hospital services, such as this, can only be done where other services can cope with the change. Otherwise the pressure in the community will increase. There is already a great deal of concern at the inability of Social Services to respond quickly and sensitively to demand. The voluntary sector can only respond to the challenge if it is adequately funded for this. It is surprising that at this time, where there is increasing emphasis on Health and Care working jointly, that so little has been seen of Social Services input. A joint proposal would have been more convincing in reassuring the public that people will not leave the hospitals without sufficient extra provision. **This is not a proposal that the health services can implement unilaterally.**

4. There appears to be an expectation that care homes will be able to cope with any extra demand**. It may well be the case that Care or Nursing Homes are a better alternative for some patients. However the number of places in these institutions is decreasing.**
5. The decision to reduce the number of places appears to be based on a statistic gleaned from national averages. **People in the local community would be more convinced by an analysis of local need.** We live in an area with a high level of deprivation. Moreover there is an increase in the numbers of older people who will need specialist services. Any reduction in provision should surely only be considered in a context where alternative provision has already been planned for, so that care at home is a reality, not just a way of putting people back in their homes with inadequate support leading to loneliness, depression and increasing isolation.
6. The difficulty for carers of getting to the North of the city from the south of the county and vice versa has been underestimated. **One would have expected a policy for transport to be included in the proposal. However even with a transport policy there are real problems.** Many carers are themselves frail and in no position to make constant journeys across the city. It is a disincentive to all carers at a time when visitors are an essential aspect of the road to recovery or serenity. In the case of the rehab patients, there will be people who will choose not to use this facility if it means being too far from their families. For long-term patients with mental health problems already adapting to a new environment, visiting could make all the difference to a tolerable way of life. There have already been concerns expressed by carers on this issue and we would like to underline its importance.
7. We are concerned that going ahead with the changes will lose valuable and experienced staff. This means the loss of familiar and trusted care.
8. The proposals are made in the expectation that with less beds and a more efficient use of specialised staff a better service will be provided more efficiently. While our comments have perhaps been negative this is not because we support the status quo. It is clear that there are staffing difficulties and that for many people their experience suffers from this. We support any efforts made to improve the patient experience. The forum would like to support the trusts in providing a service that is what people need and want in the place they choose to be. **However we are not convinced that the risks attached to the current proposed changes have been properly addressed or the concerns of very vulnerable people and their carers fully taken into account. We would therefore urge Rushcliffe PCT to defer a decision until these major issues have been addressed.**

Nottingham City Patient and Public Involvement in Health Forum
Unit 2
89 Humber Road
Beeston
Nottingham NG9 2ET

Proposals to improve Health Services for Older People across Greater Nottingham

Response from Nottingham City Council and Nottinghamshire County Council

Both Local Authorities have engaged with the process for developing services in this area and support the overall direction of travel as set out in the Joint Strategy on Older Persons Mental Health but require further detailed work before agreement on implementation. We do not wish to see people staying longer in hospital than is reasonable for their treatment and care. We also wish to see individuals discharged from the proposed services as fit as or fitter than they currently are when leaving current services.

Older People's Rehabilitation Services

We can support the model as proposed subject to the following being satisfied/answered as part of the outcome:

The development of an agreed health and social care pathway for older people's rehabilitation that covers inpatient and community based rehabilitation that:-

- Minimises the inpatient length of stay – to at least as good as the national average;
- Such that patient fitness is not compromised on discharge and their condition on discharge is appropriate for the level and capacity of community based health and social care;
- The model is supported by evidence of successful outcomes, including patient satisfaction;
- Models the anticipated future demand for older people's rehabilitation care pathway;
- Provides a detailed ***impact analysis*** on the care provided by:
    - Social care
    - Health care (separating primary and community care)
    - Home care and corresponding services
- Demonstrates the involvement and sign up of partner organisations, including the Nottingham University Hospitals NHS Trust
- Demonstrates a fully costed, value-for-money model of care, including the reinvestment profile for savings from the switch from the current model of care;
- Explicitly covers the care pathway management arrangements

We wish to see the outcome of the more fundamental review of the model of care so the changes are more than an enhancement of existing services.

It should be agreed that the timescale for completion should be no later than the end of September, and we would wish to offer a report on the Impact Assessment being presented to the Overview Committee(s) in the Autumn.

Older People's Mental Health Services

We can support the model as proposed subject to the following being satisfied/answered as part of the outcome:

The development of an agreed health and social care pathway for older people's mental Health services that:-

- Demonstrates that value for money will be achieved (including the reinvestment profile for savings from the switch from the current model of care) and that the resultant service will meet any challenge of contestability through observation of good process, patient involvement and benchmarking;
- The model is supported by evidence of successful outcomes, including patient satisfaction;
- Is a combined health and social care model;
- Models the anticipated future demand of older people in different care settings and at different levels of care;
- Provides a detailed ***impact analysis*** on the care provided by:
    - Social care
    - Health care (separating primary and community care)
    - Home care and corresponding services
- Demonstrates the involvement and sign up of partner organisations, including other local healthcare providers as well as PBC commissioners;
- Explicitly covers the care pathway management arrangements.

