

The Bristol Health Services Plan

**An assessment of the impact on
the delivery of social care
services for older people**

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EXECUTIVE SUMMARY

The Bristol Health Services Plan describes a series of changes to develop healthcare across Bristol, North Somerset and South Gloucestershire. The changes are focussed around acute hospital provision but are also characterised by the development of local services to provide more accessible and appropriate care.

Though formally welcomed there are concerns that the plan may generate unintended consequences on social care and particularly on the delivery of older peoples services.

This study was commissioned by South Gloucestershire and Bristol City Councils and NHS organisations to assess the overall impact of these changes and any risks as well as reaching conclusions and making recommendations for the future.

The fieldwork and research was undertaken over a period of 5 weeks and included interviews with key managers and practitioners both individually and in groups, a review of relevant documentation performance and management information and research evidence.

The national context explains how services have developed; identifies the key policy drivers for health and social care; the basis for planning; the strategy for older people and the centrality of partnership working in delivering effective care provision.

The local context sets out the current local situation with a focus on the financial backdrop – some key information on performance and other factors are shown in annexes to the main report.

The aims and outcomes of the BHSP are shown alongside a description of the model of care to be delivered. Much of the detail in implementing the plan has yet to be confirmed but assumptions are shown based on reduced lengths of stay, investments in community services and better means of managing demand.

Currently implementation work is proceeding which will give clarity on how funding will be redirected to support the shifts in community activity and how the planning and timing of changes will be achieved to ensure overall care is well provided for. Overall affordability of a strategic plan is always a requirement and this work is expected to be completed shortly. Local transformation teams are already in place to clarifying the detail of new local services. They will continue to play a major part as implementation progresses.

The principle causes of concern of the two councils are pressures arising from current demands and the impacts that reducing beds and shorter lengths of stay may have on the delivery of personal social care.

The report has focussed on these aspects. It has not examined other aspects of the plan e.g. the shift of outpatient and diagnostic work to community settings or the changes in specialist surgery or site rationalisation which are concerned to have little or no impact.

The report describes the importance and complexity of dynamics in the whole system, recognising the interdependencies between health and social care and the difficulty of being able to isolate the effects of change in any one part of the system.

From the perspective of managers more work needed to be done on early engagement by strategies. There had not been enough work done to understand the relationship (“gearing”) between health and social care especially the very different throughput rates in the two systems. There were both pressures in the current system as well as evidence of inefficiencies and shortfalls.

Practitioners similarly agreed on the current pressures in the system, the particular needs of older people including their mental health needs and pressures of time. Some difficulties over care co-ordination and discharge remain as well as unresolved problems of domiciliary supply.

The study of documentation showed some useful methods and results in looking at appropriateness of care in the health system which had not been extended into social care. Internally commissioned reports and regularly emphasised the need for improved strategic commissioning, improved partnership working and communication and better clarity on common purpose, priorities and objectives.

Given the short timescale for this study there was only time for a preliminary study of research evidence. Whilst inconclusive the need for flexibility, and partnership was underlined together with the need for modelling service requirements.

A summary overview of performance and management information shows how the health and social care system is performing and changing in response to efficiencies, government policy and targets and changing demography. Taking a view of health and social care system over time shows how length of stay has reduced – and will continue to reduce – with more efficiencies.

These improvements have not always been matched by efficiencies and changed practice across the system with the result there is a lag in progress, or lack of synchronicity giving rise to current pressures which have accumulated over time.

The particular needs of older people and the nature of the social work task mean that time itself has become a more precious commodity over time. Better arrangements for assessment, transitional care and for obtaining a more durable supply of domiciliary care are areas which need to be currently examined more carefully.

As the implementation phase gets underway there are positive opportunities to plan, shape and redesign services and produce more co-ordination between health housing and social care. Local transformation teams are already rising to the challenge but their work needs to take place in a context of strengthened strategic co-ordination and leadership underpinned by common objectives.

Key Findings

1. The report finds that the BHSP represents a series of changes that have been underway for some considerable time and are consistent with national policy. Adjustment through new agreements on joint commissioning is indicated to ensure efficiency in the system as is the need to adopt a whole system approach to change.
2. At this stage no direct or automatic link between shorter lengths of stay and pressures on social care have been found providing these are achieved through clinical efficiencies and better management of the care pathway.
3. The report recommends 6 actions to remedy current issues in the system along with positive steps to develop and regularise partnership working especially at strategic level along with the basis for greater transparency in planning and a framework for monitoring change and modelling demand. Areas for further work are also indicated.

1. INTRODUCTION

- 1.1 The Bristol Health Services Plan (BHSP) was published as a consultation document in September 2004. Its focus is the redevelopment of acute services for people living in Bristol, North Somerset and South Gloucestershire over the next ten years. The key features of the plan:
- a. the substantial transfer of services from acute hospitals to community settings, including the development of new local hospitals and community services.
 - b. developments in acute services in Bristol and South Gloucestershire
 - c. the establishment of a new acute/ emergency hospital replacing general hospital facilities at Frenchay and Southmead.
 - d. Rationalisation/ centralisation of specialist surgery and children's services
 - e. Expansion of services at Clevedon and Weston

have been generally welcomed and supported. The plan covers other developments already underway including the new South Bristol Community Hospital and agreed investments at the Bristol Royal Infirmary.

- 1.2 The Joint Health Scrutiny Committee (JHSC) established to examine the Plan has expressed some concerns over a number of aspects of the BHSP and in particular the impacts on social care provision, reflecting the views of Bristol & South Gloucestershire Social Services Departments which
“support the objectives of the BHSP....but remain seriously concerned about the impact on older peoples services and also of the financial recovery plans of local health organisations.”

- 1.3 In recognition of these concerns, NHS organisations responsible for implementation of BHSP together with Bristol City Council, Social & Health Services Department and South Gloucestershire Community Care Department have commissioned this independent evaluation to assess the impacts on social care. The work was formally commissioned in May 2005.

2. THE REMIT

- 2.1 The terms of reference agreed with the representatives of the commissioning organisations are
“to assess the overall impact of the BHSP and relevant recovery plans on the delivery of social care services for older people in the short, medium and longer term.”
- 2.2 The work will take into account the proposed changes in the way healthcare will be delivered (for example the proposed reductions in overall bed numbers and the associated reductions in length of stay) together with current alternative health and social care provision.

The specific objectives are to: -

- examine the impact on key areas of social care delivery and performance
- assess the level of risk of the BHSP proposals on social care departments and service delivery

- reach conclusions and make recommendations on changes in policy, practice and joint working
- outline a monitoring framework; and
- recommend any further action required

2.3 The full terms of reference are set out at **Annex 1**. It should be noted that although North Somerset have not been formally engaged in the commissioning of this study they have been kept informed of the objectives and progress and will assess the relevance of the results for local services.

3. METHODOLOGY

3.1. The study commenced in late May with a requirement for a completed report by the end of June. Necessarily this compressed timetable has meant that a comprehensive examination of every aspect has not been possible. Instead key areas have been agreed through prior discussion with representatives of commissioning bodies. Areas for further investigation or other work are indicated at the end of this report.

3.2 The general approach has been to bring together information and evidence from five key streams of enquiry:

- semi-structured interviews with managers, health and social care professionals and other staff at a range of levels in all of the key organisations
- the establishment of multi-agency reference groups to consider key aspects of service planning and delivery associated with BHSP. Two separate groups were established for managers and practitioners.
- analysis and assessment of a range of information on finance, activity and performance across the care system and including the examination of data and planning assumptions
- review of recent reports and other studies relevant to planning and commissioning of services and the organisation and delivery of health and social care activity
- summary of current research and literature relevant to the study

together with examples of approaches and best practice developments underway across the UK and despite original intentions. There has been only very limited opportunity to take evidence from user and carer representatives. In addition opportunities have been taken to hold discussions with local community teams and existing planning groups – for example the established Transformation Projects.

3.3 Liaison points were established in both Councils to facilitate early contacts with key individuals, collate relevant reports and data and to guide enquiry. Contact points were also established in each PCT and each of the two hospital trusts. The project was managed and co-ordinated from accommodation provided in the Chief Executives office of Bristol City Council.

- 3.4 The approach taken reflects the need to identify some early conclusions within a very short timescale on possible impacts and to
- Identify improvements in policy, practice and joint working
 - Outline arrangement for more systematic monitoring to inform commissioning

The approach has relied heavily on interviewing and listening to the views and experiences of those involved first hand in the commissioning and front line delivery of services; and through that process arriving at informed consensus.

