Warrington Primary Care Trust, Warrington Borough Council and Partners
(March 2009)
Joint Intermediate Care Strategy and Commissioning Intentions

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Available separately but contributing and feeding into this document are a Report from Stakeholder Interviews conducted by Sheila Williamson of Dearden Consulting and a comprehensive set of presentation material detailing policy context, service mapping and good practice examples put together by Peter Lacey from Whole Systems Partnership.
How will people experience and use intermediate services in the future ..........

1 Simon

Simon is 55 years old and retired early from a manual job a few years ago due to ill-health, predominantly respiratory problems. On retirement, and after a full discussion with his GP, Simon was ‘referred’ to the local ‘community matron’ who has worked with him to manage his condition and to maximise his ability to live a reasonably active life.

In the past Simon has become very accustomed to responding to respiratory crises by having his wife run him down to A&E, particularly when things start to deteriorate at night or at the weekend. On occasion, perhaps 2 or 3 times a year, this has led to Simon being admitted to hospital. Whilst normally this has resulted in fairly speedy stabilisation and return home there has been one occasion when his hospital stay was significantly prolonged due to him acquiring a hospital infection and becoming really quite weak and unable to return home.

Because of the involvement of the community matron and a specialist community respiratory nurse the number of ‘crisis’ events has been reduced. There are still, however, times when Simon needs additional support and for these occasions he now has the telephone number of the intermediate service response team. A call to this team results in an immediate (2-3hr) response from an intermediate services care manager who has sufficient skills and experience (and a budget) to assess Simon’s immediate needs for short term enhanced care at home to see him through the crisis. This may be for just 2 to 3 days and will involve additional specialist input or possibly just additional home care support to enable Simon’s wife not to become vulnerable herself to the inevitable strain that these crises bring.

These periods of additional support are documented and discussed at the earliest opportunity with Simon’s community matron and his records at the GP practice reflect fully Simon’s experience and health status each time such an episode of care takes place.

2 Mavis

Mavis is 85 years old and fiercely independent. She has brought up a family, cared for her husband, John, who has a long term heart problem, and remained active and engaged with her friends and neighbourhood through odd jobs and regular socialising. She is mentally alert but aware that she’s not as nimble as she used to be.

However, she recently experienced quite a severe stroke and was admitted to hospital immediately where she received expert specialist input that minimised the long term effects of the stroke, but none-the-less left her shaken and fearful of what might happen as she prepared to go home, and still not able or confident to carry out all the tasks and activities she had been able to before the incident.

On admission to hospital the intermediate service co-ordinator had been alerted to the admission and to the fact that Mavis would be unlikely to return home with the same level of ability that she had previously had. There was even the risk that either
she, or members of her family, might start to think about her being admitted to a residential care home.

Within 48 hours of Mavis being admitted a care manager from the intermediate service had visited the ward and made an initial assessment of her potential needs and sketched out a pathway that would meet her individual needs and maximise the chances of her returning home with heightened confidence. The care manager had also arranged for a social worker who was part of the intermediate services team to undertake a carer’s assessment for her husband in the light of his ongoing care needs with a particular focus on the short term.

The package that was put in place was specially designed for Mavis and consisted of an initial period of 2 weeks in a specialist nurse led rehabilitation unit with intensive physiotherapy and occupational therapy input. During this period John also received support from the local Age Concern team who had been asked to ‘keep an eye’ on his needs and link back to the intermediate service if any particular issues arose.

Following this period of intensive rehabilitation Mavis returned home with a short term reablement package that initially lasted 6 weeks and had a clear set of personal goals that would see her able to do most of the things she had been used to. The result of the support she and John had received was that 2 months after the incident they were virtually back to normal, although with the added benefit that during the time that John had been supported by Age Concern at home new opportunities to enable him to become less dependant on Mavis had been identified including a men’s lunch club that meant that both Mavis and John continue to be well integrated into their local community.

