Walsall Council

Walsall Healthcare NHS Trust

Walsall Clinical Commissioning Group

Health and Social Care Scrutiny and Performance Panel

17 July 2014

Commissioning Winter Capacity 2014/15

1. Purpose

1.1. This paper outlines the proposal to commission beds in care home settings as part of an overall Joint Capacity Plan for Winter 2014/15. This proposal aims to bring stability to the urgent and emergency care system in Walsall which is currently experiencing continuing difficulties. These include achieving the 95% target for 4 hour waits in Accident and Emergency and pressures across the health and social care system as a consequence.

1.2 The Swift Discharge Suite in the Manor Hospital has been commissioned as part of discharge arrangements between the local authority and Walsall CCG. It has an important role in supporting hospital discharge. The current location as part of the hospital means that it is not in the right place to provide the discharge to assess approach to patients with complex needs, and with such high demand on hospital beds it has become necessary to commission alternative model of care in a care home setting.

1.3 The aim in brief is to replace the Swift Ward in the Manor Hospital with alternative provision in care homes, through block contracts in the winter of 2014/15, within the current £1.8m funding under joint agreement between the CCG and the Council for this service. It will also improve the outcomes for patients in alternative provision through a homely setting and in reach of support from community health and social care.

1.4 The proposed model of care will be tested and evaluated over the next 12 months. However the current pressures on the bed based care services in Walsall means a carefully managed transition plan for bed capacity is necessary for the winter of 2014/15. Funding for interim additional capacity in the hospital will also need to be agreed between partners as part of the winter plan.

2. The recommendations approved by the Health & Wellbeing Board

2.1 To endorse the Executive Director of Social Care and Inclusion commissioning between 34 and 40 beds in care home settings, as support for people being

discharged from hospital unable to return to their own homes immediately, or to provide an alternative to a hospital admission.

2.2 To recommend to the Walsall Council Cabinet in September 2014 approval to award contract(s) arising from the procurement exercise.

2.3. To recommend to the Walsall CCG Governing Body the amendment necessary to the S256 Agreement on joint funding for this capacity with Walsall Council.

2.4. To note the requirement on NHS and local authority commissioners to ensure funding of 2014/15 winter plans incorporates the costs of this proposal spot purchase of community bed capacity and the additional costs of the residual 34 hospital beds (previously Swift) within planned budgets by the Walsall CCG and Council.

2.5 To also note the requirement on commissioners to undertake an impact assessment of this proposal on the joint funding in 2015/16 under Better Care Fund.

3. Background

3.1 There is a national target that no less than 95% people who attend A&E should be seen, admitted, treated or discharged within 4 hours of arrival. This is monitored on a daily basis and, by the end of May 2014, the standard had not been achieved at the Manor Hospital for eleven consecutive months. In the 10 week period from April to the end of the first week in June 2014, compared to the same period for 2013, attendances had increased by 6.1% (from 16,071 to 17,182), and the number of people where the four hour target was breached had increased by 95.92% from 906 to 1,775. The latest position is that the target has been achieved for 89.96% of people attending A&E since the start of April 2014.

3.2 An overall Joint Capacity Plan for Winter 2014/15 is being developed between Walsall CCG, Walsall Healthcare Trust and Walsall Council. The aim is to reduce A&E attendances using a range of initiatives including media campaigns and improving access to General Practice. The high level of A&E attendance is having a consequential impact on the number of emergency admissions to hospital, particularly people aged over 75 years. The Joint Capacity Plan for 14/15 therefore aims to not only reduce attendances at A&E, but also to reduce hospital admissions, and to reduce lengths of stay of those patients occupying a hospital bed who no longer need medical treatment.

3.3 The majority of people admitted to hospital can go home after medical treatment. There are some people who need support in the form of rehabilitation or reablement and, where they are not well enough to receive this support at home, then arrangements can be made for them to go to SWIFT, or an intermediate care bed at Hollybank or one of the nursing homes. However there is a relatively small, but still significant, number of patients whose circumstances at the point where they no longer

need medical treatment are more complex. For instance, they may be unable to make their own decision due to dementia, or their main family carer may no longer be able to cope so that they may have reached a point where they and their family need to make a decision about them leaving the family home and entering a care home.