4. CONTEXT

The National Context

- 4.1 **The NHS Plan** published in 2000 marked out the beginning of a ten-year process of reform and modernisation with an emphasis on addressing long waiting times, access and quality of care. The drive has been to improve capacity and capability whilst making services more locally responsible and appropriate to the needs of the individual.
- 4.2 The Government continues to reaffirm its focus on public sector reform with the '**NHS Improvement Plan – Putting People at the Heart of Public Services**'. The agenda continues to emphasise value for money and efficiency in NHS resources, the development of personalised care, more choice in where, when and how patients are treated, all underpinned by:
- better staffing
 - improved integration with social care
 - greater engagement with independent sector
 - significant reductions in waiting times and
 - a better focus on public health
- 4.3 This is an agenda which has many area of convergence with social care where present objectives were set out in **Modernising Social Services**, published in 1999. The recent Green Paper '**Independence Well-being and Choice**' similarly emphasises – perhaps in slightly different language the need for:
- more choice and control over care
 - greater integration with NHS and local services
 - more personalised care
 - better prevention, more pro-active engagement
- and as with the NHS – to be able to plan services more flexibly around the needs of the individual by freeing up resources and unlocking the potential of strategic commissioning.
- 4.4 The need for **integrated approaches** to planning and delivery is emphasised in current national guidance "**National Standards: Local Action – Health and Social Care Standards and Planning Framework 2005 – 2008.**" The framework requires NHS organisations and local authorities to build upon existing partnerships and work more closely together by setting local targets to achieve national standards and targets. The achievement of standards will be measured by the Healthcare

Commissions new assessment framework and by the assessments carried out by the Commission for Social Care Inspection.

4.5 For the past decade there has been relative consistency in the themes of promoting independence, shifting care away from reliance on hospitals and residential care, towards models which enable care to be provided closer to home. This model is further developed as more treatments, tests and interventions – once traditionally undertaken in general hospitals – are progressively undertaken in local community facilities with Acute hospitals increasingly focussed on emergency care, assessment, stabilisation and treatment.

4.6 **The National Beds Inquiry** (NBI) published in 2000 provided a framework and alternative scenarios for examining future needs. It describes an approach to long term planning for hospitals and related health and social care services. One scenario – “care closer to home” most closely resembles, the proposals set out in the BHSP. Key characteristics are:

- active investment in intermediate care
- expansion of community-based health and social care services
- a tighter remit and treatment focus for acute hospitals
- a shift in health activity with certain diagnostic, out-patient, treatment and aftercare procedures taking place closer to where people live

In summary the model is one in which primary and community health and social services are substantially expanded, allowing for reduction in dependence on traditional acute beds through reducing the need for emergency admissions and by reducing length of stay whilst improved clinical and other efficiencies allow for increased in-patient / day case activity. It is a model which in general principle is now being widely adopted as the basis of reshaping the delivery of care, underpinned by reforms in the way services are commissioned.

4.7 The NBI concentrated heavily on the impact of older people on health and social care resources demonstrating the high and intense resource use by this group. Those over 65:

- Account for slightly more than 50% of combined health and social care resources
- Occupy up to 2/3 of available acute hospitals bed days
- Account for 40% of all emergency admissions and 80% of GP consultations
- 75% of those over 75 have more than one chronic condition

Present national projections indicate the number of people aged over 65 will increase by 50% over the next 20 years whilst those over 90 will double.

4.8 **The national strategy** for meeting and improving the health and social care needs of older people is set out in the National Service Framework published in 2001. The four themes in the NSF were:

1. Respect for the individual
(Rooting out age discrimination and tailoring services to individual needs)

2. Development of intermediate care services
(services designed to prevent unnecessary admission to hospital, support early discharge and reduce/ delay the need for long term residential care)
3. Providing evidence based specialist care
(improvements in general hospital care, stroke services, mental health services and reductions in falls).
4. Promoting a healthy active life
(a programme of action to promote a healthy, active and independent old age).

Implementation of the strategy has been the responsibility of councils and NHS organisations working in close partnership.

4.9 **Partnership** and collaborative working between the NHS, local councils and other organisations have been an enduring theme in the delivery of care services over the past three decades. If people are to receive timely accessible and appropriate care then health, housing and social care services need to be planned commissioned and delivered with the closest of collaboration. Legislation has emphasised the importance of joint working with a steady shift from permissive powers to explicit duties set out for example in:

- 1999 Local Government Act
- Health Act 1999
- Local Government Act 2000
- Health and Social Care Act 2001

The recent consultation paper on the future of social care raises the question of whether further duties may need to be imposed to ensure collaboration in the planning, commissioning and delivery of services. Continued progress in the improvement of health and healthcare is emphasised in the recent public health white paper and the new framework for managing long term conditions.

4.10 **The Local Context**

The local context for public services is one where improvements in overall performance and delivery of service is facing substantial challenges. Financial pressures and the need to live within means are both current and recurrent themes.

4.11 **In social care** pressures arising from demand for services, requirements for greater efficiency and the need to deliver more responsive needs led (rather than service led) services are key priorities.

Both Authorities are facing budgetary pressures of differing magnitude for social services. Such pressures arise mainly from increasing demand for and expectation of services delivery from the public together with increasing costs from both in-house and externally provided services. Bristol Social Services for example overspent its 04/05 budget by £6.5million (5.7% of its net budget); South Gloucestershire overspent its adult care budget by just under £0.5million (1.2% of the net budget). Early indications for the current year suggest that both authorities will need to

develop tighter budgetary controls or alternative means of delivery services in order to maintain financial balance. Bristol for example are developing financial recovery plans which will offset an emerging in year budget pressure.

- 4.12 **In healthcare**, organisations are having to address financial deficits as well as improving performance on key areas of waiting and access. Achieving improvements in services whilst bringing performance closer to national benchmark positions for example in utilisation rates and average lengths of stay will prove particularly challenging. Several of the Trusts and PCTs in BNSSG have underlying deficits which they are planning to eradicate by 2006/ 07. Plans of PCTs in 2005/6 require savings of £23.8m with approximately £5m yet to be identified. In addition to these savings PCTs will need to manage down activity in the acute sector worth approximately £8m. Plans for 06/07 will also require savings in addition to the need to put in place initiatives to manage demand for the foreseeable future.

5. THE BRISTOL HEALTH SERVICES PLAN

- 5.1 **The key changes** associated with the BHSP are well understood and have been summarised earlier. This report is focussed on older people who remain the major users of health and social care services. For them successful implementation of the plan will mean:
- Improved access to local community hospitals and healthcare facilities providing a range of services currently carried out in larger general hospitals.
 - Better care and support at home/ closer to home provided by health and social care teams with services providing for greater independence
 - Improvement in acute facilities, including specialist care leading to faster access to emergency care and reduced waiting for planned care.
- 5.2 **Assumptions in preparing the plan.** The BHSP is planned on a model of care which aims to deliver a range of care services closer to home. The model has been outlined earlier. The consultation document promises a “substantial” transfer of services from acute hospitals with more health and social care teams, additional intermediate care services including greater provision of therapy services. The plan does not appear to specify the amount of activity or the cost of providing these services at this stage.
- 5.3 In terms of examining future demand for services the plan concentrates on the likely numbers of beds required in the system. In arriving at these figures assumptions over growth in activity will be reached following an assessment of detailed demographic data and historic patterns of demand, modified by the effects of a number of initiatives to improve efficiency and manage demand.

The overall bed requirements at NBT for 2012 is as follows:

| North Bristol NHS Trust Inpatient beds (acute and community) | |
|---|-------------|
| • Current beds needed | 1478 |
| • New beds to allow for growth | 109 |
| • Transfer to BRI | - 29 |
| • Impact of increased day cases | - 11 |
| • Length of stay improvements | - 262 |
| Total beds needed in 2012/13 | 1285 |

Separate figures for changes at UBHT including the reprovision of beds from BGH are being confirmed.

Apart from the transfer of 29 inpatient beds to UBHT the overall bed requirements assume increased capacity arising from improved performance for length of stay and day case rates equivalent to the levels of performance achieved by the top 25% of NHS Trusts.

The requirements assume reduced occupancy levels close to the 82% target recommended in the National Beds Inquiry.

5.4 **The current status of the plan.** Following a major series of decisions made on March 14th 2005 further work has begun to prepare outline business cases for implementation. This should allow for greater clarity over funding and timing – two issues of significance to the JHSC and the Bristol and South Gloucestershire councils. It is expected that shortly the Health Community will show:

- how funding released by acute service reconfiguration will support community service developments and
- how phasing of all proposals will be co-ordinated to ensure that acute services are not transferred to the community until new community services are in place.

At a local level Transformation teams, representative of key stakeholders including social services, have been in place for some time and are playing a significant part in clarifying the detail of service requirements.

