Milton Keynes General NHS Trust

Milton Keynes Primary Care Trust

Older People's Services Best Value Review 2003

A review of older people's services across the health and social care economy and a strategic plan for service improvement and development

CONSULTATION VERSION

Comments by 31 August 2003

MILTON KEYNES COUNCIL

CONTENTS

Milton Keynes Health and Social Care Services

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.

Section A - Introduction

In 2001, following the Social Services Inspectorate/Audit Commission joint review of Milton Keynes Social Services, which identified some weaknesses in our older people's services, the Council agreed to carry out a Best Value review of its services for older people.

Best Value reviews are a local authority-driven process of service review designed to ensure continuous improvement through crosscutting themes, the development of partnerships and the setting of targets (Appendix 1).

In recognition of the interdependency of services between the Council, Milton Keynes Primary Care Trust (PCT) and Milton Keynes General Hospital (MKGH), it was agreed that the review would be cross-cutting involving community health services and their interface with the hospital. The review was organised by a multi-agency steering group (Appendix 2). The Planning of the review (Appendix 4), Terms of reference (Appendix 5), Project Plan (Appendix 6), Communication Plan (Appendix 7) and Consultation Plan (Appendix 8) are attached as Appendices.

The review began in Autumn 2002 and has involved significant work around consultation and comparison. The review has not sought to look at the detail of individual services, but rather to focus on the broad strategic direction for service improvement, in light of the national Department of Health improvement agenda, with particular consideration of the potential for 'joining up' services and developing integrated structures.

The intention of the review is to develop a medium-term service improvement plan, which will drive up service performance and quality in a more cost effective way. In this review the plan for improvement is a multi-agency one, spanning community health and social care services in Milton Keynes.

This is the report of the Best Value review of older people's services. The report contains; an overview of the current services; an evaluation of the challenges that face the services; the results of the consultations undertaken and the comparisons with other authorities; and concludes with recommendations and a service improvement plan. The report provides a succinct narrative of the review process, findings and conclusions. The detailed evidence is included within the Appendices, which are referenced throughout the text.

Section B - National and Local Context

The Milton Keynes Intermediate Care and Associated Older People's Services Review (IC&AOPS) May 2002, was commissioned by the Older People's Joint Planning Group and was undertaken by the Institute of Public Care at Oxford Brookes University. It is a detailed study of the current (2001/02) services, and analysis of the capacity of those services to meet national targets over the next few years. The executive summary of the review is attached to this document (Appendix 3).

Based on the mapping exercise and research of good practice the review report provided recommendations for developing a way forward which included:

- Investment in prevention and rehabilitation services based in community and primary care.

- Care co-ordination to be improved by moving towards integrated teams and single line-management structures across health and social care.

- To develop a wider range of services to meet the intermediate care needs of older people.

Whilst this study was comprehensive in its research, it did not specifically provide a strategic way forward or devote time to consulting with staff and users.

The Older People's Services Best Value Review (OPSBVR) seeks to build on the work already undertaken. The planning of the review (Appendix 4) and terms of reference (Appendix 5) reflect the priorities and address the challenges faced by health and social care services at both a national and local level.

National Priorities and Challenges

Over the last five years the DoH has set out through white papers, legislation, policy guidance and service frameworks, a range of initiatives that collectively can be described as '**the Modernisation Agenda'**. Key elements of this agenda are:

- Services must be person-centred
- People should receive service when they need them (without having to wait)
- Services should promote independence and rehabilitation (keep people out of hospital/ long-term residential care where possible)
- Services should be well co-ordinated, especially across health and social care
- Health and social care should explore ways of integrating locally (pooled budget, integrated provision)
- Focus on waiting times including delayed discharges

The ***National Service Framework for Older People*** has 8 standards that reflect DoH priorities in developing services for older people. These standards are the responsibility of the health and social care community to implement together.

The standards are:

1. Rooting out age discrimination
2. Providing person-centred care through the Single Assessment Process, Integrated Commissioning and Integrated Services
3. Developing Intermediate Care services
4. Improving general hospital care
5. Developing integrated Stroke services
6. Developing falls management service
7. Developing integrated older people mental health services
8. Promoting healthy and active lives for older people
   There is also a requirement to implement the medicine related aspects of the NSF.

The **Modernisation Agenda** includes some specific targets:

- Improve the quality of life and independence of older people so that they can live at home wherever possible.
- Each year there will be less than 1% growth in emergency hospital admissions and no growth in re-admissions.
- By December 2004: all assessments of older people will begin within 48 hours of contact with social services and will be completed within four weeks; services will be provided within four weeks; and all community equipment will be provided within seven working days.
- By 2006, a minimum of 80% of people with diabetes to be offered screening for the early detection and treatment of diabetic retinopathy, rising to 100% by end of 2007.
- By April 2004 all general hospitals caring for people with stroke to have a specialised stroke service, and all health and social care systems to have established an integrated falls service by 2005.
- Expand the Intermediate care capacity to meet the NHS Plan targets.
- By 2006 30% of very frail older people will be supported in their own home.
- Additional services for carers by 2006, using the increased carers grant.
- No 4-hour or more Trolley waits in A&E and minimal delayed discharges in acute hospital beds by 2004.
- By April 2004 a single assessment process is in place across health and social care services locally.

Local Priorities and Challenges

The national targets are made more complex locally by several factors specific to Milton Keynes. Over the next 10 years the population of Milton Keynes is set to grow substantially with the major growth in the younger older people age group (65 – 74) and in the most elderly (85+). In the longer term the population of Milton Keynes may double in size, so services need to be robust to support this expansion.

It is believed that funding formulas applied to health and social care have been based on out of date population information and have not been adjusted to reflect the continual growth of Milton Keynes. Recent local government FSS grant settlements have begun to recognise some underfunding, but health service allocations have not. There is a history of restricted funding across health and social care locally, exacerbated by old set patterns of expenditure (eg. high spend on residential and nursing home placements).

The Council are committed to improving older people's services by supporting more people to live at home and by more integrated working with MKPCT. A Joint Health and Social Care Board has been established where there is inter-agency agreement to developing integrated services.

The Council and its partners have agreed a number of community strategy aimsfor the next ten years, including:

- A community for all
- A healthy, caring community
- Housing that meets everyone's needs
- A safe community

The Council has set a number of corporate priorities for the next three years including:

- Giving older people the help they need to keep their independence

While this review was agreed in this context, there had not been previously an agreed overall joint strategic vision for the development of services for older people. This may reflect past instability in the senior management positions of both the Council and PCT and the fact that they are both relatively young organisations. However over the past two years the Council and the PCT have sought to:

- Expand intermediate care services
- Develop community based nursing and home care rapid response service
- Ensure prompt and co-ordinated discharges from hospital
- Improve equipment service including delivery times
- Begin to develop falls and integrated mental health services for older people
- Integrate adult mental health and learning disability services

The review seeks to build on these achievements and focus on setting a strategic direction for community health and social care services for older people in Milton Keynes. The review does not seek to look in detail at individual services or groups of services, but rather to explore shared priorities and challenges across the health and social care system and the extent to which these can be more effectively met by integrating services. In discussing strategic direction, the review has also tried to engage with staff and older people to gain commitment and 'sign up' to integration as a possible way forward.

The review also looked at three service pathways; Dementia, Falls and Stroke; in order to examine the extent to which any proposed recommendations might support and add value to the re-organisation already underway in these services.

Key Questions

- To what extent is the 'whole system' across health and social care delivering the national modernisation agenda at present?
- To what extent is the 'whole system' across health and social care effectively meeting local needs at present?
- By integrating our services, will we be in a better position to meet local needs within the context of the national agenda?

Section C - Current services and needs

The review sought to establish an overview of current services and the demands on those services. This was done through research and analysis of local strategic documents (Appendix 9) and through a questionnaire sent to local service managers.

Structure and shape of services

The Primary Care Trust (PCT) and Milton Keynes Council Neighbourhood Services Directorate (MKCNS) are the main funders of services in the community. There is a mixed economy of providers including statutory health and social services, independent providers under contract, and voluntary sector services, some under contract, some grant-aided and some through their own fundraising.

