



ENHANCED AND SPECIALISED CARE COMMISSIONING STRATEGY



Northern, Eastern and Western Devon
Clinical Commissioning Group



INTRODUCTION

The Enhanced and Specialised Care system will consist of quality specialist health and care services delivered as close to home as possible that promotes choice, independence, dignity and respect. The provision that supports people in this system is mainly delivered in an acute hospital or in a residential, nursing home or a hospice setting, and also includes some people supported at home, mainly at the end of life.

This strategy is one of four integrated commissioning strategies. The services in this strategy will be required when interventions that are delivered by the other three strategies are not able to achieve the outcomes required by people who are often acutely ill or have a requirement for specialist treatment.

Successful delivery of the other three related strategies minimises the need for enhanced and specialised care. However, for a small proportion of acutely ill children and adults with highly complex needs the system must be person centred, efficient, effective and focused on a return to wellbeing, where possible. This system represents the 'top tier' of care and is, therefore, the highest cost. Often, small amounts of money invested earlier can prevent escalation or deterioration and consequently the need for enhanced and specialised care.

The services that are included in this strategy are:

- Individual Patient Placements
- Care homes for both working age adults and those over 65
- End of life care
- Specialist and tertiary services

These services are needed by people when other interventions have not achieved their outcomes and their health care needs cannot be met or provided elsewhere. Often referrals originate from another healthcare organisation.

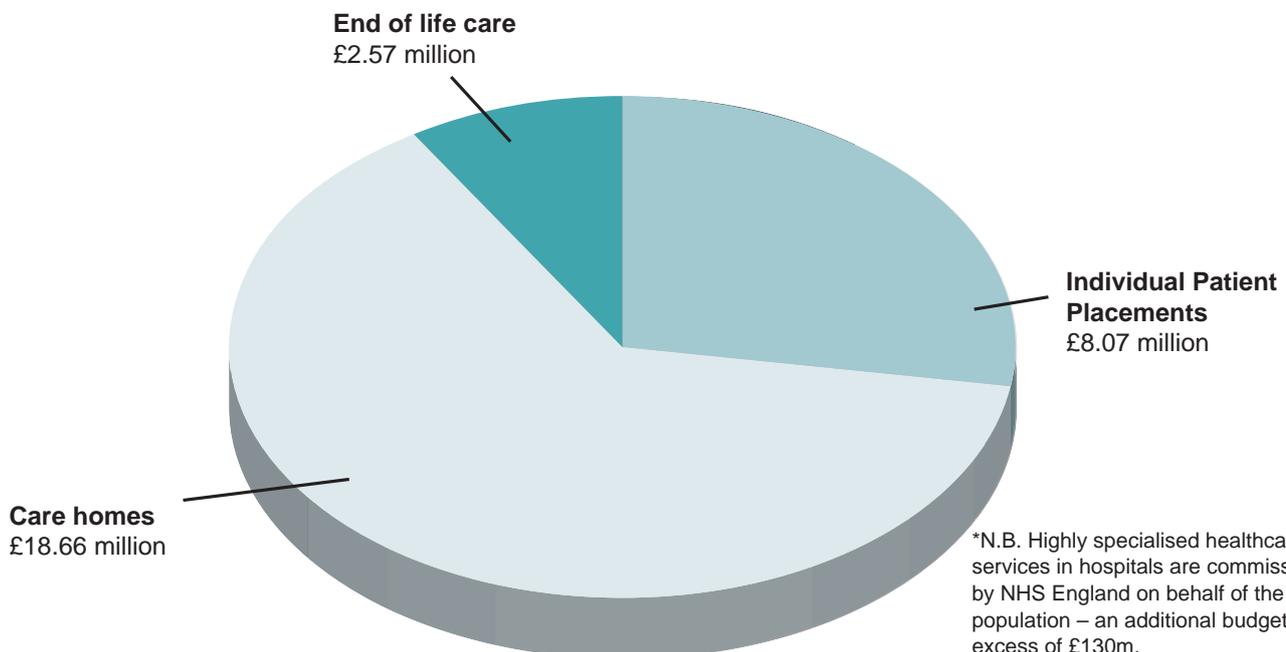
In 2015/16 the identified spend on services within scope of the Enhanced and Specialised Care Strategy is £29.30 million*. This comprises the CCG and PCC relevant spend within the Plymouth integrated fund and the CCG's relevant spend for South Hams and West Devon. The approximate breakdown of this is shown in the chart below.

In a future system we will:

- Commission services that will promote early intervention and prevention
- Up-skill staff and promote the use of technology, where appropriate
- Keep people out of hospital by prevention and earlier intervention
- Commission high quality services
- Make effective admissions to care home settings
- Improve the management of medicines in care homes
- Ensure good patient flow in and out of hospitals
- Support the local provision of specialist and tertiary services

All designed with a system aim of reducing the need for hospital and other enhanced provision and acute episodes of care, whilst ensuring ongoing provider development linked to research and innovation.

The identified spend of services within the scope of Enhanced and Specialised Care £29.30m*



*N.B. Highly specialised healthcare services in hospitals are commissioned by NHS England on behalf of the local population – an additional budget in excess of £130m.



ONE SYSTEM... FOUR COMMISSIONING STRATEGIES

WELLBEING

People and communities will be well, stay well and recover well. This strategy supports healthy and happy communities by putting health and wellbeing at the heart of everything we do.

CHILDREN AND YOUNG PEOPLE

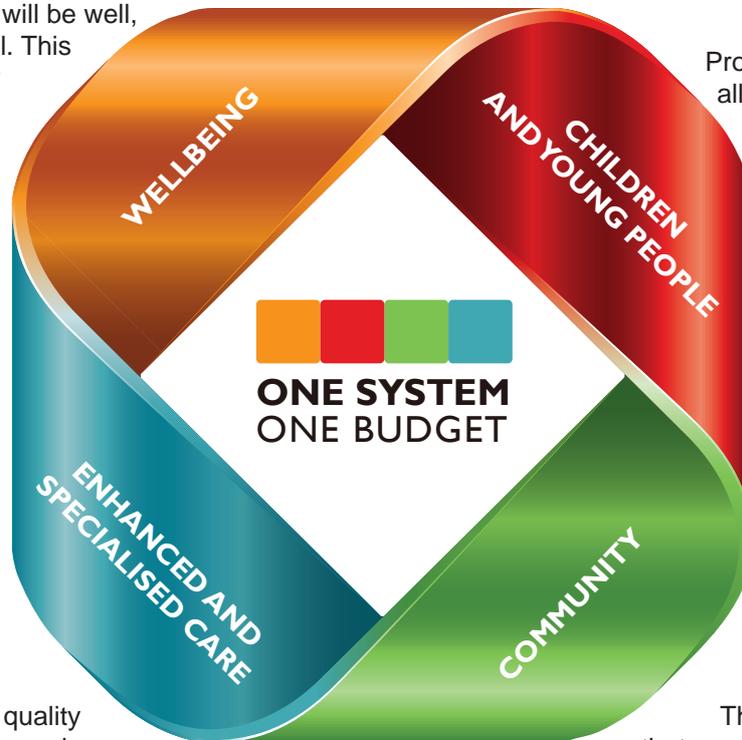
Provide the best start to life for all children from pregnancy to school age, and the right support at the right time for vulnerable children and young people.