Overall affordability of the plan is being assessed as more detailed information of each component part becomes available. It is understood this work will be completed by the end of the year.

5.5 **The concerns of the two social services organisations.** The concerns of the Bristol Social Services and Health Department (BSSHD) and South Gloucestershire Community Care Department (SGCCD) may be summarised as follows:

- that the BHSP is driven by the need – at least in part – for financial balance rather than improved services for the population

- that managing with less beds in the system may create new burdens and costs on social care services
- that shortened lengths of stay may result in the transfer of certain functions from the health service to social care
- that there is a lack of detail on key parts of the plan coupled with insufficient reliable data on which to plan any necessary re-provision of service
- that appropriate SSD engagement in the early formulation of the plan has been poor and inconsistent

6. FINDINGS

6.1 The delivery of health and social care services take place in the context of a dynamic system of interdependencies and relationships. Often quite subtle changes in one part of the system creates changes in another. Being able to isolate the impacts of any one single change – particularly when those changes take place gradually and are themselves taking place in a system which taken as a whole is subject to fluctuations in demand and other external factors – is an extremely difficult and often inconclusive affair. The need for partnership and close collaboration in steering through changes cannot be overstated. Indeed the national emphasis on the need to take a whole system view of change and the continuing emphasis on joint commissioning recognises the complexities and subtleties of change and the importance of adopting a flexible stance in deploying resources to meet the full care needs of the population. This is particularly true for older people where health, environmental and social care needs can be complex, intensive and enduring.

6.2 This brief study has been commissioned to provide an overview of the impact of the changes associated with the BHSP on the delivery of social care services. Those changes are characterised by:

- a reducing number of beds in the acute system
- shorter average length of stay
- faster throughput of patients
- a greater reliance on the management of healthcare in community settings

Activity levels will remain in line with demographic and historic patterns of growth modified by investments to manage demand in primary and community based services.

6.3 There is no standard formula for expressing the relationship between health activity and social care needs; there are simply too many variables. Given time constraints the review has taken a practical and pragmatic approach to bringing together conclusions and common themes from several lines of enquiry:

- a. the views of a large cross-section of managers at a variety of levels in the social care and health system

- b. the views of a wide range of health and social care practitioners and professionals including discussions to examine changes in care delivery in three condition areas (stroke, hip fracture and dementia)
- c. examination of recent internal reviews and other documents relating to health and social care organisations
- d. a summary review of research evidence
- e. high level examination of performance data and management information

6.4 **The views of managers.** As a starting point the work has assumed a two-way relationship between social care and health activity. Whilst there are no absolutes there are many commonly held beliefs:

- underprovision of healthcare gives rise to pressures on social care services as health problems manifest themselves in increased demands for social and personal care.
- underprovision in social care creates additional demands in healthcare with increased use of primary and community services, rises in admissions and higher rates of bed occupancy.

A valid case can be argued that there must be some level of service support that decreases for patients who prior to treatment have limited mobility / independence and need help with everyday tasks, who after treatment regain a level of mobility. This would be a case of NHS treatment with shorter waiting times leading to decrease in the need for social care support. This effect is outside the terms of this report and has not been addressed.

6.5 A series of common beliefs or propositions were gathered from an early round of discussion and examination of internal correspondence. These formed the basis of semi-structured interviews and questionnaires. They were also used as an element in discussion with health and social care managers who met together as a reference group for the purposes of the study. An example of some of the themes and propositions are set out in **Annex 2.**

The purpose of this approach was to move beyond anecdote and rhetoric in order to analyse more objectively cause and effect.

6.6 Some of the principle conclusions emerging from these discussions were:

- health and social care engagement in developing BHSP and communicating detail have been inconsistent
- whole system principles have not been adequately addressed in developing the plan
- there are current pressures in the system and these are building

- there are indications that the understandable focus on discharge may be having unintended consequences elsewhere in the system
- the social care response is struggling to keep pace with demands from both hospitals and the community
- assessment arrangements can sometimes be cumbersome, bureaucratic, disproportionate and should be streamlined
- problems in domiciliary supply are increasingly inhibiting smooth working of the whole system
- increases in activity, daily fluctuations in demand, the complexity and intensity of care needs and the different gearing between throughput in hospital and longer term community care need to be recognised in commissioning plans.

Unsurprisingly there were differences of view between managers but equally areas of consensus:

The present arrangements for planning services are insufficiently joined up. At a strategic level the need for a whole system approach to understanding change has been in large part eclipsed by something more akin to muddling through. At operational levels there are more systematic arrangements for responding to the changing patterns of care. However existing pressures in the system – arising from quicker hospital throughput and increasing frailty – need to be planned for and responded to by efficiencies, better targeting and more flexible deployment of resources.

6.7 **The views of practitioners.** There were gathered from individual meetings with those delivering services both in hospital and the community and included discussion with social work team members, clinical nursing and therapy staff, meetings with intermediate care teams, members of the Transformation Projects and those contributing to the reference group established to look at particular conditions.

The key conclusions from the discussions were:

- pressures to improve throughput are giving rise to shortcuts in agreed practice and procedures
- these are contrasts in the degree of joint working and integration across the area and between Bristol and South Gloucestershire
- running the hospital system too tightly removes the flexibility needed for the slower pace of adaption, re-orientation and recovery experienced by older people for example in recovery from surgery and trauma
- greater frailty and higher levels of dependency is being reflected in the increasing complexity of care packages and incidence of “double-handed” care

- there is some evidence of unsatisfactory co-ordination of care and shortcomings in arrangement for discharge planning
- shortfalls in domiciliary supply are seen as a common problem in parts of Bristol and generally in South Gloucestershire
- there is a marked unevenness in access to transitional care causing pressures, inefficiencies and premature decision making
- care pathways are inconsistently developed and implemented. Where these are well developed as in stroke care for example, the pathway remains weak outside the hospital
- Mental health problems including dementia remain undiagnosed or overlooked and are poorly provided for. Frequently this translates into new referrals to social work teams
- Some intermediate care teams are having to temporarily “close” in the face of increasing referrals from primary care (to avoid inappropriate admissions) from hospitals (to facilitate early discharge) and from shortfalls in domiciliary care, meaning handovers are delayed
- Prolonged lengths of stay in North Bristol are leading, in some cases to reduced prospects for rehabilitation for example in stroke care

Practitioners were remarkably consistent in their views on a range of current issues in the system. There were contrasts in the style, depth and commitment to joint working, reflected in the level of integration services delivery. Whilst various procedures were in place to managed and assure standards of care, day to day pressures often meant that shortcuts in agreed practices were taken giving rise to shorter assessment and planning time prior to discharge. Although many thought this was a growing pressure, records of ‘poor discharges’ show no appreciable rise. However there are concerns across both Trusts over the rise in readmissions. A common theme was the expressed view that more transitional care facilities would relieve overall pressures and allow the whole system to function more effectively through more realistic assessments and care planning carried out in less pressurised environments.

Mental health aspects of care remain poorly resourced and feature as an area of concern for both hospital and community teams.

6.8 Examination of documentation made available

Recent studies, reports and other papers relating to the health and social care community provide useful guidance on:

- the appropriateness of care and needs for intermediate and social care provision
- how commissioning and partnership working might be developed

This is not in anyway to be taken as a comprehensive summary but rather documentation that is of current and immediate relevance to the subject of this report.

a. Appropriateness of care studies

Two studies have been undertaken in the last year by NBT and UBHT:

- (1) The **Teamwork** report for North Bristol Health Community analysed the appropriateness of care and the needs of all adult care patients (1253) in the hospital systems in April 2004. Key points of relevance are:
 - 501 (40%) patients could be cared for in alternative settings within their local community
 - of these, 60% were considered to have social care needs
 - approximately 24% of all patients in hospital at that time were identified as having social care needs
- (2) **Matrix Research** surveyed 757 patients in hospitals under the management of UBHT in May 2004 to look at the suitability of patients for Intermediate Care. Key points of relevance are:
 - 148 (19.5%) patients were recorded as needing intermediate care
 - of those 84% required personal and social care as part of their Intermediate Care package
 - 16.5% of all hospital patients at that time required social and personal support

b. Commissioning and partnership

There have been a number of recent reports recommending the need for greater collaboration with partners in health, housing and the independent sector and more progress in commissioning.