Structure charts of the relevant section of the Council and PCT (Appendix 10) show that services in the organisations are created from very different starting points. In the PCT the structures mainly reflect professions (e.g. Occupational Therapy), but in adult social care the services are mainly structured around age (e.g. Older Peoples Services), or provision (e.g. Homecare).

The Intermediate Care and Associated Older People's Services Review (IC&AOP) report outlines the patterns of service provision across the whole of the health and social care sector in some detail (IC&AOP Chapter 3). It produced a map showing the range of services provided and their availability in 2002 (Appendix 11).

Over 90% of residential care and nursing home provision is provided by the independent sector, including four ex-local authority residential homes run by a voluntary organisation. The Council provides only one residential home, which is for older people with dementia. Similarly home care provision is split between the Council (47%) and the independent sector (53%). The Council provides rehabilitative home care for up to six weeks, following a change in circumstances and for all new users of the service. The Council has also developed some of its sheltered housing to meet social care needs, including 50 very sheltered housing tenancies and ten flats used for intermediate care.

Community health services include a district nursing service linked to GP practices and an intermediate care access team (CHAT) facilitating timely discharges from the general and community hospitals. There are also a number of separate therapy services, an integrated equipment service', a small multi-disciplinary therapy unit based at Bletchley Community Hospital, and a small day hospital at Newport Pagnell.

There are a wide range of services run by voluntary sector partners; these include preventative services, such as information and advice, lunch clubs, sitting and handyman services; and assessed community care services such as day care, meals on wheels, and sensory loss services.

Levels of expenditure

Net expenditure in 2003/4 in the areas covered by the review is estimated to be as follows:

Primary and Intermediate Care (PCT)		**£11.1m**
Therapy/ podiatry/ wheelchairs	£2m	
Inpatient/ Rehabilitation	£1.7m	
District Nursing	£3.1m	
Primary Care (Older People)	£2m	
Externally Purchased services	£2.3m	
Social care (MKC)		**£16.9m**
Assessment and care management	£3.5m	
Nursing home placements	£3.3m	
Residential home placements	£4m	
Community services (home care, day care, equipment)	£6.1m	
Acute care (MK Hospital Trust)		**£23m**

It is difficult to compare expenditure levels across the three organisations because of different systems and structures. The figure for Milton Keynes hospital is an estimate of overall expenditure on older people. The PCT and the Council have struggled to balance their budgets over the last year, particularly in relation to services for older people. The Council's original budget for older people's social care services was about £1.6million overspent in 2002/03 and the PCT has to make service reductions (including closing beds at Bletchley Community Hospital) especially around services for older people in order to get its Local Delivery Plan (LDP) agreed by Thames Valley Health Authority in 2003/04. Therefore statutory agencies are operating in a climate of limited resources, which heightens the need to consider whether resources can be used more effectively.

One example of this is the Council's relatively high level of expenditure on long-term residential and nursing home places. Of expenditure on residential and community care services, 54.5% goes on residential placements and only 45.5% on community services.

Service Delivery

A detailed set of data on performance is included (Appendix 12) with comparative analysis. The most recent comparable data is from 2001/02 and does not reflect subsequent developments.

In Adult Social Care a total of 3000 assessments are carried out each year, about 1500 by the Homecare Intake and Rehabilitation service. On any one day a total of 1300 older people receive 2300 Council community care services. Of those receiving services, **574** older people are supported in residential and nursing care and **1021** older people are supported in sheltered housing. The number of older people who receive homecare is **950**, of whom **238** receive *intensive* home care, i.e. more than 10 hours each week. About **230** people attend day centres and **560** receive other community-based services (mainly Meals on Wheels). (Figures for March 2003)

In the PCT there are nearly **5800** community nurse assessments carried out each year along with **2500** Occupational Therapy assessments. There are **53** community hospital beds available (March 2003) and over **7500** pieces of equipment and **900** wheelchairs are

issued each year. In March 2003 the level of Milton Keynes residents delayed in the acute hospital was 8, one of the lowest figures in South-East England.

Milton Keynes has a high number of people in residential care, a fairly high level of intensive home care, an average amount of intermediate care and a low level of day care services compared to similar authorities. Health services are stretched with a relatively low number of acute beds and limited GP and community health services.

Needs of Older People in Milton Keynes

Population (see Tables 1-4 in Appendix 12)
The 2001 Census has given the most up to date information on many aspects of the population of Milton Keynes. The population in 2001 was **207,057**, which is planned to rise to 248,000 by 2011. The number of people aged 65 and over in 2001 was **21,305**, which is expected to rise to 28,210 in 2011; while most of this growth will be in younger older people (65-74) the number of people over 85 years old will increase by over 700 (30%) by 2011. This is the group that makes the highest use of health and social care services. Overall the proportion of the population aged 65 or over remains low in Milton Keynes: 10.3 % compared to 16% nationally.

Ethnicity (see Table 7 in Appendix 11)
In the 2001 census the proportion of older people from Black and Minority Ethnic (B&ME) communities was 3% (643 people aged 65 or over) of the older people's population (compared to 9% B&ME for the whole population). About half of B&ME population was of south Asian (India, Pakistan, Bangladesh) descent. As the overall B&ME population is 9%, the older B&ME population is set to grow. This raises questions of how culturally appropriate services are developed.

Housing and Income (see Appendix 12)
There are nearly 90,000 homes in the borough of which 20% have an older person living in them and about 8000 older people live alone. The Council housing waiting list does not have a significant number of older people on it, and there were only 7 homeless older people last year. Older people account for 40% of Council tenants and 46% of special needs households and there are 1760 places in sheltered housing schemes (8% of older people).

Only 5% of older people households reported rent or mortgage arrears in the last 12 months compared with 9% for whole population. More older people had savings over £5,000 than the average for the whole population and less older people had debts than the average for the whole population.

Dependency / Complexity of needs (see Tables 5-6 In Appendix 12)
A number of potential indicators of need were analysed across comparable authorities. They were single and double pensioner households; the numbers of older people with a limiting long-term illness or whose general health was 'not good', the proportions of older unpaid carers, the numbers of older people without a car, and the take up of concessionary bus passes.

In Milton Keynes there are fewer older people living alone than similar authorities. Levels of limiting long-term illness and informal carer support are similar to elsewhere. The proportion of older women (67%) that have concessionary bus passes which is much

higher than for men. However women are 56% of the population over 60. This implies that many older women are more dependent on public transport and local services.

The crime statistics for the borough show in 5 out of 6 areas of crime the figures for Milton Keynes are below the national average. A borough-wide survey in 2001 showed over a 3-year period (1999-2002) an overall fall in all crimes; and that people over 60 were the least at risk of becoming a victim of crime.

The Director of Public Health confirmed that there are no public health indicators that show that the needs of older people are any more complex than those of other authorities. The overall population of older people is generally healthy and independent on all of the comparisons made. However there are some wards in the borough that are locally and regionally recognised as areas of significant deprivation, which may place high demands on services in those areas.