It should be agreed that the timescale for completion should be no later than the end of September, and we would wish to offer a report on the Impact Assessment being presented to the Overview Committee(s) in the Autumn.

Detailed information of the kind outlined would be required before advising members of the strengths and weaknesses of the proposals. For this reason this response is made by officers at this time.

Appendix 1 below gives a more detailed analysis of the consultation documents and those subsequently supplied through Joint Scrutiny.
Appendix 2 shows our joint understanding of the patient/care pathways currently and under the new proposals.

Sallyanne Johnson
Corporate Director,
Adult Services Housing and Health
Nottingham City Council

David Pearson
Director of Social Services
Nottinghamshire County Council

Appendix 1

Detailed analysis

1. The impact on patients and social care services is not adequately addressed. And needs to take account of the historical responsibility of the NHS to long stay hospital patients.

2. Any reinvestment of funding from these changes should consider both the health care needs and the social care needs of this group. Both Social Services Departments have worked closely on the concerns over these proposals and share a common position. Officers continue to work with Rushcliffe PCT towards a resolution of the concerns.

3. Using Continuing Care policy as the rationale for reducing the number of placements and beds, ignores the historical reason why these beds were initially commissioned by the NHS. These were beds to facilitate the closure of long stay hospitals such as Basford Hospital. The patients then were the sole responsibility of the NHS who continued to assume that responsibility and kept the savings from hospital closures to do so. Money was not transferred to Social Services for this purpose and so Mellers Court, Landmere and St Andrews were commissioned by Health directly, with Mellers funded to be managed and run within, Social Services.

4. The newer Trent Continuing Care policy is a ‘broad brush’ document which has been interpreted locally. Currently there are no local or national assessment tools that can be used to determine a Continuing Health Care place and this is the basis for an Ombudsman’s decision that there should be some drawn up by the DoH. (This week saw the launch of draft National Guidance for consultation, which proposes to make simpler and fairer the system for eligibility for ‘fully funded’ NHS care. The new guidance has been costed in terms of financial impact and suggests some cases which hitherto had been the responsibility of Social Services, will transfer to the NHS).

5. The impact of these proposals on Social Services budgets and services, have been difficult to estimate and require further detailed analysis. Despite this, financial details about the potential costs of replacing long term continuing care beds with residential and long term nursing placements have been provided. It has been calculated that costs for both Social Services Departments could rise to 1.2 million per annum at a time when government expects further reductions in admissions to care. In addition in the last financial year County Social Services needed to find £250,000 for the costs of additional placements due to the closure of Mellers Court.

6. Social Services have also raised concerns about the impact upon home care services particularly because of the proposed changes to

the Rehabilitation services. Estimates of the amount of beds lost can be equated with potential days when care may be required in the community. Using the PCTs' most recent figures in these papers, reducing bed stays by 17 days for 840 patients per annum, translates to an additional 14,280 days when care could be needed in the community. The medical rehab proposals say that they can meet the needs of that same number of clients by moving them through faster and shortening the length of stay, with little impact on SSD. This is an assumption. There needs to be supporting evidence to suggest how the new teams will reduce levels of dependency significantly where remodelled.

7. There is a need to undertake an impact assessment of the medical rehab proposals on both primary and social care. We would like to see the patient pathways for both proposals, clarifying before and after scenarios and indicating patient numbers and financial flows

8. Also Health papers do not acknowledge that financial support has been provided from Central Government to help reduce delays in the acute sector as part of 're-imbursement' arrangements. No such support has been provided in the non acute sector for wards at Highbury and Lings Bar and this continues to be the case for all non acute beds. The need for increased funding in this sector has been raised as a national concern by the Association of Directors of Social Services.

9. Within the City, one paper in particular indicates the role of delayed transfers of care and claims these are caused by Social Services. They state that this is a cause of longer stays in medical rehab than needed and that this is because of the wait for social care packages. Figure given for June 05 to April 06 show 746 cases (13%) with an average number of delays of 16 days per week.

10. The paper also highlights the involvement of the local authority in a way that ignores our ongoing concerns and requests for clarity and information. Both Officers and Chief Officers have been in direct discussions over outstanding concern and correspondence exists to evidence this.

11. Within the County we do acknowledge there have been problems with delayed discharges at Highbury Hospital and Lings Bar but most recently work has resulted in a general reduction in these delays, progress which has been recognised by Health personnel. In addition, by match funding some placements at the end of the year, work on a collaborative basis continues with Rushcliffe PCT to ensure delays are kept to a minimum.

12. With regard to references in these Health papers to find a longer term solution to this problem within the County, Social Service Officers felt the investment offered was too small to achieve the targets requested by the PCT to reduce delays in discharges on a longer term basis. The

offer also needs to be seen within the context of a closure of a rehab ward (already due to staffing problems) which resulted in significant savings to the PCTs and additional pressures for SSD's.