- (1) **The Parrott report** commissioned by Bristol City Council and undertaken earlier this year. It focussed on overall activities required to create a more sustainable financial position with greater clarity over purpose and responsibilities with actions to improve efficiency and effectiveness. Key messages of relevance were the need to:
 - establish clear strategic direction with a stronger commissioning role towards service provision
 - focus on the essentials of promoting independence and protecting the vulnerable
 - develop positive partnership and integration within the council and with others

- (2) Similarly in **South Gloucestershire** a review earlier this year into joint commissioning recommended:
- strengthening trust and confidence in partnership working through explicit common goals and objectives
 - defining vision, strategy and purpose
 - developing clarity on priorities, performance and outcomes
 - positioning of partnership working as mainstream
- (3) The National **Change Agent Team** in July 2003 as part of a wider study on delayed transfers of care across Bristol & South Gloucestershire, recognised weaknesses in relationships between health and social care and recommended a number of actions to establish more inclusive mechanisms to develop partnership working and improved communications
- (4) In a recent discussion document on the future arrangement for adult services produced by **Bristol Social Services and Health** proposes new partnership arrangements through the establishment of a single Joint Commissioning Management Board with delegated responsibilities to:
- set strategic direction
 - determine and pool available resources
 - review performance and
 - share and own risk

It is understood similar arrangements are under consideration in South Gloucestershire.

- (5) **The Green Paper on Adult Social Care** sets out expectations for the future vision with a particular emphasis on the need to develop partnership working with a number of organisations. Partnership with the NHS is singled out for particular attention. It suggests several ways to ensure a community wide approach to commissioning including the creation of virtual care trusts or partnership boards. One of the questions for consultation is whether explicit duties should be set for the NHS and local authority work together.

Both reports on Appropriateness of Care and Intermediate Care needs provide information to assist planning and modelling of demand for social care services. Very little reference could be found on commissioning documents to any attempt to set an agreed balanced baseline of activity or to draw any association between health, healthcare activity and activity / service levels in social services departments.

The other reports cited dealing with partnership working; all show an emphatic need for:

- Clear and shared vision with common objectives
- An emphasis on commissioning and value for money
- A focus on priorities and performance
- A stronger and higher profile for partnership working

6.9 Research Evidence

A review of research evidence was commissioned in early June. The review – which should be regarded as a preliminary exercise was focussed on impacts on social care reducing length of stay. First summary results are shown as **Annex 3**.

Within the time available it was not possible to identify any studies which looked directly at this topic. With more time it would have been possible to review more widely around the general issue. The results do not confirm a simple yes or no but do point out:

- The need for flexibility and partnership in commissioning services
- The existence of many variables which will affect results
- The usefulness of modelling in estimating impacts

6.10 Performance and Management Information

A good deal of information exists about activity and performance in the system. Using this information to illuminate the issues around current and future impacts of changes in healthcare delivery is less straightforward. How decisions in health services affect the delivery of social services is tied up with the way resources are allocated across both systems and other variables of which demography, morbidity, housing and economic factors will be of major significance. A summary of data relevant to this study is shown in **Annex 4**.

The summary shows that:

- Hospital utilisation varies considerably between NBT and UBHT (106 compared with 74 per 1000)
- Emergency admissions of over 65s continue to rise
- Average lengths of stay are falling but are still above national benchmarks. Rates for the over 65s are 8.3 and 5.9 days for NBT and UBHT
- Readmissions are rising. Rates are higher at UBHT
- Reported delayed transfers are at an all time low. The greatest cause of delays are now attributed to NHS responsibilities
- Intensive packages of care are increasing but are well below national averages
- Services provided are at a higher rate in South Gloucestershire at 74% of all assessments. The figure has dropped considerably in Bristol to 46%
- Just over half of social services clients have had their needs reviewed in the past year
- Population change for the over 65s are relatively stable in Bristol. In South Gloucestershire numbers of over 65s and over 65s living alone are forecast to rise by up to 50%.

7. DISCUSSION

- 7.1 The key concerns expressed over the BHSP focus on the reducing numbers of beds required in the system because of falling lengths of stay. It is considered likely that reduced lengths of stay/reduced beds will mean that either care or treatment will be reduced or that certain functions or responsibilities will be shifted from the hospital system to community services – and specifically to social services,
- 7.2 The average length of hospital stay has been falling sometimes quite sharply for more than 20 years and particularly for older people. Most recently progress in addressing delayed transfers of care have contributed much to net reductions. This trend currently continues nationally but is showing signs of slowing down. Local lengths of stay are high when benchmarked against national averages. The local objective is to reach equivalent lengths of stays by 2008. Older people have higher lengths of stay, more admissions (including readmissions) and it has been confirmed that such factors have been reflected in the **overall** planning assumptions. Implementation should take account within these overall assumptions of the particular needs of older people.
- 7.3 In the same way that the rapid development of day case procedures have developed as a result of advances in medicine and medical technology similar advances have been made – and will continue to be made – in in-patient treatments through great clinical efficiency and better organisation of the patient pathway. The result will be to shorten active treatment times in hospital, with follow on care (for example rehabilitation and recovery) taking place in other settings including the home. As long as reductions in length of stay are achieved through improvements in the organisation of care and clinical efficiency then the outcomes for patients should be at least as good as they are now (some would argue that outcomes will be better through a quicker return home with prompt access to rehabilitation services where appropriate).
- 7.4 In practice the concerns of the social services departments are that pressures of one sort or another will rise as the hospital system becomes more productive in treating patients more quickly. There is a sincere belief that an element of care is being transferred through these progressive changes. Moreover these changes have been cumulative over many years and are causing an imbalance within the care system.
- 7.5 Through the many discussion and meetings that have taken place over the past few weeks it has been important to understand more about exactly how the system performs in practice. Although the expectation is that the volume of activity in the NHS will remain broadly in line with something close to average growth, this activity will continue to become more intense taking place over shorter timescales. This has increased demand on assessment activity particularly in instances where there are closely monitored times for completion, required by legislation. In other words although activity remains proportional the intensity of assessment work is increasing.

Care of older people is characterised by:

- the presence of a number of conditions often chronic or long-standing

- slower time for recovery and adjustment following trauma or surgery
- an increasing frequency of confusion and disorientation
- a rising incidence of mental health problems

The task of the social worker working alongside the multi-disciplinary team is to make an overall assessment of social and other needs including the needs of carers. This often takes time to make the necessary enquiries and further time to plan and lay on services.

Busy acute, general hospital wards are not the best environment for this work to take place. There is therefore a conflict between:

- the interests of the patient in properly completing an assessment and arranging care, support or other services and
- the interests of the care system in achieving throughput and avoiding reimbursement fines

7.6 Nobody would want to see patients stay in hospital longer than they need – there are risks in terms of health and longer-term recovery and rehabilitation. It would seem that if there is one element of care that is being transferred it is the element of time, and it is reasonable to conclude that creating more time for assessment recovery and planning for the future would enable the system as a whole to work more efficiently.

7.7 Formal guidance and good practice from the Department of Health suggests the inclusion of **transitional** or **interim care beds** in planning care pathways. This is quite different to the purpose of services offered through intermediate care provision. Such provision will enable:

- swifter more predictable discharge planning
- better assessment practice
- reduced risk of premature residential placements
- increased time for adaptation
- more time for supervised recovery

Such facilities can be **jointly commissioned** in a range of ways making the best use of a range of care home, housing, or independent sector provision. Diligence would be required in designing admission and length of stay protocols to avoid misuse, but such arrangements are successfully in place in some parts of the area.

7.8 The supply of domiciliary care services is undergoing significant changes. Both authorities are changing the balance in direct provision to more services being commissioned externally by the council. This coupled with changes in employment practice is creating a more flexible workforce more able to respond

to the particular needs of an aging population. Nevertheless the rapidly increasing use of domiciliary care services to meet existing national targets in supporting more people at home is uncovering longer term supply issues. Recruitment and retention problems have been well rehearsed elsewhere; it is enough to recognise this as a priority for both organisations if effective and continuous throughput is to be maintained across the whole care continuum.

- 7.9 The BHSP as a strategic document addresses change in the healthcare system and is particularly centred on acute care. This focus has overlooked the need to take a wider whole system view of change. It is not in itself an implementation plan but as that phase progresses the need for engaged partnership work becomes imperative. In part this need is being met through the different transformation teams but at authority- wide strategic level, clear structures with linked mechanisms for accountability are yet to be developed.

With the creation of new Adult Care Departments – free of the distraction of children’s services – there are new, real and very productive opportunities to advance joint commissioning and promote the delivery of well co-ordinated and integrated services. Talk of “partnership boards” and similar in both councils will provide structure and commonality that is lacking at present. There is the further opportunity to realise a shared strategic vision built on common objectives and local practices. Leadership to do this will be critical.

- 7.10 There are two further issues which though outside the remit of this study should be mentioned, as they are critical in meeting the needs of older people but often feature as ‘also rans’.

One is the frequent comments which were made about the role of housing and how a more corporate approach should be developed to ensure those Directorates are more formally engaged in planning older peoples services. In both Local Authorities links appeared under-developed, or at least unclear, despite the existence of national targets for the development of very sheltered housing.