ENHANCED AND SPECIALISED CARE

A system that consists of quality specialist health and care services that promotes choice, independence, dignity and respect.

COMMUNITY

This strategy targets services that support people to maintain their independence in their own home within their own community.



Commissioning an Integrated System for Population Health and Wellbeing

- Overall strategic direction and response to national strategy
- Integrated commissioning – now and future
- Needs assessment

- Strong, safe and healthy communities
- Supporting and utilising social networks
- Improved emotional wellbeing and mental health
- Increasing investment in public health
- Planned health care
- Planned care for children and young people with physical illness

- Universal early help and best start to life
- Integrated education, health and care plans
- Short breaks for children and young people and their parents
- Safeguarding children and preventing vulnerability
- Support to keep children and young people stable at home, in alternative family arrangements, in foster care or alternative placements
- Residential care for children and young people, including mental health and learning disabilities

- Targeted services for people who need support in the short-term to recover from a crisis or short-term need, e.g. reablement
- Focus of people as individuals and not patients; who have their own beds in their own homes
- A joined up 'whole system approach' to support people with multiple needs
- Targeted resources for those who need long-term support in the community

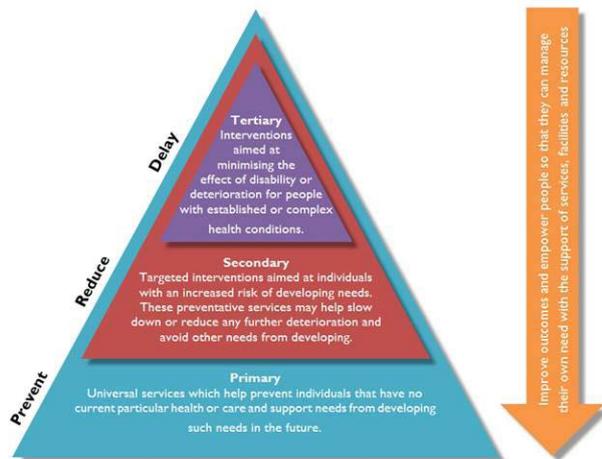
DEFINITION OF ENHANCED AND SPECIALISED SERVICES

This strategy is focusing on the provision of enhanced or specialised care. This level of care tends to be required at the third stage of prevention, where the most important aspects are to ensure that the person has high quality care, delivered in a way that is best for their needs.

On the whole, primary and secondary prevention would be delivered through the other three strategies. However, there are still some areas where these other forms of prevention are important in enhanced care. For example, ensuring that a person has access to high quality services through appropriate pathways that are clear and easy to understand can significantly assist in improving their quality of life and their carers. Carers are known to be at risk of poor health and wellbeing, and we would aim to prevent or significantly reduce this.

People who have complex needs for one or more condition may also be at risk of other conditions, and so primary or secondary prevention may be important for them. For example, in a care home setting the spread of infectious diseases such as norovirus or influenza may be reduced by taking specific steps in the management of the home.

The definition of 'prevention'



Prevention can often be broken down into three general approaches: primary, secondary and tertiary prevention. It is important to remember that services can cut across any or all of these general approaches.

Primary Prevention (Prevent – promoting wellbeing)

These are universal services that are provided to help prevent people with no current particular health or care and support needs from developing such needs in the future. Examples could include access to good quality advice and information, promoting healthy lifestyles and reducing loneliness and isolation.

Secondary Prevention (Reduce – early intervention)

These are more targeted interventions that are aimed at individuals with an increased risk of developing needs. These preventative services may help slow down or reduce any further deterioration and avoid other needs from developing. Examples could include fall prevention clinics, adaptations to housing to improve accessibility, short-term provision of wheelchairs or Telecare, as well as support for a family carer to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing.

Tertiary Prevention (Delay)

These interventions are aimed at minimising the effect of disability or deterioration for people with established or complex health conditions by supporting people to regain skills or manage/reduce their need where possible. Examples of such prevention could include rehabilitation or reablement services, community equipment services, improving the lives of carers and the use of joint case-management for people with complex needs.



AIMS OF THE ENHANCED AND SPECIALISED STRATEGY

We will:

Aim One

- Create Centres of Excellence for enhanced and specialist services

I have a sense of belonging and of being a valued part of family, community and civic life

I know that services are designed around me and my needs

Aim Two

- Ensure people are able to access care as close to their preferred network of support as possible

Aim Three

- Provide high quality, safe and effective care, preventing people from escalating to, or requiring, urgent or unplanned care

I live in an enabling and supportive environment where I feel valued and understood

WHO WILL BENEFIT FROM THIS STRATEGY?

Individual Patient Placements (IPPs)

Individual Patient Placements are generally specialist hospital placements for people who have been detained under the Mental Health Act. Individual Patient Placements include the commissioning of some highly specialist assessments, individual placements and packages of care for:

- Adults aged 18-64 years with complex mental health problems
- Older adults over 65 years: these are more often related to functional mental health problems and sometimes people will have had a forensic history. There is also a small minority of people with dementia whose needs cannot be met by existing older persons' inpatient units and so require placement elsewhere
- Adults less than 65 years with early onset dementia
- People with a learning disability and complex needs
- People with physical disability requiring rehabilitation who do not currently meet the criteria for NHS continuing healthcare; e.g. people with a brain injury requiring neuro- rehabilitation or who have challenging behaviour, or people with a complex mix of physical and mental health problems
- Health-funded components of s117 aftercare package: this is aftercare for individuals who have been detained under certain sections of the Mental Health Act
- Health component of s117 leave for 1 month: this is leave from a hospital placement when an individual has been detained under the Mental Health Act as part of a discharge process
- Psychiatric Intensive Care Units (PICU)

Care homes

The majority of people who choose to move into a care home do so due to their own personal circumstances and preferences. Following an assessment process, health and social care services will agree to fund placements where a person's health and care needs are too complex to be met effectively in their own home. This may also be subject to a financial assessment to determine if the person has to contribute to their care home fees. Many people pay for their own care.