Key Messages

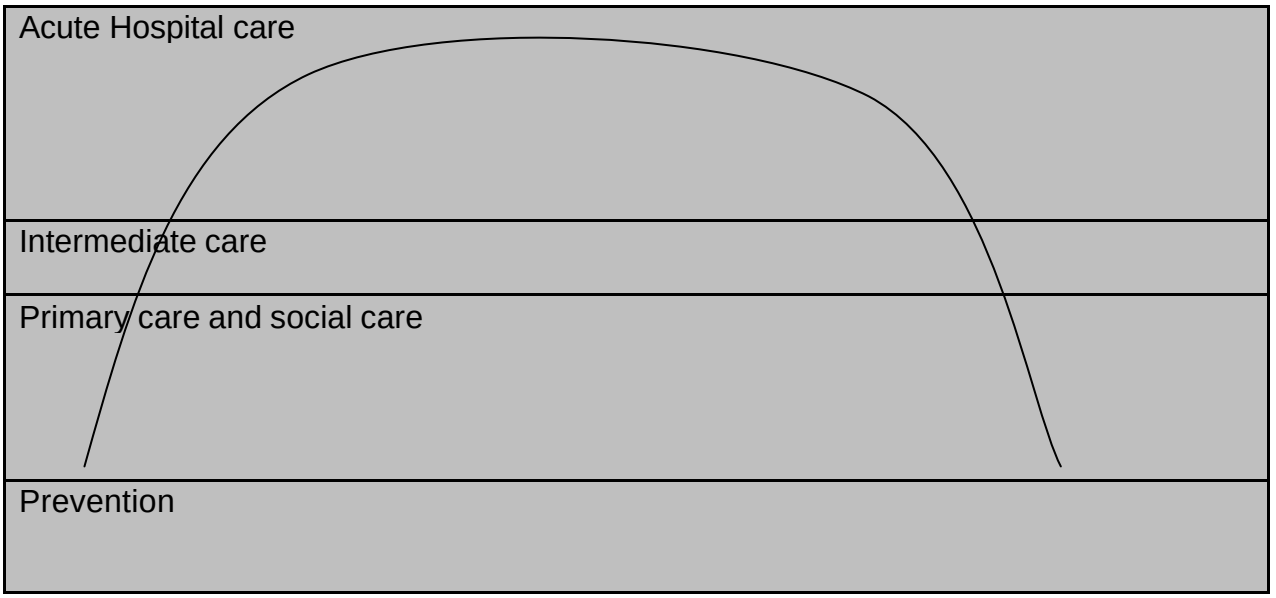
- The older people population will grow significantly over next ten years and services must be developed to meet this growth.
- The health of older people is generally good, and fewer older people live alone than elsewhere, but there are pockets of deprivation.
- The ethnic minority older population, while still relatively small, is growing and appropriate services need to be developed.
- Council and PCT services are organised around client groups or professions rather than needs.
- There is a mixed economy with multiple service providers.
- 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.
- Health and social care services locally perform well on delayed discharges
- Apart from equipment services and joint working around Orchard House, there is little integration of older people's services across health and social care.

Section D - Challenge

One of the key parts of any Best Value Review is to ask challenging questions of the services being reviewed: Why do we do this? Why do we do it in that way? Could we use our resources differently and more effectively? Such questions can best be answered when there is a clear vision and direction for the services under review.

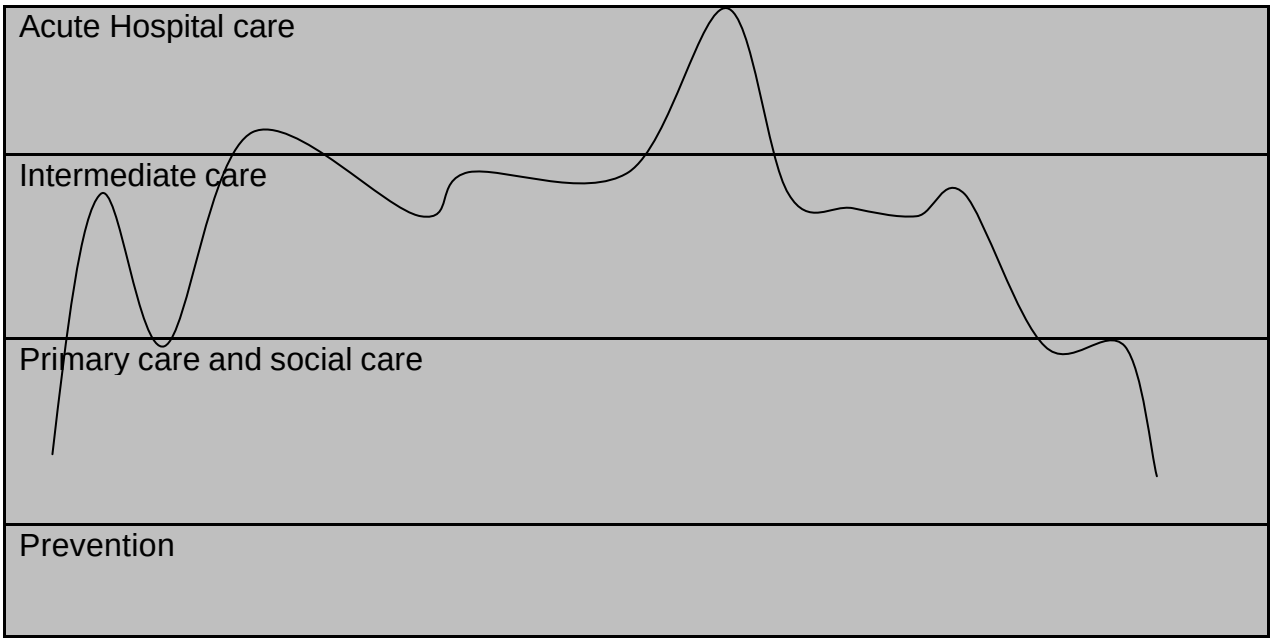
In our visit to Northumberland Care Trust we came across a potential model for overall strategic direction. This model, outlined below, bears similarities to the Audit Commission report in 1999, which described the 'vicious circle' of delayed discharges, high numbers of residential placement, and lack of investment in community based and rehabilitation services. This report led to a national focus on rehabilitation and the need to develop intermediate care services (short-term, rehabilitation focused services that seek to prevent unnecessary admission to hospital and to support people leaving hospital to return home).

We have adapted the graphs below from Northumberland. The first graph illustrates where health and social care services for older people have been historically. Most older people are well and are in the 'prevention' and 'primary/social care' band. They receive the majority of their services in a primary care setting either at a surgery or at home. If acute hospital care is needed it is accessed rapidly as an emergency, often followed by a prolonged inpatient stay, (which can decrease the person's ability to manage at home after discharge), followed by rapid discharge either to their own home or into residential / nursing home care. Intermediate care services are limited and have little impact.



Our vision for services is one focused on meeting as many needs as possible as close as possible to the older person's home. This requires the expansion of Intermediate Care services and providing more social care and specialised services than are currently provided in primary care and community settings. These Intermediate Care services would be integrated health and social care services wherever possible, thus improving communication and co-ordination, and combining resources to ensure a more person centred approach. Rapid response and intermediate care services would ensure that only those who needed acute hospital care receive it. Inpatient stays or outpatient treatment in

acute settings would be short and focused and would enable the patient to return as quickly as possible, through intermediate care services to long-term support from primary and community care services. This model is illustrated below. The line shows more community based health and social care services received by the older person (in contrast to the line in the first graph). More investment is made in intermediate care services in this model.



The challenge posed in this review is 'How can we develop or reconfigure services – do things differently across health and social care in Milton Keynes – so that services are available to older people as close to their home as possible?' This challenge is linked to the challenges posed nationally by the DoH Change Agent Team supporting local health and social care communities with delayed discharges. They pose these questions:

- What services do you (the local health and social care community – the 'whole system') need to have in place so that no one is admitted to hospital inappropriately?

- What services do you need to have in place so that no older person admitted to hospital from their own home is discharged directly to long-term care in a nursing or residential home?

These questions are related to the questions posed at the end of section A. The review seeks to recommend service configuration and models that might address these questions.

Section E - Consultation

A key component of Best Value reviews is *Consultation,* engaging with the main stakeholders, in particular with our customers – patients/ service users- and with our staff. We held 12 'focus' groups to get the views and comments of older people from different backgrounds and of a wide range of staff within the Council, the PCT, the hospital and provider organisations. We also used surveys and newsletters to glean wider views. The Consultation plan for the review is attached to this report (Appendix 8).

The consultation included:

- Consultation with the Joint Staff Committee within the PCT on the proposed BVR process
- Production of a newsletter (Appendix 14) which was circulated to all staff working with older people in Milton Keynes Council, the PCT, the General Trust, parish councils, elected members and private and voluntary sector colleagues
- An article within the Milton Keynes Citizen Newspaper (circulated free to all households)
- A series of meetings with older people including those from black and minority ethnic community groups.
- A series of meetings involving staff working with older people
- A postal questionnaire linked to the Home Care User Experience Survey 2003
- Information obtained from recent user and staff surveys conducted by, or on behalf of, the organisations involved.
- A Stakeholder Day for managers and strategic staff involved in services for older people.

The newsletter and newspaper article produced some responses and the questionnaire and survey reviews provided useful background information, however the major mechanisms for consultation were the meetings and the Stakeholder Day.

The views of older people

The meetings were arranged through Age Concern Milton Keynes and the Neighbourhood Services Community Development Officer and included over 100 older people. We also looked at three annual reports from the Older People's Forum, which have identified older peoples views of local health and social care services over several years (Appendix 9).