3 Joan

Joan is 60 and has lived alone for the last 5 years since her husband died. Her family are grown up and whilst fairly local sometimes find it difficult to stay in touch on a regular basis. On recent visits to her GP she has described herself as being a little depressed with low motivation and she often spends hours doing very little. She is developing something of a weight problem and can sometimes appear not to be looking after herself in the way she should.

Unfortunately, Joan recently experienced a fall at home. She was badly shaken and bruised and after calling for an ambulance was taken to A&E where they checked for any fractures. In A&E the intermediate service co-ordinator picked up her case and arranged for her to be transferred to a special unit where she could be supported for up to 48 hours and where a thorough assessment could be undertaken.

A key part of this initial process was for the intermediate services mental health nurse to undertake a thorough assessment and thereby to recognise the early stages of dementia. Joan went home after this short stay in the special intermediate services unit. She was visited within 24 hours by a member of the intermediate service team who had the necessary training and skills to co-ordinate a range of home assessments and support that would enable Joan to regain some of her confidence. An initial set of support arrangements through local voluntary sector groups that understood the needs of people with the early stages of dementia was established.
Executive Summary

This Intermediate Care Strategy has been produced following a review and stakeholder engagement process undertaken between August and November 2008. The review has included a service mapping exercise, a review of policy, the evidence base and best practice and stakeholder involvement including a workshop event.

The review provides a definition for intermediate care that is consistent with the current policy context and provides the basis for improved joint work with the Local Authority both in the commissioning of services and their delivery. Intermediate Care services are described as any intervention or support for adults that provides:

“A time-limited intervention that will optimise physical and mental health and independence based on an assessment of need and clear personal outcomes.”

The characteristics of such a service are outlined including the need for a single set of access criteria, consistency in assessment, provision being at home unless clinical or risk factors suggest otherwise, integrated responses of a time-limited nature that are sensitive to need and planned step-down to mainstream community services.

This strategy sets out the national policy context which features significant developments in recent years that need to be factored into future models for intermediate care. Such developments include an increasing emphasis on case finding, proactive and preventative work, as well as the move to greater personalisation of care provided as locally as possible.

The evidence base for intermediate care services is not robust at a system wide level. However, there are examples of good research that support the development of services that avoid hospital admission where safe and appropriate, in line with the current policy emphasis outlined above. Innovative practice from elsewhere is summarised and includes examples of primary care units in A&E for assessment and diversion and community based teams amongst others.

The service mapping exercise helped to identify potential gaps in the existing services against the model that would emerge from the policy and research. Local gaps focus particularly on the lack of integration and multi-disciplinary working. Eligibility and assessment processes are inconsistent and there are not enough staff with the ability to assess and support people with mild to moderate dementia. There are also gaps in active case finding and in the provision of equipment to support speedy access to intermediate services.

The service model builds on the characteristics set out in the strategy and identifies three potential ‘pathways’ into intermediate care that would need to be operated in a consistent way but with potentially different triggers for referral. Urgent, rapid response with capacity in A&E to divert admissions where appropriate forms the first pathway; planned care, for example on discharge from hospital forms the second; and screening and referral reflects
the additional pathway from case finding and closer integration with mainstream services.

As part of the review an assessment of current and future capacity requirements, sensitive to the future needs of the Warrington population, was undertaken. This strategy describes the first stage of this approach that will need to be refined in the subsequent development of business cases. However, initial indications suggest the long term need for intermediate care beds is in the order of 45 to 55, that there is the need for approximately 25 community based professionals undertaking a specialist assessment and complex case management function plus support staff and that there are likely to be up to 350 referrals a month to the intermediate care services in the future. Based on national research into costs of these services early indications are that there are potential direct savings of c.£300k pa but additional costs and benefit from additional community step-up referrals also need to be factored in and are likely to outweigh these savings.