Care homes offer accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as

young adults with learning disabilities. A care home is a place where personal care and accommodation are provided together and are integral to the health and care system in Plymouth; providing additional choices in respect to where people live and receive care to meet their needs.

Care homes can be residential or nursing or a combination, nursing homes include nursing, convalescent homes with nursing, and respite care with nursing. Residential homes include: residential home, rest home, convalescent home, respite care and therapeutic communities.

Some examples of how care home beds are used:

- As a permanent home
- Intermediate care: care services may make temporary placements in care homes as a 'step down' from hospital or 'step up' to avoid hospital admission. There are also some beds used by people who have had serious physical injuries and are recovering, which may be for several months
- Respite care: respite care supports a person and their carers with management of their condition. Respite care can positively impact the carer's health and wellbeing, which can enable them to continue providing care within their own home
- Long-term care due to frailty
- Long-term care due to complex health/physical needs

End of life

This is a range of services to provide palliative and end of life care, night time and day time nursing care, personal care and beds across the community. This includes bed-based care in hospices, hospital settings, and care homes and services that take place in people's homes, as well as care provided by other charitable organisations. Increasingly, this is leaning towards provision of end of life care to take place in a setting of a person's preferred place of care; and services need to develop to reflect this changing landscape.

Carers are a particularly vulnerable group who tend to have poorer health and wellbeing as a consequence of their caring responsibilities. Provision of high quality end of life care, responsive to the needs of the person, can have a significant impact on the health and wellbeing of carers.



Specialist and tertiary care

Specialist and tertiary care services are provided in the acute hospital at Derriford Hospital, which is the tertiary centre for the Southwest Peninsular and is also the location of choice for people requiring 'secondary' care across Plymouth, South Hams, West Devon and East Cornwall. These are funded either by other Clinical Commissioning Groups or by NHS England.

Specialist care is healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients; for example, specialist cardiologists and neurologists. It includes necessary treatment for a short period of time for a brief but serious illness, injury or other health condition and also includes major trauma, critical care and some specialised elements of end of life care.

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of patients but with catchment populations of usually more than one million. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise.

Tertiary care is specialised healthcare, usually for inpatients through referral from a primary or secondary health professional, in a setting that has facilities for advanced medical investigation and treatment. Examples of tertiary care services are cancer management, neurosurgery, cardiothoracic surgery, childhood cancer care, plastic surgery and other complex medical and surgical interventions.

All planned 'Secondary' healthcare in the Plymouth Hospitals NHS Trust which is commissioned by NEW Devon CCG is described in the Wellbeing Strategy.

Safeguarding adults

The Care Act 2014 has set out the following seven principles which provide us with a safeguarding framework:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent
- Prevention – It is better to take action before harm occurs
- Proportionality – The least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need
- Partnership – Local solutions through services working with their communities.
- Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – Accountability and transparency in delivering safeguarding

Safeguarding Adult Boards are for the first time included within a legislative framework. The Council, the Clinical Commissioning Group and the Police are working with the people of Plymouth, Board Partners and Stakeholders to achieve these principles and they have been used as the basis for the Plymouth Safeguarding Adults Board's 2015/16 Strategic Plan.

In 2014/15 we recorded in excess of 1,600 safeguarding alerts for adults, continuing the increasing trend which started in 2013/14. This increase is a result of awareness-raising among professionals in the city and supplemented by improved recording practice.

On average, over 40 alerts will proceed to investigation each month; in 2014/15 there were 542 completed investigations across the whole year. One of the focuses of internal monitoring will be the outcomes for people who are the subject of the safeguarding investigation; for example, has the risk been reduced or removed altogether.

The country as a whole is seeing a rising trend in safeguarding alerts; Plymouth is in line with the national trend.

WHY DO WE NEED TO CHANGE?

- A significant proportion of the adult social care and healthcare budgets is associated with the elderly frail population
- Early identification of frailty and appropriate interventions can reduce adverse outcomes and save money
- Residents of care homes account for a significant proportion of avoidable admissions to hospital, with falls being a major cause, and admission to hospital is more likely for people with dementia
- Lifestyle-related diseases and multi-morbidities in future years are predicted to increase, resulting in a larger number of residents who could be more dependent
- An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions, with individuals often having multiple long-term conditions. The complexity of need of people living in care homes is increasing. This will mean care home provision will need to be better at supporting people with complex needs, particularly dementia and mental ill-health
- It is estimated that 15 million people in England now have a long-term condition (Department of Health 2012), and 58% of people aged 60 years and over reported as having at least one long-term condition. In 2008, 1.9 million people had one or more non-curable long-term condition, but this is expected to rise to 2.9 million by 2018. In addition, 25% of people aged over 60 years report having two or more long-term conditions.
- The changing demographics described above will result in increasing demand for care home placements and nursing care
- Individual Patient Placements are often out of area and expensive and do not fit with the Care Closer to Home agenda, as set out within The Five Year Forward View published by NHS England.
- There is pressure from national policy and the public to ensure that people can die in their preferred place of care
- Between 5% and 8% of unplanned hospital admissions are due to medication issues (Department of Health, 2014), and it has been estimated that between 30% and 50% of medicines prescribed for long-term conditions are not taken as intended (World Health Organisation, 2003). Between 30% and 70% of patients have an error or unintentional change to their medicines when they move from one care setting to another. It is estimated that, in Plymouth alone, approximately £1.4 million of medicines are discarded rather than taken.
- Increasing elderly populations will put pressure on the specialist and tertiary care system and we will manage demand in the system to ensure that we commission care that is safe for patients, cost effective and delivered in the most appropriate location
- In relation to specialised physical and mental health services, patient feedback to NHS England tells us that current care pathways can be disjointed, particularly where the commissioning responsibility for services changes mid-pathway potentially leading to gaps in provision and poor sharing of information which can impact on outcomes for patients.



WHAT HAPPENS NOW?