The second concerns the needs of older people for mental health services. The BHSP does not address this issue. Work at present underway to review mental health services should make specific reference to how these services will be addressed in the future.

8. CONCLUSIONS AND RECOMMENDATIONS

- 8.1 There has been considerable difficulty in distinguishing between 3 aspects:
- the impacts of change which form part of the ongoing improvement and development in services and are driven by central government policy
 - changes which are being driven by financial restriction imposed by recovery plans and
 - the impacts of change arising from the present and future implementation of BHSP

The absence of any jointly agreed plan for activity and investment has made this task particularly difficult. In some ways the absence of such documents sheds a good deal of light on the substantive issues this report attempts to address.

- 8.2 The current phase of modernisation of health and social care services has been underway for some time. In both health and social care services this has been achieved by improving access, redesigning services, improving efficiency and achieving more appropriate means of providing care. The overarching philosophy has been to keep people well and independent and when they need treatment or care they should receive that promptly.

Key objectives to manage admissions to hospital and residential care through better community support, reduce lengths of stays in hospital, and reduced delays in discharge have all been the subject of targets, guidance, NSFs, special funding and support and advice from special teams and agencies established by the Department of Health.

- 8.3 The need to plan for these changes in partnership between the NHS, Social Services Departments, Housing and other organisations has been the consistent message given and received for sometime. The development of ideas around joint commissioning to ensure there is appropriate gearing in investment and activity between the NHS and local government have been supported by various requirements in the past to produce agreed plans for community services, including joint investment plans and to show agreed commissioning strategies as a prerequisite to release of grants and special funding. Legislation has been drafted to allow organisation to pool budgets and adopt methods to improve commissioning and integrate services. The message is and remains a very clear one.

- 8.4 This brief review whilst finding no automatic or direct correlation between shorter lengths of stay *achieved through clinical efficiencies and better management of the care pathway*, and increased demands on social care services has revealed some existing pressures. These now need to be addressed in a planned way to avoid possible precipitive action later. Areas to be addressed include –

- assessment practice, capability and responsiveness
- the need for interim or transitional care facilities
- supply of domiciliary services

These are current issues affecting services in South Gloucestershire but may be applicable to other parts of the area.

Recommendation I

Using existing joint commissioning mechanisms (or through new or improved arrangements):

- review the adequacy, efficiency and responsiveness of current assessment practice
- review / assess the volume / type of transitional care facilities needed to improve service efficiency and agree the means of procurement
- review the current balance and remit for in-house and externally provided domiciliary care services and agree a sustainable strategy for managing supply.

8.5 A preferred objective for BHSP would be “building better health and social care services in Bristol, North Somerset and South Gloucestershire”. A more integrated approach to the strategy would have secured wider ownership and engagement from the beginning and would reflect the whole system approach expected during the implementation phase. The current transitional arrangements in the two social services departments as they move towards adult care services departments, the consultation on the role of D.A.S.S. and the Green Paper provide opportunity for a better broader partnership approach to strategy formulation and operational implementation. At the least an opportunity exists for an equivalent social services response to reshape and modernise the way services are commissioned and provided.

8.6 Any future risk in the delivery of the BHSP is dependent on the degree of constructive engagement between both Councils and the NHS and the ability to translate this into jointly agreed implementation and commissioning plans. Future business cases should fully reflect the social care dimension and the need to ensure proportionate investment across the whole system. There should be a clear commitment and undertaking to mainstream partnership working as normal working practice rather than an additional layer of work. This should fully recognise the interdependencies in the system and acknowledge the contribution of well organise social care service in transforming peoples lives.

Recommendation II

Agree and establish new partnership arrangements for management and commissioning of services to include structures, reporting mechanisms, internal and external relationships and accountabilities.

Recommendation III

Through a series of joint events between members and non-executives (or through existing mechanisms) establish jointly agreed objectives for the development of the care system based on a shared vision of improving the health and well-being of the local population.

- 8.7 With changes in delivery and demand there is a need to establish transparency in activity and investment between health, housing and social care as a means of ensuring proportionate resourcing across the care system and to facilitate analysis of need, future developments and jointly commissioning priorities.

Recommendation IV

Produce a rolling 3-year joint activity and investment plan, initially capturing and agreeing baseline activity. Agree a formula based on a monitoring framework, (see below) to describe the association between hospital activity and those requiring social care services.

Recommendation V

Establish system performance review meetings to examine data and trends in service demand and performance.

- 8.8 The absence of any means of monitoring impacts of changes over time has inhibited constructive discussions over future needs and resource distribution. Lack of development in this area is a reflection of the acknowledgement of a large number of variables which make it difficult to make confident statements about hospital and community activity. The goal must be to produce an agreed set of reliable information, to inform future commissioning.

Recommendation VI – Monitoring and modelling requirements

Two approaches are recommended to make progress:

1. (a.) The agreement of a data set of high-level indicators which will show overall activity volumes and trends across the system.
- (b.) The development of a set of routinely collected data supplemented by local information to show overall performance and gauge the effect of any change in bed numbers / length of stay on impacts elsewhere
2. The carrying out of a modelling exercise to show the service requirements of older people passing through the system. Details of a proposed framework are set out at **Annex 5**.

9. Further useful work could be undertaken in the following areas in more fully understanding the effects of change across the system.
- Commission further work to review the research evidence in related areas.

- Consider the implications on social care services of the planned developments in Minor Injury Units and changes in the development of ambulance services
- Commission further work to assess the impact of reduced waiting for NHS services on a possible decrease in the need for underlying social care support.

10. The BHSP represents a new vision of healthcare delivery in Bristol, North Somerset and South Gloucestershire. The key changes associated with the plan should be reasonably viewed as a continuation of modernisation and efficiency improvements which have been underway for sometime. The plan has not adopted whole systems methodologies in viewing change and inconsistent involvement of social services organisations have given rise to suspicions and anxiety over consequences for community services. These come on top of existing pressure in managing demand accumulated over recent years, which should now be rectified.

Whilst there is no absence of partnership working it is uneven, poorly coordinated, lacks strategic direction and is not mainstreamed into every day working. It is seen as an additional task in many ways. In parts of the area there has been deterioration in relationships with evidence of entrenched positions and the emergence of a blame and victim culture.

With implementation and with new social care organisations with new roles and responsibility there is now the opportunity for a real step forward in partnership working and a decisive shift towards greater collaboration and problem solving.

New mechanisms are needed at strategic level to develop co-ordination and to harness and consolidate the benefits of joint working. Improvement are required in the methods used to inform commissioning with a system in place to show the relationship between health activities and demands on social care.

BRISTOL HEALTH SERVICES PLAN
SOCIAL SERVICES IMPACT ASSESSMENT

1. CONTEXT

- 1.1 The Bristol Health Services Plan (BHSP) model of care is based upon a significant transfer of activity from acute hospitals to community-based services. Capacity in community settings will be a critical factor in terms of delivering a sustainable whole systems response to the health and social care needs of older people.
- 1.2 The joint health scrutiny committee has expressed concern about the impact of the BHSP and the financial recovery plans of local health service organisations on older peoples services.
- 1.3 The NHS recognises that both Bristol social services and South Gloucestershire social services departments are concerned that there might be unintended consequences of the BHSP proposals on social services which may have resource implications. This is also likely to be an issue in North Somerset. North Somerset PCT is committed to working closely with social services in the ongoing development of services in the area.
- 1.4 The following organisations have agreed to commission an independent evaluation to assess the short term and long term consequences on social services of the BHSP proposals: -

Bristol North PCT
Bristol South and West PCT
South Gloucestershire PCT
North Bristol NHS Trust
United Bristol Healthcare NHS Trust
Bristol City Council Social Services
South Gloucestershire Council Community Care Department

- 1.5 At present, the scope of these terms of reference does not include North Somerset. North Somerset social services and North Somerset PCT have been invited to be part of this exercise and this matter is subject to ongoing discussion.

2. BRIEF

- 2.1 To assess whether, in respect of older people's services, any reductions in the number of hospital beds and associated improvements in throughput combined with the current and planned development of health and social community care alternatives will inappropriately affect the service performance of: -
- Intermediate care services
 - Residential and nursing home placements
 - Occupational therapy services
 - Delayed transfers of care
 - Domiciliary Support Services – Primary Care support services

- GP and community nursing services
- 2.2 To quantify and grade the resource and financial risks and their impact on the Social Services departments.
- 2.3 To make recommendations on changes in policy and practice to address the risks and minimise the impact, having regard to national best practice and policy.