The commissioning intentions arising from the review identify three service elements that will need to be specified and provided by the Autumn of 2009, namely:

- An integrated, singly managed, multi-disciplinary (including OP CPN) assessment and care co-ordination team that will work across all intermediate care settings and directly support the most complex cases;
- A hospital-based (A&E) primary care facing unit to manage and quickly secure alternatives to hospital where appropriate (Primary Care Assessment Unit);
- Integrated locality based teams to directly support those with a non-complex intermediate care package (therapy, nursing, social work, CPN’s and reablement assts) operating predominantly in the community and providing the key links to primary care, community matrons and local statutory and voluntary sector organisations.

It is also intended that the commissioning group that will be part of the future arrangements for implementation will undertake specific work (in partnership with services users and carers and current providers and other stakeholders) to:

- Develop an outcomes based evaluation framework that will run in parallel with service change and provide active and regular feedback into the redesign process – potentially seek research partner to undertake this.
- Develop a performance framework that identifies anticipated throughput and capacity requirements to inform the development of specifications and levels of necessary investment and ensure this ‘fits’ with the respective commissioners performance requirements.
In addition there are 14 further recommendations, namely:

1. To adopt this statement of strategy and commissioning intent and to develop and put in place regular communications about existing and future plans for intermediate care as the programme rolls out.

2. To develop service specifications for the key service elements outlined in the commissioning intentions above and business cases, including a review of options to secure best value.

3. To develop ongoing involvement and governance arrangements including a project group, joint commissioning group and engagement mechanisms.

4. To form, or build on, an existing service user and carer reference group to advise on the implementation of the strategy on an ongoing basis.

5. To appoint or identify capacity to undertake the Programme Management for the implementation phase for a limited (2yr?) period answerable to the Joint Commissioning Group.

6. To review the functioning and location of intermediate care beds in the light of the developments above as a precursor to re-specifying the bed requirement from Spring 2010.

7. To undertake a market analysis of the care home market to inform future requirements for intermediate care beds.

8. To review and re-energise the development and adoption of the Single Assessment Process.

9. To develop clear and consistent assessment and eligibility criteria based on need including ‘triggers’ for referral from mainstream services, and require it’s adoption in line with the development of services.

10. To review the functions and integration of the hospital discharge function and the hospital social work team to ensure they contribute to the development of the intermediate care model described in this report.

11. To develop options for the (re-)design of the single point of access to support consistency of access.

12. To develop active case finding in partnership with community matrons, social workers and CPNs in the context of the development of long term conditions management both in hospital and in the community.

13. To establish and/or strengthen links with housing providers and equipment services to ensure speedy response to comprehensive needs.

14. To use the initial systems model to explore capacity requirements based on assumptions informed by practitioners within the local system.

Finally the strategy provides an outline implementation plan with more detail provided in an appendix.
1 Introduction

1.1 Background

A review of the intermediate care service need for Warrington has been conducted between the months of August and November 2008 and has consisted of:

- A service mapping exercise to ascertain the nature and capacity of current intermediate care services;
- Stakeholder interviews to explore current perceptions about the intermediate care service;
- A review of policy, the evidence base and best practice from elsewhere in order to provide direction to the service model for Warrington;
- Capacity and needs projections based on local data and national evidence to indicate the likely shape of future service models;
- Holding a stakeholder workshop event to share emerging findings and to inform the development of this strategy.

Other material is available in support of this strategy including a report from the Stakeholder Interviews and a comprehensive set of presentation material supporting the policy, evidence base and best practice elements of the review. In addition a systems model has been developed to underpin the capacity projections. This tool will be used to refine future options and to develop the business case and economic evaluation during the next stages of implementation. Appendices within this report also provide information about the Project Group and the Stakeholder event.

1.2 Defining what intermediate services are

The development of 'Intermediate Care' services became an expected part of local services following the NHS Plan (2000). The original aim of these services was to 'provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living' (so as to reduce admissions to long term care).