13. More generally the Rehab papers must show how the funding saved as a result of these changes will be reapplied in the future. The changes proposed to the medical rehabilitation services, although reducing beds will still approximately cost as much. The new investment, is hospital rather than community focused.

14. The demographic projections given need to be taken further into actual figures showing patient flows.

15. The comparisons with the rest of Nottinghamshire for the number of Continuing Health Care beds are not valid. Comparisons with a relevant comparator area have been requested. It is not useful to compare numbers of Continuing Care beds needed between a city like Nottingham and Bassetlaw or Newark.

16. The audit by clinicians was a desk top audit not a round of full assessments. We were not involved. They may well have come to the same decisions.

17. The reduction to 45 beds is not fully evidenced and sites the Trust as the source of this number.

18. The community based model of care in both proposals is not fully worked out costed or agreed. Within the Mental Health Teams, as well as investment in nurses and doctors, SSD's are eager to see significant funding provided for workers who can give 'hands on' support to carers and dementia sufferers. Ideally such help would be provided outside office hours. We believe such proposals would be welcomed by service users and their families

19. The performance figures for the City do show an increase in placements in nursing care since the placements into Continuing Health Care beds was stopped by the PCT. There is emerging evidence that this is the case in the County. In order to meet the performance targets in the City the Community Mental Health Teams would need to reduce admissions to care homes by 15 per year. Similar targets would also be required in the County. Work is needed to identify what has happened to those people who would have gone into this provision but must now be going elsewhere. The admission figures should have been going down due to other work and our hypothesis is that these are in fact remaining steady because of the loss of Continuing Health care beds. This hypothesis needs to be tested.

20. There is concern that existing services are being withdrawn without an alternative service in place before the new proposals can come on line. There is no indication of the need for augmenting of existing services

or transitional funding to social care while funding is being withdrawn from existing services in both continuing care beds and medical rehab configuration.

21. It is suggested that in current partnership redevelopments 'financial viability' for all organisations should be a guiding principle to prevent cost shifting. Whilst the 'general direction of travel' of these proposals is welcome, they still pose significant financial risk to SSD Departments because of the potential increases in funding required for additional care home placements and increased demand for home care and other services. These proposals do not provide solutions to these concerns currently.

22. There remains a commitment to constructive partnership and the development of appropriate services. It is proposed that any such partnership should be set within the following framework:

    - Financial viability for all organisations
    - Acknowledgement each organisation must make efficiency savings
    - Demonstrably better outcomes for service users/patients and carers
    - Clear and robust information about the implications of any proposals for each organisation

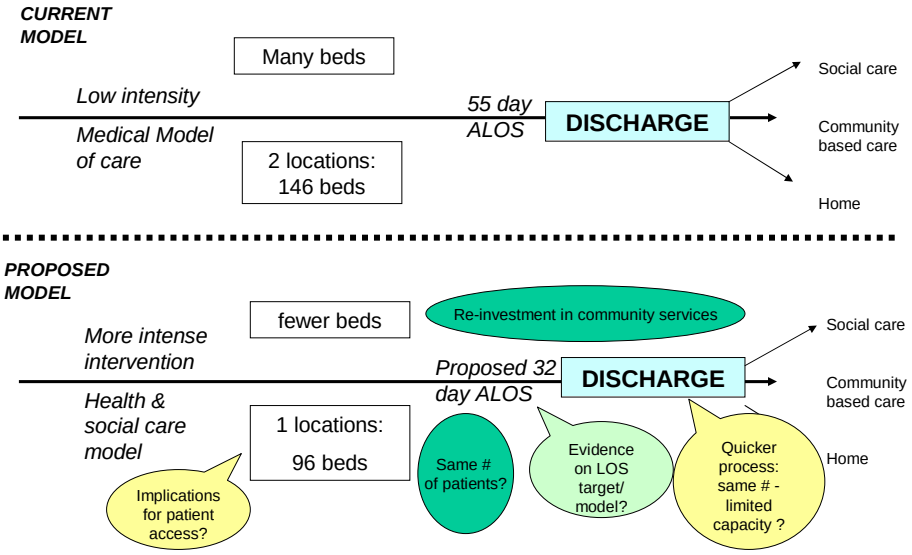
23. In relation to these proposals, SSD have requested specifically the following:

    - That patients in health care beds affected by these proposals should not have to pay for their care if transferred out of hospital. This has now been accepted by health colleagues
    - That any re-investment in health services should be linked to jointly agreed targets particularly numbers of people helped to live at home and reductions in admissions to care homes
    - That Health should make transitional funding available over the next few years or until the implementation plans are complete.

24. These points have been discussed in some detail at senior level.

Appendix 2

Current & Proposed Pathway transition: Older People's Rehab services



Current & Proposed Pathway transition: Older People's Mental Health services