The adult Individual Patient Placements system

Individual Patient Placements generally refer to locked rehabilitation and locked and open specialist mental health placements that fall outside of the service specification for forensic secure services (low, medium and high secure) for adults 18 years plus with mental health difficulties.

- Planned mental health hospital placements and planned independent sector supported placements are required due to the assessed primary mental health needs of the individual, including individuals with other diagnoses and conditions such as Huntington's disease, Acquired Brain Injury, Physical Disability, Learning Disability, where the assessed primary need is mental health
- The person's needs cannot be met through contracted services
- Specialist Mental Health Assessments
- Health-funded contribution for adult mental health placements on Section 17 leave. This would normally be for a maximum of one month
- Full or part (jointly) funded adult mental health placements in accordance with agreed local section 117/17 aftercare policy
- Mother and baby specialist individual support packages as an alternative to hospital care
- People aged up to 65 years with the diagnosis of early onset dementia
- Psychiatric Intensive Care Units
- People accessing locked placements will usually be subject to detention under the Mental Health Act. In exceptional circumstances, people who have an informal Mental Health Act status may require a diagnostic assessment for complex needs but treatment needs of informal clients should be met locally

It also includes physical disability requiring neuro-rehabilitation with specific therapy outcomes, e.g. people with a brain injury requiring neuro-rehabilitation or who have challenging behaviour, or people with a complex mix of physical and mental health problems. S117 aftercare describes the duty of local authorities and Clinical Commissioning Groups to arrange or provide aftercare for individuals who have been previously detained under Section 3 of the Mental Health Act. Individuals often have a combination of both health and social care needs.

This provision is provided by a wide number of providers on a spot purchase basis. Most of the providers of hospital placements are currently provided out of area.

There is very little national benchmarking data available to be able to compare our performance with other areas.

Currently there are approximately 60 people registered with a Plymouth GP who have an s117 aftercare package with a health funded component.

There are currently 23 people in an Individual Patient Placement, of which 15 are placed outside of Devon.

There is not likely to be an increase over time in the number of people with a severe learning disability or challenging behaviour so this is not an area that will put pressure on the need for more IPPs

The following functions are required in order to commission safe and high quality care through individual placements:

Quality assurance: Winterbourne View brought the importance of quality assurance of out of area providers into stark relief. Quality Assurance nurses reside within the Individuals Commissioning team

Care coordination: Including monitoring of care against treatments outcomes, review and discharge planning. This is currently provided through the Plymouth Community Healthcare Mental Health and Learning Disability teams. There is no clear arrangement for people with physical difficulties or a complex mix of physical and mental health problems. There are also a number of clients who are in secure accommodation commissioned by NHS England. There remains some disclarity about roles and responsibilities with NHS England care managers and care coordinator roles for clients in secure settings outside the IPP budget

Process control: there is no current IPP panel (for the consideration of applications for out of area placements and care reviews) established in Plymouth, although there has been a panel in the past. Control processes could be improved with the greater inclusion of both clinical staff and commissioners in decision-making processes and it is the intention to develop this.

The care home system

There are three routes into a care home:

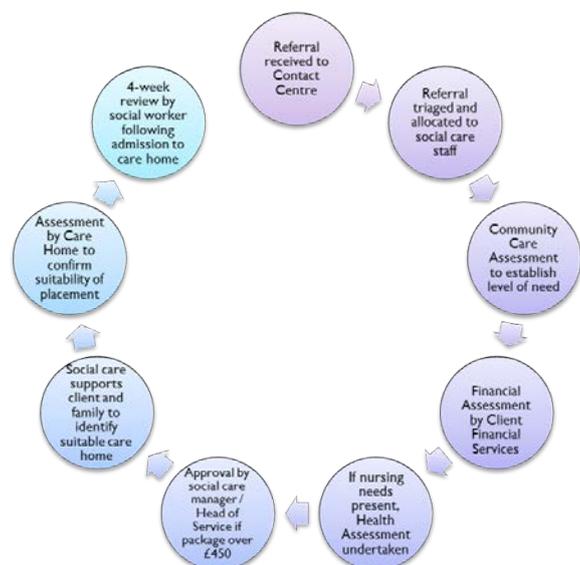
- Following an Adult Social Care assessment
- Following a health assessment (Continuing Healthcare or Funded Nursing Care)
- People choosing to move into a home who are not eligible for public funding and who pay for themselves (referred to as 'self-funders')

Often a move into a care home is suggested because of an illness or a fall – but it is not always the only reason. It is also possible to have a short stay in a care home for a trial period or obtain respite care to give a person or their carers a break. When choosing a home, it is important to make sure that the one chosen is the right one. To help with this, a person should get advice and information from their social worker or care manager, a district nurse, a health visitor or their family doctor.

Care homes have to make it very clear what level of care they provide and how they will meet each resident's needs. If a resident is unable to leave the bed, or has a medical condition or illness that requires frequent medical attention, they may need to look for a care home that provides nursing care. This type of home should have a qualified nurse on duty 24 hours a day.

If a person is thinking of moving to a care home or has been paying for their own care in a care home and wants to see if the local authority can help with the fees, they must first have their needs assessed by the local authority to see if they are eligible for adult social care support. After the social care needs have been assessed, and if the person is eligible for social care support, the local authority will conduct a financial assessment. This will decide whether or not the person has sufficient money to pay towards some or all of the cost of the support they need. If a person has capital or savings valued over the set threshold they will have to pay the full cost of care.

The Care Home Referral Process



The establishment of the universal deferred payment scheme means that people should not be forced to sell their home in their lifetime to pay for their care. By taking out a deferred payment agreement, a person can 'defer' or delay paying the costs of their care and support until a later date so they do not have to sell their home at a point of crisis. Guidance includes how much can be deferred and security for the agreement, as well as the interest rate for the deferral and administrative charges that can be applied by the local authority.

Demand for care home placements derives from three main sources: Plymouth City Council commissioned activity, NHS Continuing Health Care activity and people who pay privately (self-funders). There are a small number of other factors that influence demand for care home beds, such as other local authorities and charitable funding.

Projecting Older People's Population Information (POPPI) projects an increase in demand in over-65s care home places in Plymouth. The total population aged 65 and over living in care homes with or without nursing is predicted to rise from 1,524 in 2014 to 2,408 in 2030. This increase in provision will need to be met through an increase in bed capacity unless alternative models of care are developed.