Older people were asked about:

- Their current knowledge and experience of services, including access and response times
- The types of help they find most useful and which of these is a priority
- Their views on where very vulnerable people should live (Own home/ sheltered housing/ with family/ residential/nursing home)
- Their understanding of and views about the organisation of health and social care services i.e. that they are separate organisations

A full report of the older people's consultation meetings is attached to this document (Appendix 15).

The main finding of this was that older people want "good" services. A good service is one that is easily accessible when they need it, without overlong waiting times. They want reliable services with continuity of staff and good standards of care. The majority of service users' comments were about community based services that help them do the things they want to do in their own home. They are not especially interested in how those services are structured or who is the providing organisation.

" Elderly people don't want different people in and out of their homes everyday"

"People are missing their "days out" because home care turn up too late"

"Public transport is rubbish, can't get to bus stops, too far from home."

To help older people access services, we need to provide clearer, better co-ordinated, more accessible and reliable information. This is especially important when people are trying to "get into the system". Older people are put off by what they perceive as the large number of possible access points and associated telephone numbers

" It's got to be simpler so that you only have to say what you want once".

"Too many phone numbers, just have one, keep it simple, I don't like menus"

"Once in the system it works well – but you have to know how to get in".

Current experiences of services are generally good although there are problems with waiting times for appointments

"GP is the way in, but almost impossible to get to GP"

"Services are ok when they arrive, but you have to wait a long time".

People spoke of being "rushed" when they receive services and that they value having time to do things, which includes the opportunity for conversation, as sometimes services are their only social contact that day.

Older people confirmed that the services they value include information, transport (particularly more buses to surgeries/hospital), and practical help in the home (household maintenance, shopping); this is similar to previous consultations.

The views of Black and minority ethnic Older People

To try to gather the specific views of older people from the black and minority ethnic communities the Community Development Officer for older people from black and minority ethnic community groups circulated a questionnaire in 4 languages, and 40 written responses were received from different minority ethnic communities. A visit to the Afro-Caribbean lunch club was also arranged and comments sought from the people gathered.

Many comments were common across the communities. The lack of transport appeared to be the most common comment across the communities.

" In MK it is difficult without transport"

" (we need) Help with getting to hospital and surgeries and to collect medicines"

They identified that services need to support people to remain independent in their homes, by keeping it clean, supporting exercise and by providing culturally appropriate meals.

" Vegetarian meals at home"

" Provide help with cleaning , cooking, personal care etc….gardening service"

Services need to develop a wider understanding of the needs of different cultures and religions and each community also identified the need for culturally specific social meetings eg. lunch clubs / social groups.

"I would like to see a drop in centre where my people could have a cup of tea"

" the actions of the council ;and NHS are not sympathetic to wards the sensitivities of older Sikhs who have special adherences regarding food, dress religious norms"

The views of Staff

To ensure that a range of staff views were obtained a series of meetings were arranged and staff were invited from the three agencies directly involved in the review, the voluntary sector and private agencies. In total over 100 individuals attended.

At the beginning of each session either the Head of Adult Social Care or the Director of Primary and Intermediate Care gave a brief presentation. This explained the background to the review, the local and national context and the issues to be explored. To encourage a free discussion they then left. The sessions had two main focuses:

- To share and discuss the implications of the national and local strategic agenda for how we work in Milton Keynes
- To discuss how we should develop and/ or reconfigure our services to meet the strategic agenda

A full report of the staff consultation is attached to this document (Appendix 16).

Overall there is agreement with the strategic aims and staff want to provide services in the best way possible to people who need them. They recognise the complexity and conflicts between different priorities and demands on the services although they are not always clear about the reasons behind these. Staff want to provide good services but consider that the systems they work in can hinder their ability to do this. To help them to provide services in the way they consider best, staff want better management, clear care pathways and clear roles and responsibilities.

" There are too many people doing and assessing the same services…. We also overlap"

" It (the system) needs good holistic assessment, clear key worker role, and sharing information"

" There is Inequality between services – not whole system planning. Consequences of changing one part of the system are not thought through for the others".

To improve services to customers, staff identified assessment as a key part of the service delivery process and consider it should be provided at the right time, in the right setting and by the most appropriate person. Staff want less paperwork and bureaucracy to give them more time to spend with the service user. Services to keep people at home (e.g. therapy) are not currently joined up enough and there is a need to expand services beyond "office hours".

" We need to provide quality assessments and review, use Single Assessment Process as building block" " We need a 24 hour team of nurses and social care staff with medical backing"

There is inter-professional mistrust, which appears to be based on stereotyping and is sometimes dispelled by face-to-face contact. Staff are positive about how they have worked together but do not feel that they have the time or permission from managers to develop networks further.

" Its us and them, not my responsibility" " We need to learn to trust each others assessments"

"Currently it works well because of good relationships – if professionals or service providers don't know or understand each other's services, it doesn't work"

Staff experience and knowledge of multi agency working is positive and they are keen to develop this; they want more joint training and co-location. There were very positive comments regarding current multi-agency teams both from the staff involved in these services and from staff who had contact with them.

"Need joint training - recognise differences in language and understand it"

"Working in the same location helps with relationships"

The majority of the staff considered that integration could have positive benefits. Mostly they considered that service users would benefit from better organised, more efficient and more effective services. Staff felt that an integrated service would be easier to understand and access both for service users and workers. They considered that integration would resolve problems and issues regarding management, responsibilities and budgets, that it would allow for information sharing and resolve data protection issues and it would reduce duplication, infrastructure costs and provide economies of scale.

" Working under one umbrella may allow preventive services to happen – proactive not reactive services" " provides the right skills mix"

The concerns that were expressed regarding integration included a loss of professional power and democratic control. The difficulty of joining together different, legislative, strategic and financial systems was also discussed. These concerns were more prevalent amongst managers. Some workers considered that the professional and working cultures are too different to bring together and that we should concentrate more on finding ways of working together effectively.

" The trouble with integration is that so many are working on getting integration – the services are not being looked after!" "There are different targets and driving forces"

" Working together is more important than who you work for"

Stakeholder Day

To develop the consultation process, managers and strategic staff involved in services for older people were invited to a Stakeholder Day, which aimed:

- To share the draft findings of the review
- To provide an opportunity to discuss the strategic options
- To sign up to a strategic way forward
- To decide and recommend the shape of future services

A full report of the stakeholder day is attached to this document (Appendix 17).

In preparation for the Stakeholder Day, the BVR steering group identified some key discussion points and recommendations to present on the day. These included a proposed model of service integration.

During the stakeholder day there were in depth discussions about the aims and functions for each element of the model and how to take it forward. The participants agreed that that the proposed model did appear to provide an appropriate way forward and that services should integrate. Intermediate Care services were considered to be the best starting point for integration, but there was also a strong view that we had to begin work on developing a single point of access (referral) for community health and social care services.

Key Messages

- Older people want:
- A single contact point to get good information from one place when they need to access services
- Reliable and good quality services when and where they need them
- They do not mind who the provider is or how the services are structured as long as they are delivered effectively
- The needs of people from black and minority ethnic communities taken into account and culturally appropriate services developed

- Staff want:
- Less bureaucracy and better management allowing them to provide better services
- Clear care pathways
- More joined up working and integration where possible
- Better coordination / integration of nursing and therapy at home services
- More services available out of office hours

- Staff and managers are concerned about:
- Dilution of professional roles and boundaries
- Complexities around different HR, Finance and IT systems, eligibility and charging
- Retention of professional support/ supervision

- Stakeholders demonstrated broad commitment to integrating Intermediate Care services under one manager, and to carrying out detailed project work to establish integrated Access and Assessment teams.

Section F - Comparison

Another key element of best value reviews is to *compare* performance, budget, staffing etc with similar authorities and areas, as well as to look at examples of good practice to learn from. We compared the health and social care system in Milton Keynes with other areas through a range of methods:

- Comparing performance on published set of key indicators with our comparator group of similar authorities
- Questionnaire to these Councils and PCTs (poor return)
- Census and similar data, and financial information
- Visits to Luton and Peterborough (unitaries with co-terminus PCTs) and Northumberland (Care trust)

There are a large number of performance indicators for local authority older peoples services that have been publicly available for several years. Milton Keynes Council has a group of comparator authorities drawn up by the DoH and CIPFA, based on population and demography. The most recent comparable information is for the year 2001/02, so does not reflect changes as a result of Intermediate Care developments over the last year.

