Briefing for: Surrey Health Scrutiny Committee

Subject: Preventing avoidable emergency readmissions for over-75s

Date: 13 March 2013

Request
The Committee has requested information on Surrey Downs CCG's plans to reduce the number of emergency readmissions for people over the age of 75 years living in the local area. This follows a question the Committee has received from one of its members who has enquiried about the plans in place to address this across all Surrey CCGs.

Background

From 1 April 2013 Surrey Downs Clinical Commissioning Group will become the statutory organisation responsible for commissioning healthcare for the patients living in the Surrey Downs area. This includes the boroughs of Epsom and Ewell, Mole Valley, the eastern part of Elmbridge, as well as Banstead and surrounding areas.

Over the past few months local clinicians have engaged with key stakeholders and local people to lead the development of the CCG's commissioning intentions for 2013/14.

Improving care for the frail and elderly, which includes reducing unnecessary hospital admissions, is one of seven key priorities for Surrey Downs.

Work is already underway on a range of initiatives to reduce unplanned admission and readmission rates among older people. These include the introduction of a new community contract and the expansion of virtual wards, collaborative working to support frail and elderly patients in the local area, an initiative to enhance dementia care and plans to deliver improved end of life care.

These initiatives, and the work already underway to reduce unnecessary hospital admissions in the Surrey Downs area is summarised below.

New community contract and the introduction of virtual wards

As an emerging CCG, one of our first areas of work was the re-procurement of the community services contract for the area as the current contract had run its course. Clinicians in Surrey Downs CCG led this process and welcomed the opportunity to develop a new service specification that would improve care and ensure local health needs are being met, including those of older people.

The new community contract, which commenced on 1 February 2013 with Central Surrey Health included the introduction of a new integrated model of care which will help ensure frail and older people get the care they need, when they need it. The contract includes the expansion of virtual wards in the Surrey Downs area. It also places a greater emphasis on identifying those who need help earlier and supporting older patients to manage their health conditions in the community, with the right help.

Virtual wards are managed by GP practices and supported by Central Surrey Health who provide case management support to patients with long-term conditions or other co-morbidities. Many of the patients referred into this service are over the age of 75 years.

The virtual wards are supported by Integrated Community Teams, which operate in each area and have a single point of access for elective referrals, rehabilitation services and urgent care rapid response services. Further support is provided through an integrated mental health service provided by Surrey and Borders Partnership NHS Trust.

Through virtual wards GPs are able to manage more patients in the community by making sure they have the right level of support to help manage their conditions at home and in the community.

As a result of virtual wards we are already seeing a reduction in preventable unplanned admissions. In view of this, plans are already in place to extend this service and increase its capacity so that from 2013/14 1,000 local patients can benefit. This will enable us to further reduce unplanned admission and readmission rates for these patients.

Supporting older people and the frail and elderly

With an ageing population, and more people living with long-term health conditions, ensuring the right care is available in the community is a key priority for Surrey Downs CCG.

Working with Kingston Hospital Trust, social care colleagues from both Surrey and London, and other local commissioners, local clinicians have already put plans in place that will improve care for patients in the East Elmbridge area.

Working together, clinicians have developed a shared vision that focuses on delivering the right care in the right place at the right time through a fully integrated and patient-centred care pathway. The organisations are also working differently to reduce duplication of services and ensure closer working between all agencies, including better sharing of information.

Following a successful grant from the King's Fund, and with the support of Surrey Council Council, clinicians have mapped the range of services available for frail and older patients that are referred into Kingston Hospital and have already starting working on a number of joint initiatives. This includes opportunities for jointly commissioning older patient psychiatric liaison services and agreeing joint processes and standards of care across health, social care, the voluntary sector and in

residential homes.

Clinicians have also established a Whole Systems Transformation Group involving providers and commssioners in the Kingston and East Elmbridge area that will focus on the frail elderly and access to urgent care. As a result of this group, a joint commissioning quality target has been established with community services, Kingston Hospital and social services to incentivise providers to work together to deliver a reduction in re-admissions in the frail elderly group over the next year.

Furthermore, following on from this work a co-operative working arrangement is now in place between A&E consultants/therapy staff and community nursing staff that enables patients in the Elmbridge area to be discharged directly into the virtual ward or community hospitals if there is a risk of readmission.

Following the success of this initiative, these principles are being applied across other areas of the CCG, where similar improvements are being made for the benefit of local patients.

Improving care for people living with dementia

In Surrey Downs clinicians are leading a major programme of work to improve early diagnosis and support for people living with dementia.

Using funding secured through the national Dementia Challenge Fund, Surrey Downs Clinical Commissioning Group is working with NHS and community partners on two projects that focus on making sure dementia patients get the care they need.

With a focus on early detection and diagnosis of dementia, the first project aims to help reduce unplanned hospital admissions and improve dementia care by making sure patients have the support they need at home or in the community.

Based on similar initiatives that have delivered improved dementia care in other parts of the country, we are introducing a team of new community-based specialist nurses. Working closely with mental health and community colleagues, their role will focus on diagnosing dementia earlier and closer integration of services to make sure services are joined up and patients get the level of support they need.

Partnership working will be key and we are working closely with Surrey and Borders Partnership NHS Foundation Trust, Central Surrey Health, Princess Alice Hospice, Alzheimer’s Society and Carers Support so that together we can improve dementia care for local patients.

Enhancing end of life care

Working with local care homes, we want to ensure patients receive the best possible care at the end of their life. We also want to make sure their wishes are respected. To achieve this we will be recruiting an End of Life Care Facilitator who will be a single point of contact for care homes, offering education, support and advice to homes to help them reach the highest standards of care (known as the Gold

Standards Framework).

Recognising the crucial role of carers at this sad time, we will also be supporting carers to make sure they are looking after their own health and well-being and receiving the advice and support they need.

Through more co-ordinated care and better support in the community, this area of work will enable us to further reduce the number of older patients who are admitted or readmitted to hospital as part of an unplanned attendance for people who are in the last stages of their life.