3.4 These are difficult decisions and patients/families often need more time to recover from their medical treatment and to decide what should happen next. Sometimes the whole family is involved in these decisions. During the last 12 months there has often been between 50 and 70 of these kinds of patients occupying a hospital bed.

3.5 If patients remain in hospital after they are medically fit to leave then there is a risk of hospital acquired infection; of falling over in an unfamiliar environment; or of losing independence to the point where returning home may impossible. Therefore, it is important to ensure that these patients are discharged as soon as possible to a care home setting with in-reach support, and thus have the time needed to complete the process of deciding what should happen next.

3.6 The role of adult social care is to work with health colleagues to assist these patients/families through a process of multi-disciplinary assessment and care planning. This assessment process must take into account many factors including the overall health and prognosis of the patient; the need for active rehabilitation via physiotherapy or occupational therapy; ongoing nursing and care needs; medication; carer circumstances; financial circumstances; transport arrangements, the suitability of the home environment for the patient to be able to go home, and so on. Social Workers and social care reablement staff are located in the Manor Hospital working closely with ward based staff to conduct these assessments and to plan for discharge.

3.7 The planning assumptions for 2014/15 are that the number of intermediate care or transitional beds will not be lower than was in the system during 2013/2014; this might include residual beds left in the space vacated by the Swift Discharge Suite; the aim is to stabilise the system as a phase 1 over the lifetime of a joint capacity plan for the future.

4. Swift Discharge Suite

4.1 Swift Discharge Suite is a 34 bed ward sited in the modular block at the Manor Hospital. The suite has been operational since 17 October 2011. The suite plays an extremely important part in facilitating complex discharges, enabling effective and efficient patient flow by placing patients in a different, and more appropriate environment, enhancing the patient experience and outcomes and in helping to maximise independence, effective utilisation through nurse led services and GP involvement.

4.2 The Swift Discharge Suite in The Manor Hospital is commissioned by Walsall Council through a S256 Agreement with Walsall CCG at a current cost of £1.8m per year. This provision is to provide somewhere for these patients to be able to leave the hospital and transfer to more of a care home setting so as to be able to prepare to return home, or to make a decision about a permanent move to a care home.

4.3 The profile of the patients being admitted to Swift Discharge Suite are that of frail elderly with multi-pathology who have difficulty in participating in active rehabilitation and reablement due to the nature of their needs. An evaluation of the unit in early 2012 concluded that it could more realistically be described as a complex care discharge unit.

4.4 The location on the hospital site was chosen because either local nursing homes did not have the space for such a unit, or those that did were the subject of concerns about quality of care and there was no other suitable site. However, the location has meant that over time the unit has become more like another hospital ward, particularly at times of high escalation when there are people in A&E who have been waiting for more than 4 hours for a bed to become available. This, together with the need to improve the hospital discharge process between the hospital and social care staff, has meant that it is not working as effectively as was originally intended to support those people with a complex range of circumstances to go home in a timely way.

4.5 The Health and Social Care Integration Board has therefore examined the benefits of commissioning an equivalent amount of beds in an independent sector care home setting(s), which will operate as was originally intended for Swift as part of the Joint Capacity Plan for winter 2014/15. This is described as a 'Discharge to Assess' unit on the basis that the aim is to support the patient to transfer out of a hospital bed and to complete the assessment process elsewhere in a care home setting which is much more homelike and less medically oriented. Such an arrangement is referred to as 'step down' from hospital, and so these beds would be 'step down' beds. A clear time limit of usually up to a period of around 6 weeks (with acceptance that some people may need longer) for these placements is agreed as part of the care plan. These are not permanent admissions to a care home and patients are not charged for the short periods involved.

4.6 The patients for this unit would be identified via the new hospital discharge arrangements as described above. The daily care will be provided by the care home and the multi-disciplinary assessment and care planning arrangements will be led by social care, working with Dudley and Walsall Mental Health Trust for mental health placements.

4.7 The aim is to improve the flow of patients out of the Manor Hospital and to enable the individual and family members to have the time needed to make sometimes difficult decisions about what happens next. This will improve the patient experience and lead to better outcomes.

4.8 The new unit will also support some people who need a clinical intervention that means they can no longer remain at home, but which does not have to be carried out in a hospital. Transferring from the family home to this kind of unit is referred to as 'step up' and is an alternative to a hospital admission. Due to the limited capacity available in care homes within Walsall It may be necessary to have a greater number of units in different care homes. This may be necessary to enable these homes to ensure high quality services; the precise details will be determined by the procurement exercise.