3. METHODOLOGICAL GUIDANCE

3.1 The review will be expected to take into account the: -

- Views of the relevant professionals
- Local experiences of practitioners on the ground
- Relevant information on service activity, performance and finance
- National and local good practice
- Inspection reports
- Experience of service users

4. TIMESCALE AND DELIVERABLES

- A draft report setting out the conclusions to the issues posed in the terms of reference and a clear set of recommendations by 30th June 2005
- A presentation to the BHSP programme board by mid-July 2005
- A presentation to the Directors of Social services by mid-July 2005
- If requested, a presentation to the joint health scrutiny committee at a date to be agreed
- This report will then form the basis of collaboration and joint action planning between the NHS and local authorities

5. PROJECT DIRECTION AND MANAGEMENT

5.1 The project sponsors will be the chief executive of Bristol North PCT and the Directors of Social Services of Bristol and South Gloucestershire Councils. An external independent consultant will be appointed jointly by the project sponsors in April 2005. The BHSP office will manage the client relationships with the consultant.

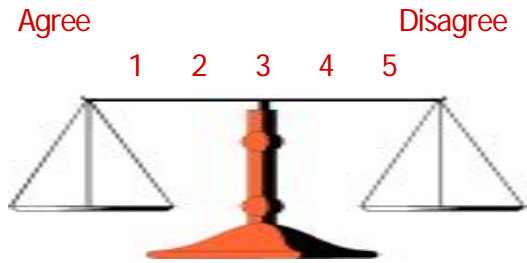
6. BUDGET

6.1 A budget will be agreed and established for the purposes of this exercise.

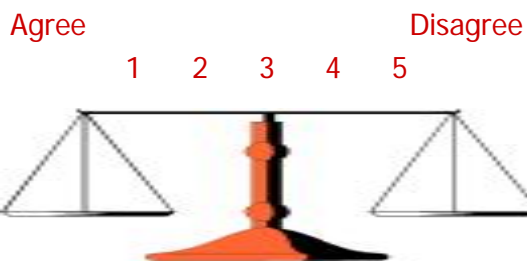
BHSP Impact assessment

**Part 1
Assessing the Impact on
Health and Social Care
Systems**

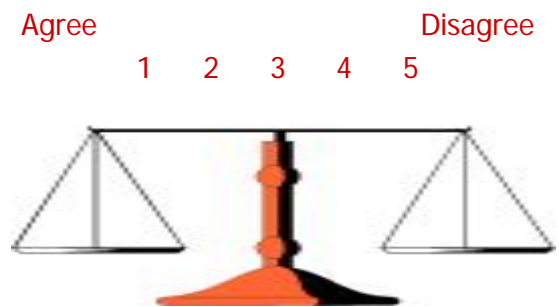
Demands on Social Care may well be neutral or lessened a treatment continues to improve



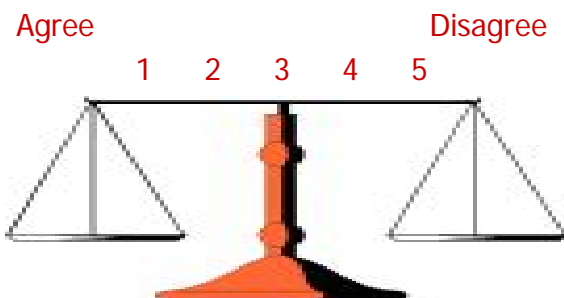
There will be no long-term effect on Social Services as broadly the same number of people will continue to pass through the system. There may however be a short-term impact on care management capacity



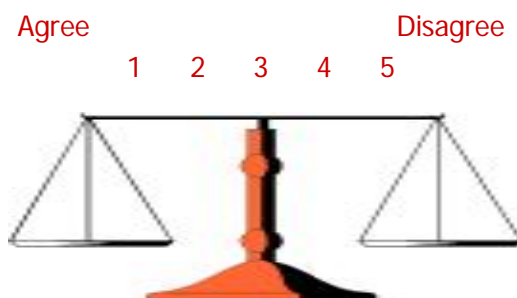
Social Services are struggling to keep pace with the growing level of hospital activity



There are serious supply side and HR issues that need to be addressed



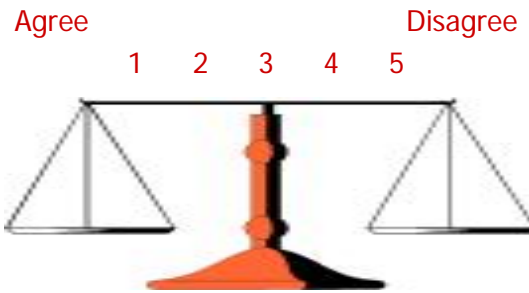
The BHSP has not been developed with sufficient Council input and attention to demography. Few people understand what the changes will mean



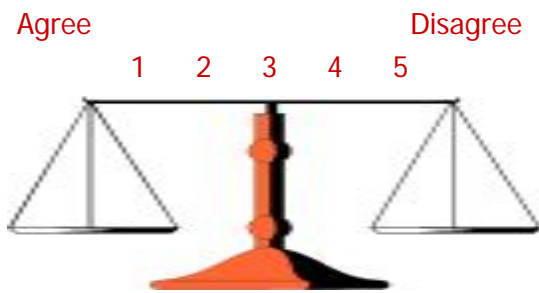
BHSP Impact assessment

Part 2 Assessment & Review

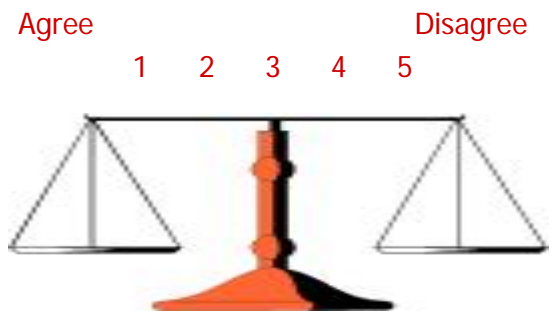
The assessment process is under pressure,
resulting in poor after care for patients



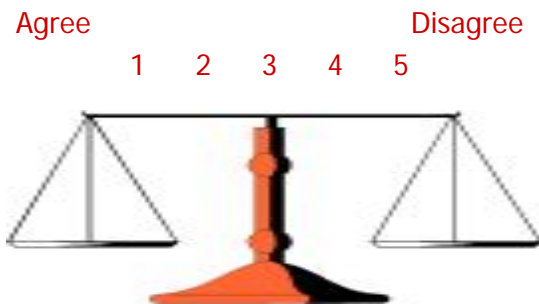
Provision for carrying out assessments, in
time for recovery or sudden increases in
demand has not been planned for



Case review is not prioritised



SSDs need to do more to control access
to services and target more vulnerable
individuals

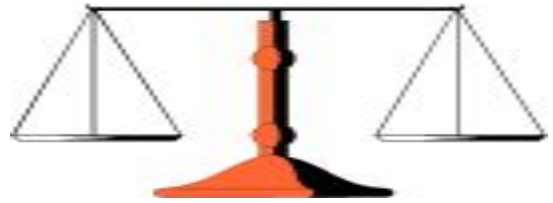


BHSP Impact assessment

Part 3 Discharge and Aftercare

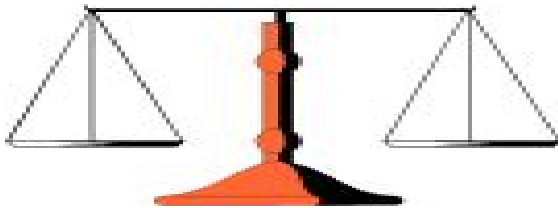
Domiciliary care services are under increasing pressure from both community and hospital services

Agree 1 2 3 4 5 Disagree



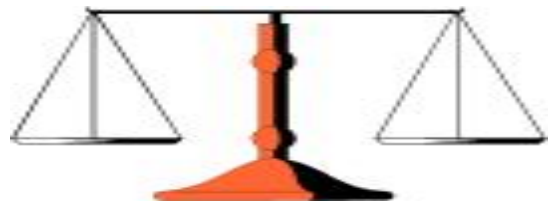
The BHSP with proposed overall reductions in bed numbers will lead to an increase in delays because 'slack' has been taken out of the system

Agree 1 2 3 4 5 Disagree



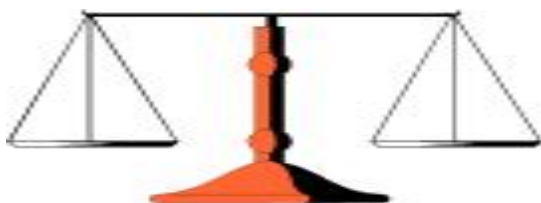
More complex care packages at discharge, reflect reduced lengths of stay and growing frailty