An ageing profile of older people will mean increased prevalence of dementia and other long-term conditions, with individuals often having multiple long-term conditions. Indeed, the complexity of need of people living in care homes appears to be increasing.

The number of physically frail elderly in nursing and residential care has fallen since 2005, whereas there has been an increase in NHS-funded placements in care homes with nursing.

There has also been a significant increase in the proportion of older people with mental health needs in care homes. These trends are expected to continue and reflect the desire and ability of physically frail older people to remain independent at home for longer, as well as the growth in the number of older people with dementia.

Projecting Adult Needs and Service Information (PANSI) reports that the number of people with a severe learning disability and those with a learning disability who also have challenging behaviour is predicted to remain stable over the next 15 years. The number of care home places for people under 65 is predicted to fall as people with learning disabilities are better supported to remain in the community.

Plymouth is expecting to see a rise in the number of older people in the city over the next 20 years. This, together with the predicted rise in those living with dementia and the projected increase in other illnesses leading to a longstanding health condition, is likely to have an impact on the residential care services required in Plymouth.



The Care Act will result in increased pressure on public funding and will potentially have an impact on the care home market.

As a result of the Act, it could significantly extend the number of individuals receiving local authority contribution toward their residential care costs - in effect, a new class of 'self-funder top-ups'. Given that individuals who become entitled to a local authority contribution to their residential care costs cannot be expected to move, these self-funder top-ups are therefore likely to be subject to existing rules on top-ups, which seek to protect local authorities, providers and families.

Residential care services for children and young people with a mental health condition and children and young people with learning disabilities are described within the Children and Young People Strategy. Short break services for children and young people, which are designed around supporting outcomes for children and young people, as well as breaks for parents, are described in the Special Educational Needs and Disability section of the Children and Young People Strategy.

Continuing healthcare and funded nursing care process

There is complexity in ensuring the statutory obligations for assessing and awarding eligibility for continuing healthcare funding across the NEW Devon CCG footprint. An assurance programme is underway to ensure all responsibilities are discharged lawfully; ensuring people are assessed against the National Framework. In November 2015 the CCG released an 'Interim Choice Policy for the provision of NHS Continuing Healthcare/NHS Funded Care to adults in registered care home placements; and in the person's own home in receipt of a personal health budget'. This describes the policy on how decisions are made regarding the funding of placements.

Currently there is no central point for referral and collation of the activity so, whilst we know who we have assessed who is eligible and when the review is due, we do not know how many people have not yet been assessed or who should be. Risks associated with non-assessment at appropriate times equate to those surrounding inappropriate care packages, missed opportunity for recovery or improvement, safeguarding issues not being picked up, poor outcomes and poor value for money.

The social care and health processes for accessing funding are complex, with clear opportunities for future join-up.

Quality in care homes

There is an established Quality Assurance and Improvement Team (QAIT) within the Plymouth City Council's Co-operative Commissioning Team. It was developed to have a structured and proactive approach to monitoring and supporting the improvement of the quality of care in the care home sector. The team includes care home practitioners who undertake quality reviews based on a risk assessment framework. The quality reviews take place in the care home, in collaboration with the registered manager, over a period of 2 days. The care home practitioners review documentation within the home, including various audits, staff files and care plans. The review also involves speaking to various staff members and, where possible, residents to gain their feedback on the running of the home. Since the team was established in July 2012, QAIT have undertaken reviews in all care homes within the city.

The Quality Assurance and Improvement Team has developed a quality assurance framework, and is encouraging care homes to develop their own framework to support continuous service improvement.



QAIT Quality Framework



Plymouth established a Dignity in Care Forum in February 2009 which is now led and facilitated by the Quality Assurance and Improvement Team. The purpose of the forum is to look at operational issues around training, help and advice with improving quality of commissioned services. It also aims to improve dignity standards in care home settings and raise awareness of current local and national initiatives in the sector. The Forum is focused around the eight key themes of the My Home Life programme. Every third forum is dedicated to the topic of 'Celebrating Excellence' and sharing best practice. The forum also delivers best practice sessions on themes identified through local CQC compliance, hospital admissions and safeguarding. The Forum supports a multi-agency approach and is attended by colleagues from Plymouth Hospitals NHS Trust, the Medicines Optimisation Team, NEW Devon CCG and the voluntary sector.

Plymouth City Council worked with partners and groups of older people to develop a charter made up of 11 pledges which outline the standards and approaches to service delivery that older people should enjoy. The Quality Assurance and Improvement Team will encourage care providers to sign up and embed the pledges from the Charter through the Dignity Forum and the quality assurance framework.

The Dementia Quality Mark model, created in 2010 by David Francis, was implemented in Plymouth in 2011. The Dementia Quality Mark was established to:

- Establish a local accreditation system
- Improve person-centred care
- Improve the quality of commissioned services
- Reduce admissions into acute settings
- Reduce substantiated safeguarding alerts
- Improve discharge pathways into good quality services

Forty care homes have been awarded the Dementia Quality Mark and further applications are in progress.

Plymouth has established a Leadership Programme for registered care home managers, and the programme is intended to:

- Embed the principles of the Leadership Qualities Framework
- Provide individuals and organisations with a benchmark against which to measure their current leadership capabilities
- Improve the public and professional awareness and understanding of leadership by using quality and innovative training
- Maintain and support the quality framework for care homes
- Ensure good leadership which is crucial towards delivering excellent social care and will make a significant difference to the lives of people who use the service

The QAIT offers support and advice to providers and professionals across the city and endeavours to build relationships with key stakeholders, such as Healthwatch Plymouth, Public Health and health professionals.

Supply of care homes

There are currently 65 care homes in Plymouth providing care for people over 65. There are 100 care homes in total including those for the under-65s.

As of December 2014 the total numbers of residents in care homes break down is:

- 800+ adults over 65 years funded by Plymouth City Council
- 250+ adults under 65 years funded by Plymouth City Council



- 582 funded by Health:
 - 402 – Continuing Health Care
 - 180 – Funded Nursing Care

This does not include placements by the care co-ordination teams or Reablement.

- 103 self-funders: Plymouth City Council contract for their care and the person is charged the full amount. Many of these will have a deferred payment arrangement based on the capital value of their own home which will be sold when the person dies or no longer requires long-term social care, either because they become eligible for funding by Continuing Health Care or they go into hospital at end of life.
- 577 private residents: those who admit themselves and fund all of their care

A snapshot taken in July 2014 reports there were 101 vacant beds across the care home sector in Plymouth (not including learning disability). At the end of January 2015 there were 67 vacancies in nursing and residential (not including learning disability). This is lower due to the development of 39 step-down beds in response to pressure on the urgent care system.

