Milton Keynes NHS
Primary Care Trust

MILTON KEYNES COUNCIL
Neighbourhood Services

ATTACHMENT C

Milton Keynes General NHS
NHS Trust

Older People's Services Best Value Review 2003
Executive Summary

Background

The review was cross-cutting involving community health and social care services and their interface with the hospital. It did not look at the detail of individual services, but focused on the broad strategic direction for service improvement, with particular consideration of the potential for 'joining up' services and developing integrated structures.

Review process and findings

The Best Value review process involves Challenge, Consultation, Comparison and Competition. The review methodology was a mix of research and analysis of local and national strategic documents, published performance data for Milton Keynes and comparator authorities, questionnaires, consultation and visits. Key findings were:

- The health of older people is generally good, and fewer older people live alone than elsewhere, but there are pockets of deprivation.
- Council and PCT services are organised around client groups or professions rather than needs.
- Resources across Health and Social Care are severely constrained and there is some evidence that significant amounts of resource are tied up in expensive forms of institutional care.
- There is limited integration of older people's services across health and social care.
- Older people want a single contact point to get good information and reliable and good quality services when and where they need them
- Staff want more joined up working and integration where possible with clear care pathways and increased nursing and therapy at home services available out of office hours.
- The performance of the Council and PCT is about average when compared with comparator areas.
- Compared to the national average 7% more money is spent on residential and nursing home placements (especially nursing home) and 7% less money is spent on community based services. Placements direct from hospital account for two thirds of all nursing home placements.
- A large amount of intermediate care funding in the PCT is tied up in beds, and community based intermediate care services in people's own homes are not well developed.
- The experience of integration in other areas has been based on a history of multi-agency working, "champions" in all organisations and an acceptance that it is an evolving process that cannot require all the answers at the outset.

Conclusions

Older people, staff and users consider that current services could be improved by further co-ordination of information and service provision, the availability of services outside core hours, a reduction of duplication particularly in assessment, clear pathways and roles, and joint training and skill sharing within and across agencies.

The lack of Intermediate Care services, especially the lack of capacity to provide enough intensive short-term rehabilitation in the community, has led to more older people being discharged from hospital directly into residential / nursing homes.

By integrating community-based intermediate care services and extending their capacity across the PCT and Council, a significant number of older people may be able to return home. This is what most older people prefer. This would also free up resources to develop rapid response and hospital at home type services that would in turn reduce emergency admissions to the general hospital.

This reinforces the inter-dependency of the three agencies to support the development of the whole health and social care system. Without a comprehensive range of community based health and social care services, hospitals cannot reduce admissions and therefore cannot develop new ways of using their hospital beds, releasing money to provide treatment in new and innovative ways.

Recommendations

- To sign up to a vision that develops community-based services that are rehabilitative and therapy focused to prevent unnecessary hospital admissions and to facilitate timely and effective discharges.

- To adopt a model of integration based on the function provided (e.g. integrated access and assessment services, multi-disciplinary therapy services) rather than single professions or services.

- To set up a project steering group, as a sub group of the Partnership Project Team, to develop and implement a detailed project plan for integrated intermediate care, access and assessment service and long term / specialist services.

- To develop a proactive programme to support change and change management.

- To develop and co-ordinate out of hours services.

- To develop a culture, criteria, protocols and an agreed approach to support older people in their own homes or sheltered housing as much as possible.