Agree 1 2 3 4 5 Disagree



People are discharged in poor states of health without treatment being fully completed

Agree 1 2 3 4 5 Disagree



People are discharged in poor states of health without treatment being fully completed

Agree 1 2 3 4 5 Disagree

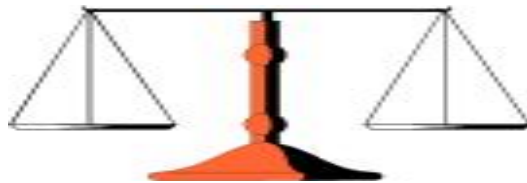


BHSP Impact assessment

Part 4 Intermediate Care

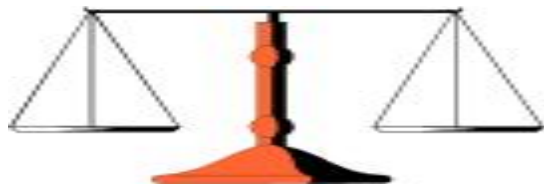
Investment in intermediate care, together with better management of long term conditions will reduce or limit the rate of growth in admissions

Agree 1 2 3 4 5 Disagree



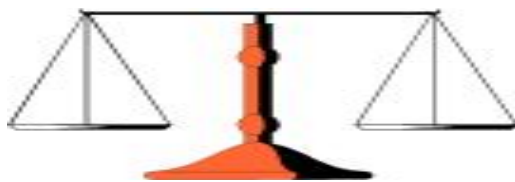
We do not yet have the correct level of investment or even accessible deployment in intermediate care and other support services to match the changes in the acute hospital sector

Agree 1 2 3 4 5 Disagree



We do not yet have the correct level of investment or even accessible deployment in intermediate care and other support services to match the changes in the acute hospital sector

Agree 1 2 3 4 5 Disagree



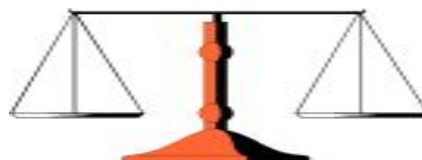
The criteria for intermediate care services are insufficiently developed

Agree 1 2 3 4 5 Disagree



There are frequent problems in moving people on from intermediate care because of shortages in domiciliary care

Agree 1 2 3 4 5 Disagree



Research evidence on the impact of reducing hospital length of stay on social services costs.

Studies designed specifically to assess the impact of reduced hospital length of stay (LOS) on social services have not been identified.

Further searching aimed to find research reports that quantified cost impacts of schemes that might be implemented in Bristol as part of the BHSP, to support achievement of reduced LOS. Intermediate care is an umbrella term, under which schemes for prevention of inappropriate hospital admission facilitated earlier discharge and avoidance of premature admission to long-term care are included. Schemes are diverse in the interventions they offer, evaluation reports are relatively few and literature searching is complex¹. Three relevant studies were identified: one evaluating a hospital at home scheme and two evaluating different models of stroke care.

Hospital at home

Evaluation of a hospital at home scheme found hospital at home to be less costly than inpatient care. This evaluation randomised 241 medically stable elderly patients fulfilling early discharge criteria to either early discharge to hospital at home or continued care in the acute hospital.

Per patient, use of social services in minutes (including home help, home aid and social worker time) and the number of meals on wheels visits were lower in the hospital at home group during the 3 months following randomisation compared with hospital care. Social services costs were £123.45 and £44.13 respectively, plus meals on wheels costs estimated as £42.16 and £25.01

Slightly higher mean costs to patients for hospital care were due primarily to increased contributions to care by social services. Patient contributions to social services' costs were £44.22 in the hospital group, and £29.55 for the hospital at home group².

Early discharge to community stroke services

A randomised controlled trial compared costs of providing care to stroke patients in an early discharge scheme, compared with conventional hospital care. In the early discharge group there were higher average costs for meals on wheels (£16,526 for 167 early discharge patients vs. £12,906 for 164 conventional care patients) and home helps (£74,715 compared with £70,229). The early discharge group used the lunch club less than conventional care group (£2376 compared with £5244).

The early discharge scheme included home based physiotherapy, speech therapy and occupational therapy. Across the whole continuum of care, costs at 12 months for the early discharge group were 8% lower than the conventional care group. Social work costs were not specified³.

¹ Martin GP et al. Diversity in intermediate care. *Health and social care in the community* 12(2), 150-154.

² Coast J et al. Hospital at home or acute hospital care? A cost minimisation analysis. *BMJ* 1998;316:1802-1806

³ Beech R et al. Economic consequences of early inpatient discharge to community-based rehabilitation for stroke in an inner-London Teaching hospital. *Stroke* 1999;30:729-735

Stroke units vs. stroke care on general wards vs. domiciliary care

A randomised controlled trial compared care on stroke units with care on general acute wards (supported by a specialist team) and with domiciliary care involving GPs, stroke specialists, specialist and community services. 457 of 979 patients on a community stroke register were randomised. Stroke units were most effective in reducing mortality, institutionalisation and dependence. Care on general wards had the least favourable mortality and dependence rates. Domiciliary care achieved the same cost per day alive as the stroke unit. It was substantially cheaper to provide, but mortality and institutionalisation rates were higher than in the stroke unit.

The proportion of patients admitted to nursing homes was highest for general ward care, then domiciliary, with the lowest proportion in the stroke unit group (the same pattern was seen in inpatient admission rates during 12 months). The stroke unit group had the highest percentage of patients making contact with social work, personal care, meals on wheels, and social services day centres. But when total resource use was calculated, it was the general ward group who used the most resources for social work, personal care, meals and wheels and several other categories of social support. The domiciliary group had the highest rate of resource use for nursing/residential home weeks and respite care days⁴.

Discharge to permanent care

A review of 36 cases of patients admitted to hospital from home but discharged to permanent care assessed 14 as having been suitable for the alternative of discharge to intermediate care followed by independent living. It implied that admission to permanent care was premature⁵.

Historical observation on service changes

Declining NHS bed stock between 1984 and 1996/7 was associated with growth in nursing home beds. No workload data to show whether there was substitution for NHS nursing workload. 'Strong statistical association' between acute bed closures and increased NH beds (ratio of 1 acute bed closure to 5 new NH beds)⁶.

Conclusions

These studies provide some insights, but it cannot be assumed that they are completely generalisable to new schemes being planned for Bristol. The schemes had distinctive characteristics, which may or may not be replicated locally. The health and social care environment in which they operated is constantly evolving. The observed association between acute bed closures and nursing home expansion in the mid 80's to 90's may reflect national policy direction applicable to that era – but less applicable now. Only patients meeting specific inclusion criteria were included in the trials. Nevertheless, the results should stimulate discussion on the range of options available for responding to shorter acute hospital LOS, and evaluation of impacts on different agencies and professions.

⁴ Kalra L et al. A randomised controlled comparison of alternative strategies in stroke care. Health Technology Assessment 2005;Vol 9: no 18.

⁵ Intermediate care strategy for Medway and Swale. Summary of intermediate care needs assessment. Medway PCT May 2004

⁶ Hensher M et al. Better out than in? Alternatives to hospital care. BMJ 1999;319:1127-1130

The need for flexibility, partnership and evaluation in financial and service planning is clear. The evidence does not support a simple 'yes' or 'no' to the question of whether reducing LOS will increase social services' costs. Impacts will depend on the types of schemes put in place, and the ways in which costs are allocated across the continuum of health and social care. Modelling might be helpful in estimating impacts of the various options.

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Bristol and South Gloucestershire PCTs

22.6.05

Acknowledgement: Jason Ovens, KRIS provided search support.