There are 99 care homes in Plymouth provided by the private and voluntary sector and one local authority care home.

The fees currently paid by Plymouth City Council are as follows:

Residential

Standard: £450.00

Enhanced: £467.00

Complex: £485.00

Nursing (not including funded-nursing care)

Enhanced: £474.00

Complex: £501.00

We currently place in 90 care homes which are out of the local authority area, accounting for approximately 138 placements.

The end of life system

This provision is commissioned mainly by the Clinical Commissioning Group.

There is externally provided hospice provision with outreach to people at home. Hospital and palliative care is also provided by statutory community teams. Other end of life provision is provided by Marie Curie nurses.

In May 2015 there were around 100 End of Life patients in Continuing Health Care.

Medical advances enable us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expectation to die at home will mean increasing resources in terms of the cost of nursing complex conditions. Indications are that when people are asked about "Preferred Place of Care" at the end of their lives, the majority of people would choose home. If their usual place of care is a care home, this should be supported, although it has implications in terms of service provision to safely support complex packages of care.

Specialist and tertiary services provided in hospital

Specialised services are those provided in relatively few hospitals, accessed by comparatively small numbers of people but with catchment populations of usually more than one million. This includes specialised services for children and young people; for example, cancer and heart disease treatment. These services tend to be located in specialised hospital trusts that can recruit a team of staff with the appropriate expertise and enable them to develop their skills.

NHS England South West Commissioning Hub (based in Bristol), within the South Region team are the commissioners for Plymouth Hospitals Trust and Plymouth Community Healthcare. NHS England have separate contracts for around £130m of services per year from Plymouth Hospitals and Plymouth Community Healthcare provider.

The CCG and local authority work together with NHS England to ensure commissioning is joined up and to develop improved mechanisms for collaborative commissioning in the future. However, the system is not wholly joined up and current care pathways can be disjointed, particularly where the commissioning responsibility for services changes mid-pathway which can lead to gaps in provision and poor sharing of information which can impact on outcomes for patients.

WHAT DOES THE FUTURE LOOK LIKE?

Many of the elements of the Enhanced and Specialised care system cross over with elements of systems described in the other three strategies – Wellbeing, Community and Children and Young People. Some of the actions in this strategy will link with actions in others.

For example, preventing unnecessary admission to hospital or speeding up a smooth discharge from hospital is linked in with actions in the Community Strategy.

Individual Patient Placements

The aim is to provide care at home or as close to home as possible in the least restrictive environment. This will be achieved and sustained in the long-term by developing the ability of local services to work with greater levels of complexity and risk, supported by specialist services where necessary.

The key achievement is we will be working with providers so that clinical services can directly manage the budget to commission placements to meet their client's needs, knowing these best, thus ensuring that care is the best quality and value for money and the individuals only remain out of area for as long as they need to be.

The CCG has developed commissioning intentions to devolve responsibility for the commissioning of Individual Patient Placements for Plymouth GP-registered people to Plymouth Community Healthcare as the main local provider of specialist mental health services in Plymouth. This would strengthen clinical decision-making in the process of making an Individual Patient Placement out of area. It would also allow the provider to be more creative in the utilisation of resources to offer alternatives to admission in the community.

Improving quality and reducing the usage of out of area placements requires the implementation of a range of both transactional and transformational strategies:

- Quality control and improvement of processes such as referral for IPP, clinical and placement reviews. This will also include improved exacerbation and contingency planning, blue light policies etc, a greater focus on information about clinical outcomes related to placements
- Excellent provider assurance processes
- Improved system flow including through local recovery services
- Detailed individualised needs assessment
- A strategic commissioning approach, with local services better commissioned to meet the needs of all and people with the most specialised needs

- Market management - the potential development of new providers within the market
- Continued commissioning of cost effective enhanced community support packages
- New ways of working within existing providers; for example, the strengthening of integrated approaches to dual diagnosis and personality disorder and more staff trained in therapeutic approaches such as Dialectical Behavioural Therapy
- Improved transition processes for young people with complex needs in community services or out of area
- An increased focus on effective packages of support for complex young adults aged 16 to 25 years
- Primary preventative approaches such as Families With a Future
- The potential role of risk stratification in identifying people at risk of out of area placement and complex individuals who would benefit from integrated personalised packages of care and/or integrated case management
- Identification of timely repatriation plans for services uses placed out of Devon

The aim is to provide care at home or as close to home as possible in the least restrictive environment. Being placed away from home can fracture a person's social support networks and de-skill local community services in the management of complexity. Reduction in Individual Patient Placements, particularly out of area placements, is a clinical as well as a financial necessity. This will be achieved and sustained in the long-term by developing the ability of local services to work with greater levels of complexity and risk – supported by specialised services where necessary – and by a greater focus on earlier intervention, preventing complex needs developing.

Improved commissioning for people with complex needs will be achieved through six broad strategic aims:

- Ensuring effective quality assurance of placements
- Improved process control
- Greater focus on prevention and early intervention strategies
- Better commissioning to meet more needs locally
- Improved community services including access to psychological therapy and crisis response
- Improved systems flow – making best use of existing commissioned local services



What Will Success Look Like?

- Less people will be placed out of area
- Reduced length of stay
- Better monitoring against treatment outcomes
- Improved patient experience
- More people cared for closer to home
- Decreased acute admissions
- Improved transition processes
- Improved community services for people with a personality disorder
- Improved access to therapy
- Less spend out of city and greater investment in local services

Care homes

A good care home system will be one that meets the needs of people with dementia or multiple long-term needs, avoiding unnecessary hospital admissions. The key thing we will achieve will be to work with the ten care homes as part of a pilot to try and understand their hospital admissions and action plan with those homes as to how these admissions can be reduced.

It is important to review the evidence of what works to reduce hospital admissions from care homes. Brownhill (2013) undertook an observational study looking at training in care homes to reduce avoidable harm. This study investigated the effectiveness of using workshop-based education and service-improvement models in care homes. The models were designed around both threshold and predictive modelling and were intended to raise awareness of the symptoms that may result from a fall, pressure ulcers or urinary tract infections. The project exceeded targets. Preventive assessments, care planning and timely referrals resulted in a reduction in avoidable hospital admissions and district nurse and GP visits.