The definition adopted for 'Intermediate Care' in the NHS Plan was applied to services that met all the following criteria:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care;
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- Have a planned outcome of maximising independence and typically enabling patient/users to resume living at home;
- Are time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols;
- An intermediate care episode should typically last no more than six weeks.
Whilst this definition set some clear boundaries and formed the basis for joint working between health and social care significant differences in emphasis have emerged in the extent of collaboration and partnership working across the country. It has been noted (BMJ 329, Aug 2004) that no consistently applied ‘definition’ has emerged, hampering a consistent approach to evaluation and firm research evidence for what works. There remains a tension between a ‘narrow’ intermediate care sector (distinctives being health/nursing input, often bed based and maximum of 6 weeks) with other active rehabilitation or reablement functions.

Most PCTs and Local Authorities are now defining intermediate services, or the intermediate tier, more broadly. The research evidence above, and experience of intermediate tier services developed elsewhere in England, suggests that the direction of travel is one where intermediate services are provided in a wide range of settings, including peoples own homes, by ‘specialist’ and generic staff who provide for:

- Time-limited interventions responding to an episode of need;
- Are provided within a rehabilitative and enabling culture (physical, psychological and social) – designed to prevent avoidable hospitalisation or entry to long term care;
- Achieve prevention planning with those whose needs may predictably lead to loss of independence or crisis at some point in the short to medium term (i.e. 12-24 months);
- In the context of a wider preventative, case finding, proactive environment in all sectors and across all pathways.

Intermediate services could therefore be described as any intervention or support for adults that provides:

“**A time-limited intervention that will optimise physical and mental health and independence based on an assessment of need and clear personal outcomes.**”

The characteristics of intermediate services will be:

- That access will be gained through a consistent set of assessment and eligibility criteria with an emphasis on assessed need not ‘exclusion’ criteria;
- That an intermediate care service should be comprehensively considered for everybody whose needs suggest that an admission to long term care may be necessary, whether the person is in hospital or in their own home;
- That consistency of assessment and equity of access will be aided by there being a single point of access for a range of intermediate services in a designated geographical patch including both health and social care professionals;
- That services will be provided in the least intensive setting as appropriate, and normally, therefore, at home as the default position unless clinical or risk factors dictate otherwise and that maximum use will be made of local or neighbourhood facilities as part of an intermediate services package;
- That the service response will be delivered through integrated services wherever appropriate;
- That the ‘time-limited’ nature of the service will be determined in the light of an individual’s ability to benefit and will be characterised by regular review, for example at week 1 and then at agreed intervals;
The length of an intermediate care episode will be sensitive to the needs of people with mild or moderate dementia where longer may be necessary, whilst still retaining the focus on improved outcomes;

That there is planned ‘step-down’ from intermediate services and clear pathways between intermediate services, reablement and the management of long term conditions in the community.

This ‘definition’ for intermediate services can then be translated into a local service model that ‘fits’ with local needs. It also informs the way in which such responses to individual need should be organised, whilst continuing to leave local flexibility in management and precise scope for intermediate services.

The impact of securing such a range of services on the local system of care will need to be captured and monitored with a robust performance framework, with targets clearly set by commissioners. This would include the monitoring of factors such as admissions to long term care, increased numbers of people helped to live independently at home and unscheduled hospital bed days. In addition, in the light of the still emerging evidence base and the opportunity to add to this locally, any service developments should be set against a clear outcomes focussed evaluation framework. The capacity, and therefore the commissioning resource, will be a function of local needs and existing service configuration.

Together with the definition and characteristics described above these further elements (service model, performance expectations and resource) combine to provide the basis of a more robust commissioning specification and will support the delivery of effective commissioning functions in line with the approach to strategic commissioning being adopted.

2 National context and pointers to the future

2.1 Policy context

This section sets out a range of national policy documents that relate to the development of intermediate services. In addition, the remainder of this report has also taken into account wider policy drivers, in particular:

- Emerging models of chronic disease management and ‘case finding’;
- The likely development of ‘urgent care’ centres and models of services as part of the national Darzi review within the NHS;
- Local social care redesign and emerging evidence and drive toward a more focussed ‘reablement’ approach for social care needs;
- The growing demographic pressures from an ageing population;
- The increasing influence and commissioning role of GPs and primary care more generally;
- The focus on providing care close to home wherever safe and appropriate to do so.