DATA SUMMARY

| INFORMATION | WHAT THIS SHOWS | SITUATION/ CURENNT PERFORMANCE IN BRISTOL AND SOUTH GLOUCESTERSHIRE |
|---|---|---|
| TOTAL ADMISSIONS / RATES OF ADMISSIONS | Total hospital activity for planned and emergency activity. The rates of admission expressed per 1000 population | Between 1997 and 2003 admission have steadily fallen and then risen. The range is small. Admission rates in NBT are much higher when compared with UBHT |
| EMERGENCY ADMISSIONS >65 | Total emergency admissions for the over 65 | Emergency admissions between 1997 and 2003 have risen consistently at NBT with rising rates of admission for over 65s. UBHT shows a steadily falling rate. |
| AVERAGE LENGTH OF STAY | The average length of stay for all ages over the period 2000 – 2004 | Average length of stay at NBT is falling at a slow rate with a quicker rate of fall at UBHT |
| AVERGAE LENGTH OF STAY >65s | The average length of stay for over 65s for the period 2000 – 2004 | The average length of stay at NBT has fallen steadily over the period at 8.3 days. The average figure at UBHT for the same period is 5.9 |
| RATES OF READMISSION | The rate of readmissions for all ages within 28 days of discharge trends over the period of 2000 – 20004 | After a fairly steady rate of 5% at NBT, readmissions have grown in the last year to 6%. At UBHT the rate has grown over the last two years from 5% to 6.5% |
| | | |
| DELAYED TRANSFERS OF CARE | The number of patients whom discharge is delayed. Lower levels allow for better patient care and shorter length of stay | Reported delays have fallen to an all time low for social care reasons number are 1 at UBHT and 7 at NBT for March 2005. The biggest cause of reported delays are now attributed to NHS reasons |
| | | |
| ADMISSIONS TO RESIDENTIAL CARE | Supported admissions of those over 65 to residential and nursing care per 10,000-population aged 65 or over. This figure should fall as more community support develops | South Gloucestershire rates have fallen to 100 in 2003/04 at the average comparator authorities. In Bristol the figure has risen to 132, well above the average for comparator authorities |

| INFORMATION | WHAT THIS SHOWS | SITUATION/ CURENNT PERFORMANCE IN BRISTOL AND SOUTH GLOUCESTERSHIRE |
|---------------------------------------|---|--|
| NUMBER HELPED TO LIVE AT HOME | Older people aged 65+ helped to live at home per 1000 per population aged 65+. This data serves as a proxy for the amount of 'low level' preventive care provided | In South Gloucestershire 80 people per 1000 are helped – just below the comparator average. The figure is stable. In Bristol the figure has fallen to 102 for 2003/04 slightly above average for comparators |
| INTENSIVE HOME CARE | An 'intensive' home care package means more than 10 contact hours per week with more than 6 or more visits. Increases in home care should reflect a falling trend in residential care | There is a steady increase in both councils but performance is well below comparator organisations. For 200/ 04 6.4 intensive packages were in place per 1000 residents in Bristol. In South Gloucestershire the figure was 5.2. |
| ASSESSMENTS LEADING TO SERVICE | The percentage of adult and older service users whose assessment leads to provision of service | The current rate for South Gloucestershire is 74%. Strengthening of eligibility criteria in Bristol has reduced the rate from 90% in 200/03 to 46% in 2003/04 |
| CLIENTS RECEIVING A REVIEW | Shows how many social care clients receive a review, and is used as an indication of how well social care services are being managed | There has been progress in this are over recent years. Both councils now review just over 50% of care received by clients |
| POPULATION CHANGE >65s | The rate of growth in the over 65 population. Older people make disproportionate demands on services relative to the rest of the population | The percentage of over 65s in the general population rises from 15% in 2003 to 19.2% in 2021 for South Gloucestershire. For Bristol the proportion of over 65s drops from 14.4 to 13.65 over the same period |
| NUMBER OF LONE HOUSEHOLDS | The number of people aged over 65 living alone. It is an important indicator of likely demand for health and social care intervention | Projections for the next 15 years are stable for Bristol but show a 50% increase for South Gloucestershire |

MONITORING FRAMEWORK

| HIGH LEVEL INDICATORS - ACTIVITY | |
|---|--|
| HEALTH | <ul style="list-style-type: none"> • Total admissions • Total admissions >65 • Total non-electives >65 • Length of stay |
| SOCIAL CARE & HOUSING | <ul style="list-style-type: none"> • Section 2 notices received • Assessments • Assessments leading to service • Intensive home care packages • Residential placements • Very sheltered / extra care |
| INTERMEDIATE CARE | <ul style="list-style-type: none"> • Total admissions from hospital |

| INDICATORS OF PERFORMANCE | |
|----------------------------------|---|
| HEALTH | <ul style="list-style-type: none"> • Readmissions >65 • Delays – bed days lost – by cause • Poor discharges • Early death following discharge • 00 referrals from discharge patients |
| SOCIAL CARE & HOUSING | <ul style="list-style-type: none"> • New referrals following discharge • Incidence of assisted care • Expenditure on intensive care packages • Expenditure of care (domiciliary & res) • Carer breakdown |
| INTERMEDIATE CARE | <ul style="list-style-type: none"> • Referrals back to hospitals • Average length of stay • Delays in handover • Dependency on admission • Mental health needs |

MODELLING SERVICE REQUIREMENTS – DEVELOPMENT FRAMEWORK

To understand gearing in the system (i.e. the relationship between hospital activity and the requirement for service in social care) a quantitative analysis modelled on the overall hospital population aged >65 (or by specific condition / intervention) is required. This will enable a baseline to be set and agreed for future commissioning and to assist redesign or reprovision of services. Repeat exercises may be required to take account of seasonal variation and to confirm trends.

There are two ways in which this information can be obtained:

- A retrospective analysis of patients completing the passage through the system
- A predictive view of need based on patients in the system at a given time.

The data required should encompass:

Patients:

- returning home who need no support
- returning home who need domiciliary care only
- returning home who need equipment
- returning home who need complex care packages
- returning home who need complex care plus nursing
- returning home who need complex care plus CPN

Patients:

discharge from hospital and needing:

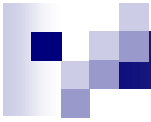
- transitional care
- intermediate care
- residential care
- nursing home care
- nursing home care with mental health service
- supported housing
- continuing healthcare



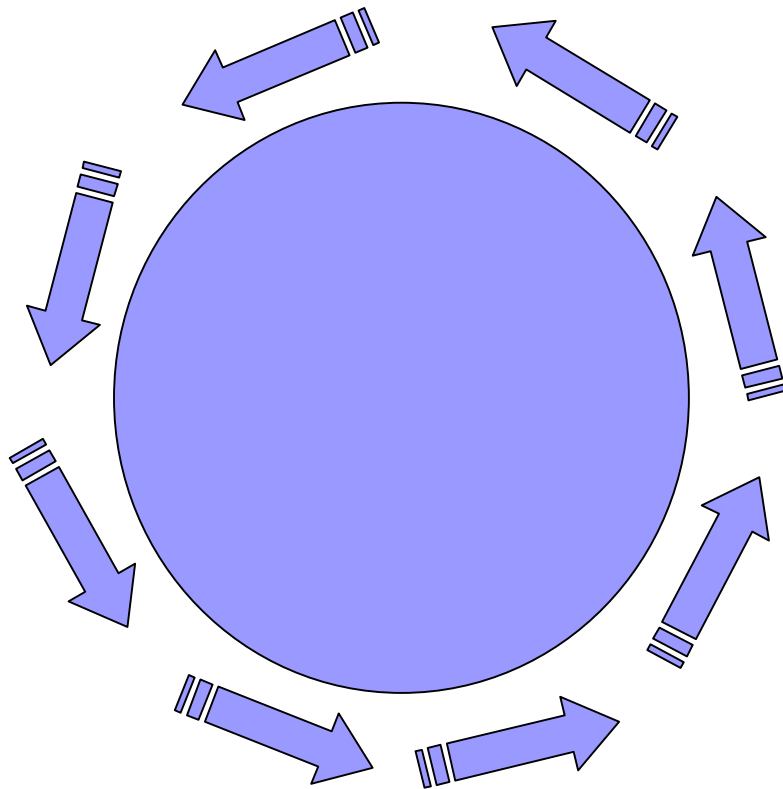
Bristol Health Services Plan

Assessment of the impact on
social care delivery for older
people

Ian Plaister Consultancy July 2005

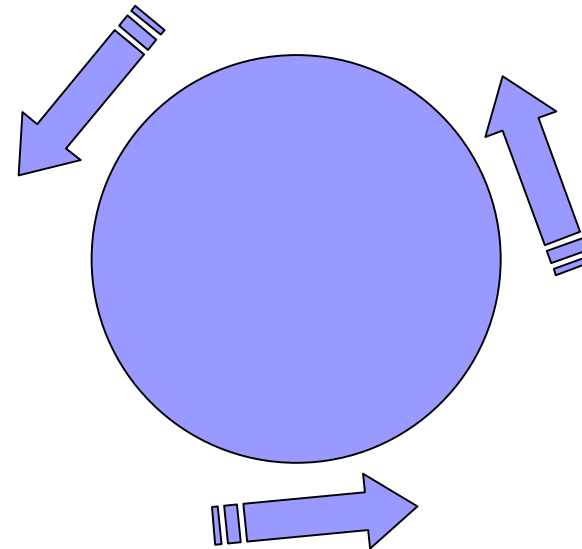


Hospital System



**Short quicker
throughput cycles**

Social Care System



**Long slower
throughput cycles**

Developing Older People Services

A Continuum of Organised Care