Each home was set the following reduction targets:

- Falls - 40%
- Recurrent falls - 60%
- Care home-acquired grade 2 pressure ulcers - 75%
- Care home-acquired grade 3 and 4 pressure ulcers - 95%
- Urinary and catheter-acquired infections - 40%
- Hospital admissions - 60%
- District Nurse visits - 40%
- GP visits - 40%

Once the targets had been reached, the study aimed to sustain the levels through continuing to work with the care homes. Through a robust training package and tailored support, the study reported a reduction

in the number of avoidable hospital admissions from participating care homes by 51%. By raising awareness of symptoms and encouraging early risk assessment and care planning, the study reported that the level of care delivered to vulnerable patients was raised. It reported a significant link between falls and urinary tract infections. Early assessment by care staff, including recognition of symptoms and urine dip test results, reduced the number of recurrent falls in care homes.

We will work towards:

- A well-defined, transparent and fair assessment and placement process
- A consistent oversight of the market across health and social care
- Quality health and care placements to meet individual need that promotes choice, independence, dignity and respect
- Supporting people to die with dignity in a setting of their choosing
- Reducing demand on the health system by promoting healthier lifestyles, the early identification of illness and provision of high quality health care
- Good advice and information around financial planning and paying for care
- Reducing the length of stay in care homes whenever possible
- Admissions to hospital only when necessary
- Developing the integrated commissioning of care home placements to ensure consistency, transparency and quality - including assessment and review processes, care planning and case management
- Ensuring there is sufficient local market provision of placements to meet need
- Ensuring the commissioning model allows for the effective management of the market and, in particular, management of market failure
- Developing an integrated commissioning approach to quality assurance and safeguarding that challenges poor practice including an integrated Quality Assurance and Improvement Team
- Continuing the workforce development strategy for care homes, including continued investment in the Leadership Programme for Registered Managers, investment to develop and facilitate the quarterly Dignity in Care Homes Forum, and Care Act workshops for care home managers to enhance knowledge and understanding
- Developing the Quality Assurance and Improvement framework to ensure that care home staff are able to implement preventative assessments, care planning and make appropriate referrals to reduce the risk and impact

of falls, secondary fractures, pressure ulcers, urinary tract infections, dehydration and COPD

- Developing excellent care-coordination for frail older people with support for the most complex patients from geriatricians, pharmacists, the voluntary sector and older persons' mental health services
- Commissioning an effective Dementia Pathway that includes prevention, early diagnosis, carer support and case management and co-ordination to best support people to live well for as long as possible and ensure they are not admitted to hospital unnecessarily. Early diagnosis will often take place when the person is living in their home and the full commissioning intentions for dementia will straddle the Wellbeing, Community and Enhanced and Specialised Care strategies
- Ensuring that people living in care homes will be able to access the same level of healthcare as anyone living elsewhere in the community:
 - In assessment, review and treatment by their GP and Consultant Gerontologist and Consultant Psychiatrist
 - The specialist knowledge of community nurses, tissue viability, continence, nutrition and end of life practitioners should be equally accessible to people living in care homes with nursing
 - Dentist, Optometrists and Pharmacists, Allied Health Professionals
- Reducing the length of stay of people in care homes by ensuring that there are excellent delivery mechanisms to reduce long-term placements, including reablement, respite support at home and end of life support at home.
- Optimising the benefits from medicines by working with people to support them to understand more about their medicines and the associated health benefits, and optimise the use of medicines to reduce preventable medication-related harm and reduce medicines-related admissions and readmissions to hospital.

End of life

The key thing we will achieve for end of life care will be creating a whole system approach and partnership working, which has the "one chance to get it right" ethos at its heart, in order to achieve seamless, person-centred care that provides dignity and respect for people at the end of their life.

Medical advances allow us to keep people alive for longer and there will be a continuing increase in the number of people who are living with increasingly complex conditions. Whilst the number of people dying at home is gradually increasing, the public expression of the preferred place of care to be at

home will mean increasing resources in terms of the cost of nursing complex conditions, although these costs will be offset against secondary care savings.

A future system will need to respect people's autonomy and respond to their expectations whilst recognising that this will not always be possible. There will be opportunities to support this; for example, by enabling all parts of the system to understand the importance of recognising when someone is approaching the end of life, developing staff to have the appropriate conversations and supporting people to die with dignity in the most appropriate setting. This will include staff enabled to have difficult conversations and to discuss advanced care plans.

We will work towards:

- Increasing the numbers of people being supported at end of life within their preferred place of care
- Care provided closer to home where possible
- Carers supported to provide good end of life care
- Consistent and joined up assessment of needs at end of life
- Preventing avoidable hospital admissions
- Fewer delayed transfers of care from hospital to the community for end of life care
- Good quality end of life care across all providers which promotes dignity and comfort

The aim is to have co-ordinated care through good communication with individuals and professionals across the wider health and social care system.

We will achieve this by:

- Working with providers to make sure that the right services are in place to support people at home and in care homes
- Continuing to improve the quality of care in hospital for those at the end of life
- Continuing to develop good quality care across all providers
- Joining up assessments through integrated services
- Supporting carers in the care they provide at the end of life
- Preventing avoidable hospital admissions
- Reducing delayed transfers of care from hospital to the community
- Developing advanced care planning across the community for those people in EOL phase
- Ensuring that families and carers know of the bereavement services that are available



Specialist or tertiary services

NHS England, as commissioners of specialised and tertiary health services, are committed to consistency and equitable access to services across the country and removal of unwarranted variation.

NEW Devon CCG will continue to collaborate with the commissioners of specialised and tertiary care, NHS England, and with other relevant CCGs in the South of England to support this and, importantly, to ensure that the needs of our local population are well served by specialised and tertiary services that are integrated with local acute services for physical and mental health. NHS England set out their commitment to collaboration in their document 'Developing a More Collaborative Approach to the Commissioning of Specialised services: Guidance Document (4 March 2015)

We aim, as local commissioners, to ensure that the commissioning of these services meets the principles set out in 2015 by the South West Clinical Senate, namely that:

- The care commissioned is safe for people, cost effective and delivered in the most appropriate location. We are committed to delivering integrated care pathways that encourage organisational partnership and co-operation.