4.9 The care home would need dual registration with the Care Quality Commission for nursing care and residential care and will also need a registration to support older people with mental health problems (referred to as Elderly Mentally Ill (EMI)). Dudley Walsall Mental Health Trust Community Teams for Older People with Mental Health Problems provide case management support for EMI placements in care homes, and will be involved in the planning and commissioning of these additional beds. Case management capacity will be needed within the Council Assessment and Care Management Teams, and for mental health expertise for the case management process.

5. Financial Considerations

5.1 Funding for the current Swift Discharge Suite is currently transferred from Walsall CCG to Walsall Council under a S256 Agreement, which enables the Council to commission the Unit from Walsall Healthcare Trust. The sum is £1.8 million per annum and this will be incorporated in to the Better Care Fund from 2015/16 onwards. This is the sum available for the Council to commission alternative beds in care home settings, and the S256 Agreement will be amended to reflect this change on award of contract in September 2014.

5.2. The Walsall Clinical Commissioning Group is currently in discussions with Walsall Healthcare Trust over how the Swift Discharge Suite will continue to be used once the new unit is up and running. The hospital remains under considerable pressure and there is agreement in principle to continuing to use the ward to contribute to the management of the high numbers of frail elderly people with multi-pathology entering hospital on an emergency basis. However, there is a financial risk to Walsall CCG associated with continuing in using the ward (albeit on a different basis) that was previously used for Swift.

5.3 The cost of these beds in a care home setting will be higher than the standard fee levels paid by the Council, because the residents will have a higher complexity of need. However, it is envisaged that overall these costs will less than in a hospital setting and represent better value for money. The precise costs will be determined by the procurement exercise.

5.4 Further funding within the £1.8m for this scheme may be needed to cover the costs of joint community health and social care to these care home beds. Longer term decisions on funding these support elements will need to be made in the context of the overall funding commitments set out in the Better Care Fund for 2015/16.

6. Governance Arrangements and Timelines

6.1 The Walsall Health and Social Care System Resilience Group is supporting the arrangements needed to commission these care home beds, as part of a "Whole system" approach in advance of the Better Care Fund arrangement from April 2015. The Health and Wellbeing Board is being asked to provide oversight and endorsement to the tender, prior to the Walsall Council Cabinet making a decision on the award of contract(s).

6.2 Notice to the Walsall Healthcare NHS Trust will be served by the Council to vacate the Swift facility for its present purposes and, subject to final award of contract, for replacement by March 2015.

6.3 The provision of adult social care services are currently covered by Part B of the Public Contracts Regulations 2006 (as amended). In these circumstances, there is no mandatory requirement to subject the contract to the full EU procurement requirements, although the council must still act in an open, transparent and non-discriminatory way so as to comply with EU Treaty principles.

6.4 The award of a Part B Service Contract should be subjected to "a degree of market testing to ensure the general principles of equal treatment and non-discrimination on grounds of nationality are not undermined." The European Commission has suggested that the procurement obligations can be met if there is a "publication of a sufficiently accessible advertisement prior to the award of the contract".

6.5 In order to satisfy the above requirements, the process to complete procurement and then recommend award to Walsall Council Cabinet is likely to take 3 months. An item has been added to the forward plan for a Cabinet meeting in September 2014. The aim is to complete the procurement exercise in time to award contracts during October 2014.

7. Conclusion

7.1 A Joint Capacity Plan for Winter 2014/2015 is being developed which aims to bring stability to the urgent and emergency care system in Walsall for the winter 2014/15. The aim of the plan is to ensure patients receive urgent and emergency care in the right place at the right time and have an enhanced patient experience. It also aims to ensure that there is individualised multi-disciplinary support for people on discharge.

7.2 This proposal to commission ‘step up’ and ‘step down’ beds in care home settings is a part of this plan and, together with improvements to the hospital discharge process, will mean that a small but significant cohort of hospital patients with complex needs who no longer need to occupy a hospital bed, but are not yet ready to return home, will have a high quality interim placement in a care home setting. The aim is to improve the flow of patients out of the Manor Hospital and to enable the individual and family members to have the time needed to make sometimes difficult decisions about what happens next. This will improve the patient experience and lead to better outcomes.

Report Author

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