Within the NHS performance indicators that are relevant to older people are very difficult to identify, because services are not structured around client groups. A new series of publicly available indicators have recently been agreed and the collection of such information is beginning. Comparisons between PCT's and hospitals on the performance of services to older people should become possible over time.

Due to these differences in publicly available statistical returns local authorities can be compared more rigorously than the NHS. The comparisons that we have been able to make are a mixture of hard statistics from the DoH, Commission for Health Improvement (CHI) and other websites (Appendix 12), and information gathered on the visits. (Appendix 13).

Comparing overall performance with other authorities

We identified the most relevant key indicators from the Social Services Performance Assessment Framework (PAF) and these were compared across the comparator group (figures for 2001/02).

By scoring each authority between 1 and 5 for each indicator, we were able to assess Milton Keynes overall performance relative to our comparator group. This placed Milton Keynes in the middle of the group with a score of 34 compared to a top score of 39 (Luton) and a bottom score of 27 (Swindon).

Milton Keynes performed well in terms of intensive home care provision, emergency admissions to hospital and number of care reviews carried out. It performed badly in relation to admissions to residential/ nursing home admissions, proportion of older people from minority ethnic communities receiving services and the unit cost of home care and residential care.

In health terms, Milton Keynes performs well in terms of admissions of people over 75 to hospital because of falls/hypothermia and delayed discharges and badly in relation to access to GPs and hospital re-admissions.

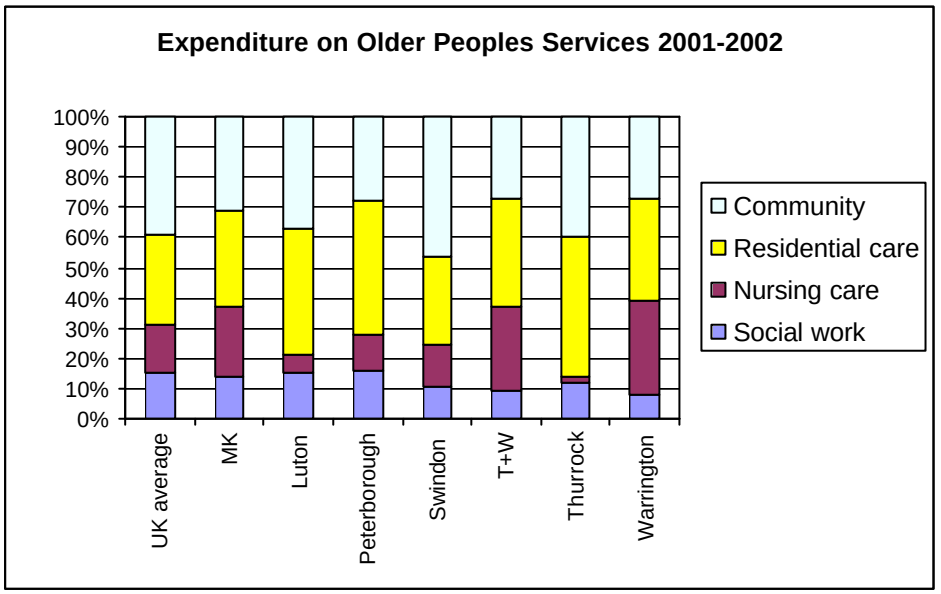
The data suggests that the health and social care community in Milton Keynes performs overall at an average level, but an increase in community based services is required to improve overall performance.

Patterns of expenditure

The Council does not spend significantly more or less money overall than other authorities on its services for older people.

The table below shows the percentage of expenditure on different aspects of older people's services (Source: DoH PSS Expenditure and Unit Costs 2001-2002)

It shows that Milton Keynes Council spends a larger percentage of its older people social care budget on residential and nursing home care (54.6%) compared to the national average (46%), and conversely less on community-based services such as home care & day care (31.4% compared with 39% nationally). By contrast, Luton spends 48.2% of its budget on residential and nursing home care and 37% on community-based services.



N.B. (T&W = Telford and Wrekin).

Specifically Milton Keynes Council spends 22.7% of its budget on nursing home placements, which is 7% more compared to the UK average. If there were 80 less people in nursing homes (a reduction from 230 to 150), about £700K more would be spent by the Council on community based services. As the PCT now fund the nursing element of nursing home care, with 80 less people in nursing homes the PCT would spend £350K less on the Registered Nurse Care Contribution (RNCC) than currently. This would still leave more older people in nursing homes per capita than in comparative authorities like Luton and Thurrock.

In practice such a change can only be made gradually by reducing new admissions to residential and nursing home care and supporting more very frail people in their own

homes or in sheltered housing. To some extent it is a chicken and egg situation. Investment up front in community based services will enable more people to be diverted from long-term care and thus free up resources more quickly for more community based services.

The total spend on PCT intermediate care and therapy services in Milton Keynes is not significantly different to those in other authorities; the differences are in the way it is spent. Milton Keynes invests in 17 Intermediate Care beds at Bletchley Community Hospital (BCH). Other PCTs have created community based intermediate care teams, reablement teams and hospital at home/ rapid response teams that provide rehabilitative focused care in people's own homes, through multi disciplinary and multi agency working, and available 24 hours a day, 7 days a week.

With the current levels of expenditure shown, 54.5% of the Council's budget for older people's provider services is spent on just 574 people in residential and nursing homes, whilst the other 45.5% is shared across more than 1750 older people living in their own homes. The majority of older people receive no social care service from the Council.

Comparing service configuration

Recent developments in older people's services, in line with the modernisation agenda, have included closer joint working, particularly through Intermediate Care services. The review team undertook visits to Luton and Peterborough to look at their services to older people and particularly Intermediate Care services, and to Northumberland where the first Care Trust for Older People's Services was set up in April 2002. Notes from the visits are attached to this report (Appendix 13).

There were several important learning points from the visits.

- It is not sensible to try to replicate exactly systems from other localities in Milton Keynes; there are too many local differences; but there are broad lessons to learn.
- Care management teams in the authorities visited have much higher proportions of unqualified staff to whom they provide access to training, so that they grow their own pool of skilled staff, without any loss in the quality of services provided, but often with more responsive and flexible service.
- Intermediate Care services do support all people who need intensive rehabilitation, whatever their diagnosis or condition, eg. in Peterborough 55% stroke, 45% conditions with complications such as MS+UTI, as well as terminally ill people.
- Experience has led to the conclusion that intermediate care services should be integrated under one manager (Luton advertising, Peterborough in place), with partnership agreements being developed.
- The key to their successful integration has been the development of trust amongst all levels of staff. This has taken time and commitment and has been "change managed" through facilitated meetings, joint training and shared vision documents.
- Localities have not sought to have total clarity of roles and arrangements prior to integration but have taken a "leap of faith" on the basis that the time was right and commitment was there. The view was that working out all the detail beforehand would cause indefinite delay.
- Northumberland, after a long history of joint working, considered that the best way to achieve integration was by integrating the Council and PCT into a Care Trust with one

board and one integrated senior management structure. Service integration could then effectively proceed from this.

Key Messages

- Financial comparisons do not show Council spending is significantly less than comparative authorities, but the way in which the money is used is different.
- The performance of the Council and PCT is about average when compared with comparator areas.
- Compared to the national average more money is spent on residential and nursing home placements (especially nursing home) and less on community based services.
- A large amount of intermediate care funding in the PCT is tied up in beds at BCH, and community based intermediate care services in people's own homes are not well developed.
- Other areas have developed integrated community based intermediate care services under one manager.
- Other areas have fewer qualified staff, but have invested in building the skills of unqualified staff.

Section G - Competition

This section of the review considers, in the light of the *Challenge* in section C and the information gathered through consultation and comparison, what *competitive options* might best improve services for older people in Milton Keynes.

In this context we take c*ompetition* to mean options for service development and reconfiguration, as the services we are looking at are primarily professionally led health and social care assessment services, where there is not an independent sector market for their provision, and there are legal barriers to their provision outside statutory bodies. Despite this, *competition* has relevance in that it helps us seek new ways of delivering key services more efficiently and more effectively.