- Decisions and configuration of service are based on objective/logical evaluation that best meet population need. This may include the use of computer aided demographic mapping (GIS)
- Funding flows are flexible and ensure that solutions are sustainable and affordable for providers, with money following the patient, thus ensuring that services can be developed outside of historic arrangements
- Priority is given to solutions that deliver outcomes across all five domains of the outcome framework, as measured by agreed KPIs
- Solutions maximise the interdependencies within and between providers, and within and between NHS England Area team regions
- Prioritising of innovative solutions that utilise new technologies and approaches to ensure that care is delivered as close to home as possible without compromising outcomes

Overall, for specialised care our aim is to deliver:

- Enhanced recovery
- Reduced length of stay
- Reduced hospital acquired infections
- Achievement of national referral to treatment standards



- Consistent offer of service to all patient population, regardless of geography
- For our population we ensure wrap around support for discharge, rehabilitation and return to health

We will manage demand into specialist and tertiary care where possible by:

- Agreeing the most cost effective and clinically effective community-wide pathway, including the commissioning of:
 - Increased management in primary care by GPs
 - Increased self-care and prevention
 - Increased management in primary care by GPs
 - Better medicines optimisation to reduce demand
 - Better pathology optimisation to reduce demand
- Continuing to develop community-based services to pre-referral within clinical pathways
- Commissioning alternative/additional supply in community-based interface or other community services
- Developing alternative, more efficient models of care in secondary care that promote best practice in reduced routine patient contacts, shorter lengths of stay in hospital, more cost effective components of the pathway and more efficient patient flow

Commissioning intentions:

NHS England commissioning intentions for 2015/16 are set out in 'Commissioning Intentions 2015/16 for Prescribed Specialised Services' available on their website <http://www.england.nhs.uk/wp-content/uploads/2014/10/comms-intents-2015-16.pdf>.

The stated ambition of NHS England is to bring equity and excellence to the provision of specialised care and treatment, to be achieved through a commissioning process which:

- Is patient-centred and outcome based. The patient must be placed at the centre of planning and delivery. Commissioners, working with providers, must deliver improved outcomes for them across each of the five domains of the 2013/14 NHS Outcomes Framework
- Is fair and consistent throughout the country, ensuring that patients have equal access to services regardless of their location
- Improves productivity and efficiency.

Changes to the scope of specialised services are that:

Local commissioners will play a lead role in the creation of clear business cases for the retention of services locally where this can also meet the requirements for safety and quality.

Ministers have already agreed that the following services should no longer be commissioned by NHS England and should be reflected in CCGs contracts from April 2015:

- Specialised wheelchair services
- Outpatient neurology referrals made by GPs to Adult Neurosciences Centres
- Outpatient neurology referrals made by GPs to Adult Neurology Centres

Ministers have also agreed that the following services will no longer be commissioned by CCGs; these services will be reflected in NHS England contracts from April 2015:

- Some highly specialised adult male urological procedures
- Some adult oesophageal procedures
- Services for patients with homozygous familial hypercholesterolaemia
- some adult specialist haematology services

NHS England have recommended to the Prescribed Services Advisory Group that the following services currently commissioned by NHS England should in future be commissioned by CCGs:

- Renal dialysis (excluding encapsulating sclerosing peritonitis surgery)
- Surgery for morbid obesity



THE FUTURE 'ENHANCED AND SPECIALISED CARE' SYSTEM MODEL

The Enhanced and Specialised Care system will consist of quality specialist health and care delivered close to home that promotes choice, independence, dignity and respect.

The future model for each element of the system is described below:

Enhanced and Specialised Care - System Overview				
"Quality specialist health and care, delivered as close to home as possible, that promotes choice, independence, dignity and respect"				
Individual Placements Specialist placements for people who have been detained under the Mental Health Act Strategic aim: "Care provided at home or as close to home as possible in the least restrictive environment"	Residential and Nursing Care Accommodation and personal care for people who may not be able to live independently Strategic aim: "Meeting the needs of people with dementia or multiple long-term needs and avoiding unnecessary hospital admissions"	End of Life A range of services to provide palliative and end of life care, night time and day time nursing care and personal care across the community Strategic aim: "People supported to die with dignity in the settings they chose"	Specialist and Tertiary Necessary treatment for a short period of time for a brief but serious illness, injury or other health condition Strategic aim: "High quality effective care focused on recovery"	
System Enablers				
Prevention and Wellbeing	Pro-active Primary Care	Seamless Integrated Care Pathways	Skilled professionals, supported by Clinical Effectiveness and Medicines Optimisation	Safe, high quality and cost effective services
System Outcome				
Reducing Hospital and other Specialised Provision and Acute Episodes of Care so that this care is only used where there is no better alternative				

To achieve this we will:

- Commission services that will promote early intervention and prevention
- Up-skill staff and promote the use of technology where appropriate
- Keep people out of hospital by prevention and earlier intervention
- Commission high quality services
- Make effective admissions to care home settings
- Improve the management of medicines in care homes
- Develop a planned patient care pathway
- Ensure good patient flow in and out of hospitals
- Support Derriford Hospital as a regional centre of excellence

HOW DO WE KNOW IT'S WORKING?

The following outcome performance indicators have been identified as key to measuring how this strategy is performing.

Table 3: Performance dashboard

Performance is managed locally for Individual Patient Placements and local indicators are being developed.

System Element	Indicator	Indicator / Source Type
Care Homes	2.24i - Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population	Public Health Outcomes Framework
	ASCOF Permanent admissions of older people (aged 65 and over) to residential and nursing care homes (rate per 100,000)	Adult Social Care Outcomes Framework
	ASCOF Permanent admissions of people (aged 18-64) to residential and nursing care homes (rate per 100,000)	Adult Social Care Outcomes Framework
	NHSOF Health related quality of life for people with three or more long term conditions	NHS Outcomes Framework
EOL	NHSOF Bereaved carers' views on the quality of care in the last 3 months of life (Percentage)	NHS Outcomes Framework
Specialised and Tertiary	CCGOF Referral to Treatment waiting times (patients waiting over 18 weeks on incomplete pathway (%)) (PHNT)	Clinical Commissioning Group Outcomes Framework
	CCGOF Incidence of healthcare associated infection (HCAI), MRSA, C. difficile, proportion of patients with category 2, 3 and 4 pressure ulcers, Hip fractures from falls during hospital care MRSA C.Difficile Pressure ulcers Hip fractures from falls	Clinical Commissioning Group Outcomes Framework





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