Recent service developments

Over the last three years national reports and guidance such as the National Beds Inquiry, the National Service Framework for Older People (NSF), and Intermediate Care guidance have all supported the development of rehabilitative focussed services delivered in or as close as possible to people's own homes. In response to this the PCT and Council have begun to work more closely together and to develop new services locally, such as:

- 17 intermediate care beds at Bletchley Community Hospital (BCH)
- 10 intermediate care community flats at Orchard House
- Integrated community equipment services
- Intake and Rehabilitation home care (I&R)
- Community Health Access Team (CHAT)
- Extra care sheltered housing
- Step-down beds in residential homes

Although these developments have sometimes been joint, they have rarely been properly integrated across Council and PCT, and there remains confusion and/or uncertainty about function, role, referral criteria, pathways and objectives in many cases.

There is a perceived need to expand the availability out of hours nurse-led rapid response services and to provide better co-ordinated therapy services. There is also some concern that the beds at BCH are not used as effectively as they might be, that the average length of stay could be reduced and that a broader view of intermediate care/ rehabilitation could be adopted with clearer criteria and clearer pathways.

In addition the NSF and new Health and Social Care Bill poses further challenges in the need to develop integrated falls and stroke services, to implement the Single Assessment Process across health and social care, and to develop improved discharge pathways.

As yet we have made no use of Section 31 Health Act flexibilities in older people's services. Behind all of this, we need to improve the quality of care provided in all settings by making it more person-centred.

What the review has found

Older people and 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 current performance of services compared to other authorities is average in most areas. However in comparison to other authorities there is less intermediate care and rehabilitation provision available outside hospital settings, there is a lack of rapid response nursing/ therapy led community based service out-of-hours, and there is a high admission rate to residential care and nursing homes, especially to nursing homes.

Both the PCT and the Council face severe resource constraints, exacerbated in part because a larger proportion of their resources are spent on institutional care (hospitals and care homes) than in other localities.

It can be concluded that 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. Many older people going into long-term residential/nursing homes pass from the acute hospital to long-term council funding without engaging PCT services. Placements direct from hospital account for two thirds of all nursing home placements.

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 or to sheltered housing settings. This is what most older people prefer. This would also free up resources, including PCT funding of the nursing element of nursing home care, to develop rapid response and hospital at home type services that would in turn reduce emergency admissions to MKGH.

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 health and community 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.

The organisation of services

The question then moves to how community health and social care services should be arranged. The review listened carefully to both staff and older people, looked at different models of arranging services and held a stakeholder day with key managers to consider a proposed model.

The services currently are structured around professions and to some extent conditions and age groups. This will make large-scale integration challenging because health services are structured differently (more by profession) than social services (more by age). However there are significant policy and financial pressures from the DoH pushing health and social care services closer together.

Older people want good information and good services as close to home as possible without waiting. They did not express strong views on which agency provides a service, or how services are organised, as long as they did the job well. Staff recognise the need to work together and, for many, integration appeared to be the logical way forward. However there are concerns about the complexity of integration, such as legal, HR and financial matters, as well as issues of management, accountability and resource control.

Leaving the health and social care systems unchanged raises questions of how we will meet the national modernisation agenda and does not satisfy local staff and managers who want to provide better services. Those consulted were overwhelmingly in favour of some form of integration.

Integration can be considered at a number of different levels. The Northumberland model of creating a Care Trust and integrating at board and senior management level might prove the most robust way in the long-term, but appears to delay integration at a service level (in Northumberland it has taken a year to integrate senior management).

Locally we have experience of integrating the mental health and learning disability services. The adult mental health service had a history of joint working through the CMHTs. This was less developed in the learning disability service and as a result the integration process has been slower. In both cases the complexity of working through the details of a partnership arrangement have taken some energy and focus away, in the short term, from the drive to improve services, although service improvements have been made.

There is no single model for developing integrated services that can be applied, but the experience of successful organisations show that the steps to delivery of good services include:

- Building a strategic vision including the views and aspirations of older people
- Mapping services at a system and individual level to ensure a comprehensive range is provided
- Investing in development capacity to redesign services and encourage small scale innovation
- Ensuring there are enthusiasts at key points in whole system to exploit opportunities for new organisational relationships
- Ensuring new approaches penetrate mainstream services
- Integrating services and teams under one manager on the principle that managers can manage all disciplines as long as parallel systems of professional support are in place
- Monitoring progress

A model for integration

The steering group has developed a model of integration that it considers could be achieved locally and would better support the modernisation agenda and deliver better services to older people. This model received widespread acceptance on the stakeholder day. The model aims to keep older people independent and at home for as long as possible, by providing assessment and rehabilitation structured around functions rather than professions. Key to the model is the development of *single point of access* so that professionals, older people and carers can access appropriate community services with a minimum number of referrals and a single form of assessment. This model calls for the

development of ***single point of access*** **integrated access and assessment teams** in Milton Keynes. There might be two or three such teams serving localities.

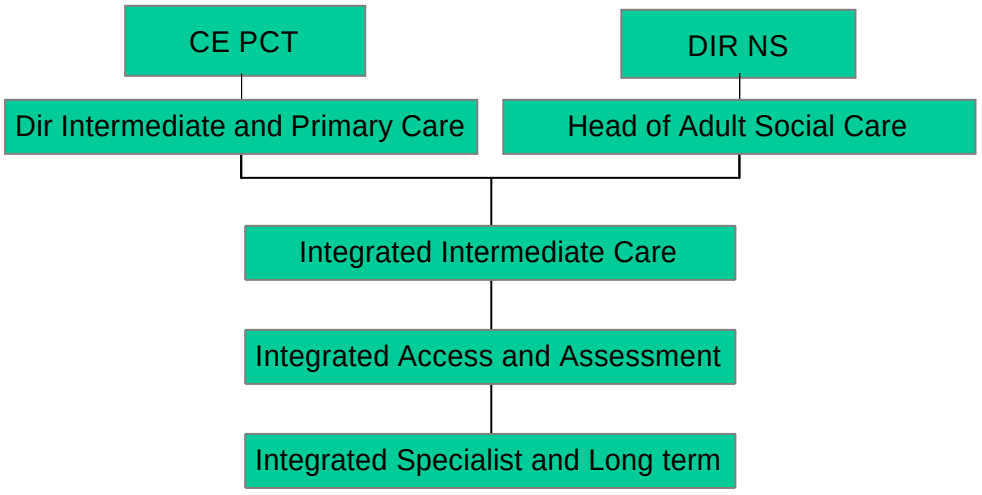
The model includes an ***integrated Intermediate Care service***. This would provide rapid response nursing therapy and home care within people's own homes to prevent unnecessary admission to hospital and long term care and enable early discharge from hospital. The service would be easily accessible and available 24 hours per day, 7 days per week, and provide a time-limited intensive nursing and therapy service that provides care through a crisis without disrupting the long-term support systems and increases the ability and confidence of the older person, while supporting their carer. There would be a single point of access for all Intermediate Care services with multi-skilled generic workers working alongside specialists.

The ***Integrated Access and Assessment service*** would aim to provide a single point of information and access to appropriate assessments, which would be provided promptly, sharing information across agencies to prevent duplication and using clear care pathways to ensure that the person accesses the correct service first time. It requires multi disciplinary and multi agency teams containing nursing, therapy and social care staff able to complete contact and overview assessments and commission care to meet the health and social care needs identified.

The third element of this broad model of integration would be the development of services supporting **people with chronic conditions/ long-term needs** organised in part along specialist lines. These would be multi-agency and multi-disciplinary teams with specialist staff and they would complete comprehensive and specialist assessments, commission health and social care services and review care needs regularly. The Older People's mental health service already has plans to create two locality based specialist teams in line with this model, over the next six months.

The model would sit within the current senior management structures and services would be accountable to both the PCT and Council. There is no proposal to place the managerial responsibility in one organisation. The review considered that senior management commitment in both organisations was needed to implement the proposed integration, and therefore consideration of integrating senior management should wait until service integration was achieved.

The model is shown diagrammatically below:



There might be one intermediate care team, two or three Access and Assessment teams, and long-term/specialist teams for older people physically frail (2?), older people mental health (2), and younger adults physical disability, or other combinations.

If it is agreed to implement this level of change within the organisations there will be a need for careful and coordinated planning. A steering group will be needed to manage the process (see Recommendation 2) and a suggested flowchart showing the accountability of this steering group has been included (see Appendix 19).

Care Pathways – Stroke, Falls and Dementia, and services for people under 65

Alongside the Best Value Review, work was undertaken within the relevant services developing care pathways in three areas: for stroke care; for management of falls; and for people with dementia (see Appendix 18). Stakeholders involved in developing these pathways were invited to the review stakeholder event. The review has sought to find a broad, generic (to older people) model of integration in which each pathway can be accommodated. The review also developed a model that accommodates services for younger disabled or chronically ill adults in recognition that many services are not provided on age lines.

The model supports the pathways work as it includes the potential to have either specialist roles within functional teams eg. stroke therapy specialists within the intermediate care service or specialist teams eg. stroke therapy team managed within the intermediate care service. We envisage the Falls service being part of an integrated intermediate care service. Services for people with dementia will de delivered primarily through the specialist teams (see above) with screening and contact/overview assessment taking place in the integrated access and assessment teams. Access and assessment teams are seen as generic first points of contact and therefore would carry out contact and overview assessments for adults under 65 as well who are ill or disabled and have care needs. The model also envisages a younger adult specialist integrated physical/sensory disability service.

Key areas for service improvement

A consistent message from the review is the need to expand **services out of hours** and to move towards services that are accessible whenever they are needed. A national plan and targets have been set to better coordinate the primary care out of hours services and links could be made to this group locally to support the coordination of out of hours community health and social care services. Integrated intermediate care services would act as a focus to develop responsive out of hours services.

Now that the PCT is responsible for the nursing element of nursing home care and there are clear joint assessment arrangements for continuing health care, the **pooling** of the PCT continuing care budget for older people with its budget for the nursing element of nursing home care and the Council's budget for nursing home placements would support joint-working and help develop a shared culture and aim to find ways to divert people from nursing homes to residential and community based options, thus freeing up resources for more community based care.

One of the challenges in moving services forward is the **workforce planning** needed to meet changing demands for services. Nationally the need for new types of generic workers has been recognised and is being developed. Locally the changes can be supported through more joint training and multi-skilling of staff. There are National Occupational Standards that outline competencies for promoting independence and supporting therapeutic treatments that could be used to provide an assured level of competency.

The process also needs to be linked to an effective change management process that addresses necessary cultural changes. In particular we need to recruit and develop multi-skilled non-professional staff who can provide a range of skilled care services in both health and social care settings.

Information technology is a major challenge for joint working. Currently there are multiple systems that are unable to share information, within a single agency as well as across agencies. There are targets to enable the creation of single electronic records in health and social care and the electronic sharing of records across locations and agencies.

Locally an Information Systems Strategy has been produced that sets out a way of joining up existing IT systems (using XML) and outlines how the project could be taken forward. This needs to be supported to ensure that integrating services does result in the reduction of duplication.

In carrying forward any model of integration, we need to have a clear understanding of the role and importance of **local voluntary and independent providers** in the delivery of health and social care services, and make sure we fully utilise their resources where they are of good quality and cost effective. We need to explore the potential of independent providers to provide rehabilitative services, for example.

Demographic information shows major growth in the young elderly, aged 65-74. These people will be fitter, healthier and more economically independent than ever before. They also hold huge potential as a **voluntary sector workforce**, supporting people to remain at home and also developing their own understanding of the role of the health and social care services in supporting older people. To do this the statutory services need to provide a stronger enabling role with the voluntary sector to develop a coordinated approach to encouraging voluntary work amongst this age group.

What needs to be in place to achieve an integrated service

There are also risks to the implementation of the vision and model outlined. These include the lack of financial robustness in the budgets for services to older people. In all organisations demand is running ahead of current budgets and any reorganisation of services may need an **invest to save approach**. This is likely to require more initial investment until services are developed, which in the current financial circumstances will require a high level of trust between the organisations.

In developing integrated services through partnership arrangements the complexity of **financial, legal and human resource issues** is significant. Considerable and detailed work needs to be undertaken to understand and address these issues. This requires senior level commitment in the PCT and Council, and freed up capacity to do the necessary work.

Lastly without a proactive programme of **change management** to develop champions and enthusiasts throughout the system, to manage the concerns of staff around change and the different cultures of the two organisations, any progress in developing joint structures could be severely undermined.

It is suggested that a **small project team** with dedicated staff resources from both PCT and Council will need to be established to carry out detailed consultation and planning, to explore issues of team structure, make-up, location and function and to establish clear protocols and pathways to implement integration across intermediate care and access and assessment services.

This review is advocating **medium term strategic change** through the integration of assessment and care management services with rehabilitative nursing and therapy services and home care. The change will need to take place over a number of years.

The review sees change starting by integrating intermediate care services under one manager, while developing plans to create integrated access and assessment teams in a year to 18 months time. The development of integrated specialist teams will happen at a different pace in different services, with the Older People's Mental Health service likely to integrate first.

Section H - Recommendations for change

1. To adopt the vision outlined below for the future joint development of services

We will provide integrated community-based health and social care services that are:

- Person centred and needs led
- Easy to understand
- Focused on keeping older people at home
- Provided without delay, when and where they are needed
- Better organised, making the most effective use of resources
- Designed to ensure no-one is admitted to acute hospital unnecessarily or discharged to permanent residential/nursing home care from acute hospital
- Organised around functions rather than individual professional activity/service areas

2. **To adopt the model agreed at the stakeholder day for the future joint development of services.**

A description of the model is in section F - Competition.

3. **To set up a project steering group to develop and implement detailed project plan for integrated intermediate care, access and assessment service and long term / specialist services**.
   - To integrate the Intermediate Care services under a single manager as stage one (over next 9 months)
   - To fund dedicated project development capacity 50/50 from Council and PCT to develop and implement the detailed plan integrating services.
   - To develop integrated locality based access and assessment teams each with single manager as stage 2 (over next 18 months/2 years)
   - To develop integrated long-term/specialist team over next three years, starting with older people's mental health.
   - To accommodate stroke and falls specialist staff for community services within integrated intermediate care services

4. **To develop a proactive programme to support change and change management**
   - Develop and resource a joint training programme to support integration
   - Develop workforce planning strategy for recruiting and developing/multi-skilling staff based on the National Occupational Standards.
   - Continue to develop IT systems that can share information and revise policies on confidentiality/ information sharing to enable sharing across organisational and professional boundaries
   - Agree a joint approach to develop information about a wide range of services, making preventative services across both statutory and voluntary sector easier to access

5. **To develop and co-ordinate out of hours services**
    - Priority for investment in community based nurse/ therapy led rapid response services
    - Seek to establish ‘hospital at home’ service, combining focused short-term nursing, therapy, equipment and home care input
    - Greater co-ordination needed across community health, emergency social work, home care, community alarm service, NHS direct and primary care out of hours services locally

6. **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**
    - Ensure all services are person-centred and focus on rehabilitation
    - Ensure older people receive recuperation and rehabilitation services (away from acute hospital) before making a decision on long-term care needs
    - Establish clear criteria and pathways which compliment each other for all intermediate care and rehabilitation resources including Bletchley Community Hospital, Orchard House, step-down beds, CHAT and Intake and Rehab. Home care.
    - The PCT and Council explore development of pooled budget combining continuing care, ‘free’ nursing care and nursing home placements budget
    - Develop culturally appropriate community based services for older people from black and minority ethnic groups to support them to remain at home
    - Council sheltered housing is developed to support older people with high care needs including older people with dementia

Section I – Service Improvement Plan

To adopt the vision and model for the future joint development of services.				
Recommendation	**Action needed**	**Lead name**	**Timescale**	**Cost / savings**
To adopt the vision for the future joint development of services.	• Sign up across all agencies • Communicate the vision • Incorporate in policy and training	JHSCB AG/RW AG/RW	Oct 03 Mar 04 Mar 04	Nil
To adopt the model agreed at the stakeholder day for the future joint development of services.	• Sign up across all agencies	JHSCB MKC Cabinet PCT Board MKGH Board	Oct 03	Nil
To set up a project steering group to develop and implement detailed project plan for integrated intermediate care, access and assessment service and long term / specialist services.				
Recommendation	**Action needed**	**Lead name**	**Timescale**	**Cost / savings**
To fund dedicated project development capacity 50/50 from Council and PCT to develop and implement the detailed plan integrating services.	• Establish agreed joint dedicated capacity • Establish project group • Produce project plan	JHSCB AG/RW AG/RW	Dec 03 Dec 03 Mar 04	+£40k for two years Nil Nil
To integrate the Intermediate Care services under a single manager as stage one	• Appoint Intermediate Care coordinator • Develop detailed model of integration for IC services • Develop agreed aims, protocols, criteria and pathways for all IC services • Implement integration of IC services under one manager • To develop an integrated community stroke service • To develop an integrated falls service	AG/RW IC coordinator IC coordinator AG/RW NSF Stroke Group	Oct 03 Feb 04 Apr 04 Jul 04 Mar 05	From Performance Fund 03/04 Joint funded manager post (+£50k or from existing resources) costs to be identified by group Reconfigure existing resources

		NSF Falls Group	Mar 05	(or +£30K Falls coordinator / advisor)
To develop integrated locality based access and assessment teams each with single manager	Consult widely with staff and other stakeholders on integration project plan Develop detailed model of integration for Access and Assessment Develop agreed aims, protocols, criteria and pathways for referral and assessment Implement integrated assessment service	Project Group Project Group Project Group Project Group	Jun 04 Oct 04 Jan 05 Jun 05	Nil Nil Nil Potential relocation /accommodation /IT costs
To develop integrated long-term/specialist team over next three years, starting with older people's mental health	• Develop integrated OPMH service • Develop integrated frail OP service • Develop integrated younger adult (PD) service	Chris Moody Project Group (2nd stage) PD Review Group	Mar 04 Oct 05 to Oct 06 04/05	Nil Nil Nil

To develop a proactive programme to support change and change management

Recommendation	Action needed	Lead name	Timescale	Cost / savings
Develop and resource a joint training programme to support integration	• Draw up integrated services training programme • Implement programme on multi agency basis	Project Group and MKC and PCT staff development sections	Mar 04 Apr 04 to Mar 06	Nil +£50k shared between PCT and MKC
Develop workforce-planning strategy for recruiting and developing/multi-skilling staff based on the National Occupational Standards.	• Develop joint recruitment and training plan for unqualified staff to work across health and social care boundaries • To appoint and develop above staff	MKC and PCT HR services IC service / Access and Assessment service	Apr 04 Oct 04 onwards	Nil From existing vacancies or from funded expansion of IC services
Continue to develop IT systems that can share information across organisational and professional boundaries	• Establish secure IT links between PCT / MKC / MKGH • Revise policies on confidentiality / information sharing	PPT IT sub group	Oct 03 Apr 04	Capital already found Nil

	• Implement Single Assessment Process electronically		Apr 05	Capital cost to be identified
Agree a joint approach to develop information about a wide range of services, making preventative services across both statutory and voluntary sector easier to access	• Develop single point of access for information for older people within voluntary sector • Develop clear, easy to understand and accessible information about health and social care services in plain English and translated	Joint commissioning team Communications group	Oct 04 Oct 04	Nil Existing budgets

To develop and co-ordinate out of hours services

Recommendation	Action needed	Lead name	Timescale	Cost / savings
Need to develop community based nurse / therapy led rapid response service	• Refocus and expand CHAT to cover evenings and weekends – with homecare support	RW	Oct 04	+£200k
Seek to establish 'hospital at home' service, combining focused short-term nursing, therapy, equipment and home care input	• Combine with CHAT or develop specialist team – with homecare support	RW	Apr 05	+£200k
Greater co-ordination needed across community health, emergency social work, home care, community alarm service, NHS direct and primary care out of hours services locally	• Establish out of hours project group • Develop models for improved coordination / integration	RW/AG	Jan 04 Dec04	Nil

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

Recommendation	Action needed	Lead name	Timescale	Cost / savings
Ensure all services are person-centred and focus on rehabilitation (NSF Standard 2)	• Develop multi agency person centred training programme	Project Group and MKC and PCT staff development sections	Apr 04 – Mar 05	From within existing MKC/ PCT/MKGH budgets
Establish clear criteria and pathways which compliment each other for all intermediate care and rehabilitation resources including Bletchley Community Hospital, Orchard House, step-down beds, CHAT and Intake and Rehab. Home care.	• Produce clear multi agency Intermediate Care services criteria and guidance • Ensure clear aims and criteria for each service and that services work together	IC coordinator RW/AG and IC coordinator	Apr 04 Apr 04	Nil Nil

Ensure older people receive recuperation and rehabilitation services (away from acute hospital) before making a decision on long-term care needs	• Establish clear and rapid pathways to IC services • Develop plan to reduce number of older people entering long term residential and nursing home care • Reduction in supported older people in nursing home care (80 over 3 years) – maintain current level of residential care. Dependent on IC services investment. As community IC services develop (see ?? above) and numbers in res/nur care reduce so resources are freed for further community service development.	RW/AG, MKGH and IC coordinator RW/AG, MKGH and IC coordinator RW/AG	Apr 04 Apr 04 Apr 04 – Mar 07	Nil -£1.05m Reduction of 80 places in nursing home care would release £350k for PCT and £700k for MKC to invest in admission prevention and rapid discharge services.
The PCT and Council explore development of pooled budget combining continuing care, 'free' nursing care and nursing home placements budget	• Carry out detailed work to establish pooled budget • Set up pooled budget	PPT Finance sub group	Oct 04 Apr 05	Nil, but joint management of pooled resources will produce savings to reinvest over time.
Develop culturally appropriate community based services for older people from black and minority ethnic groups to support them to remain at home	• Develop strategy for BME services • Develop culturally appropriate preventative services	Joint Commissioning Joint Commissioning / ASC	Apr 04 Apr 04 – Mar 05	Nil +£50k
Council sheltered housing is developed to support older people with high care needs including older people with dementia	• Develop plan for long term use of council sheltered housing • Develop specific sheltered housing schemes with care support to meet the needs of very frail older people	AG/Sandra Rankin AG/SR	Apr 04 Apr 04 onwards	Nil Within existing resources (possible small capital expenditure)

Risks to the Service Improvement Plan

The improvement plan above in many cases involves the development of jointly agreed clear vision, strategy, aims, care pathways, criteria and working protocols. With commitment across PCT, MKC and MKGH, these should be relatively easy to put in place. However each partner needs to be committed to developing these and ensure that capacity is found at the appropriate level of seniority to make a meaningful contribution and take ownership.

The improvement plan main recommendation concerns the integration of intermediate care and access and assessment services under a single management structure. To achieve this involves a very significant change management programme, including interdisciplinary working, non-professional management structures, an agreed single assessment process and possible changes of location and accommodation. The PCT and MKC need to be signed up to this level of major organisational change and devote the necessary resources to project manage the change over the next two years.

In terms of investment and disinvestments and service redesign the improvement plan proposes increased investment in years 1 and 2, in community based rapid response, nursing / therapy led services, including operating out of hours, focussed on hospital admission prevention, and facilitated and timely hospital discharge with rehabilitation. It is considered that such an expansion of community based intermediate care services will lead to a reduction in numbers of older people in long term residential / nursing home care (especially nursing home care) thus freeing up more resources to reinvest while at the same time assisting the hospital by reducing emergency admissions and facilitating timely discharge. However if investment is not able to be made in community based IC services, then it will be much more difficult to release resources through the reduction of residential / nursing home placements.

If investment is not made in community based services, we run the danger as the population of older people grows of getting into a vicious circle of increased delayed discharges, increased admissions to long term care and over commitment of available resources with a consequent reduction in community support and prevention leading to increased admissions to the acute hospital etc.

For effective integration to take place MKC and PCT together must ensure that compatible support systems, especially in relation to HR policies, finance systems and IT systems are put in place to enable staff to focus their energies on service provision for older people. We must also find a way to ensure that the least bureaucratic forms of legal agreement, management and reporting systems into each organisation underpin integration.

If we are committed to integration at any level it requires some degree of initial investment in terms of staff time and capacity as well as sufficient financial resource. The PCT, MKGH and MKC are operating under significant financial constraints. Each organisation needs to decide whether the implementation of the improvement plan is a priority for it, and if so, ensure that sufficient resource and capacity is made available.