2.1.1 Out health, our care, our say

A number of significant links to intermediate care are made, which, in particular:

- Promote and require integrated joint health and social care managed networks and/or teams to support those with the most complex of needs;
Identify the need for local intermediate care teams that provide at home support to prevent admission and support recovery;

Support the use of intermediate step down beds for orthopaedic patients;

Highlight the potential to replace acute bed days with less intensive beds;

Suggest step down for recuperation;

Identify the need for intermediate care to be supported by the integration of health and social care services to enable people getting home as soon as possible;

Set out a vision for a more intermediate care system.

2.1.2 Commissioning for Health and Well-being

The Commissioning Framework for Health and Well-being is part of the White Paper Our health our care our say implementation. It is designed to enable commissioners to shift investment patterns to earlier targeted interventions that promote health, independence and well-being. The framework sets out eight steps that health and social care should take in partnership to commission more effectively. These include:

- Putting people at the centre of commissioning - so that services are personal, sensitive to individual need and maintain independence and dignity;
- Understanding the needs of populations and individuals – (through the Joint Strategic Needs Assessment); and
- Assuring high quality providers for all services.

The framework’s vision for the future includes:

- A focus on enabling people to do things for themselves (e.g. homecare, re-enablement);
- A greater focus on prevention, early intervention and support for self-care;
- Making support more convenient and closer to home;
- Seamless transition, with services configured around a person’s needs.

2.1.3 NHS Operating Framework

The Operating Framework sets out a brief overview of the priorities for the NHS next year. It identifies a number of enabling strategies, which help organisations to improve services for patients, including empowering patients through choice, information and personalisation. In redesigning care pathways, PCTs should aim to create a more personalised service that provides:

- Choice and control;
- Health and wellbeing outcomes that are as good as possible for the individual and their carers;
- Joined-up services;
- Access and convenience – including care closer to home;
- A good user experience, where service users feel that their dignity is respected;
- Support for carers by (among other things) taking on board their views about the people they care for, and recognising their need for breaks from caring.
2.1.4 NHS Next Stage Review, Interim Report: October 2007 (DARZI)

“Our aim should be nothing short of creating a world-class NHS that strives relentlessly to improve the quality and personalised nature of the services and care patients receive”.

In his interim report Lord Darzi sets out a vision of an NHS that provides care that is personalised to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to services at the time and place of their choice.

Darzi stated that integrating care is also a key driver of personalisation because, for example, there are likely to be fewer appointments on a typical pathway, greater familiarity between patient and staff, better information for the patient, and a more ‘seamless’ experience for the patient.

This pathway approach will be taken locally for part two of the Review and at the heart of this will be the relationship between local government and the local NHS. Practice-based commissioners will be encouraged to use NHS funds more flexibly to secure alternatives to traditional NHS provision where this would provide a better response to an individual's needs, e.g. through respite care, installing grab rails to help maintain independence and self monitoring equipment for people with long term conditions.

Lessons could be learnt from social care about the use of individual budgets about how to support and allow eligible service users increasingly to design their own tailored care and support packages.

The results of regional Darzi workstreams are being launched at the time of finalising this review with the National response due to be published last toward the end of June 2008. The full impact of these developments will need to be taken into account in the refinement and implementation stages arising from this review.

2.1.5 Putting People First (December 2007)

This concordat sets out the way in which the adult social care system will undergo a radical transformation, giving people more control over the services they need and supporting independent living. A LA-led partnership with the NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community will create a personalised, high quality care system which is responsive to the individual needs of those who use services and their carers.

There will be a major shift of resources and practice to prevention, early intervention and re-enablement. Transformation will build on existing tools and technologies to support change e.g. the POPPs pilots, DWP's LinkAge Plus pilots, Individual Budget pilots and the work of In Control.

An integrated approach with local NHS commissioners and providers will aim to achieve specific outcomes on issues including: preventative public health policies e.g. fall reduction strategies; hospital discharge arrangements; the provision of adequate intermediate care; the management of long term conditions; co-located services- social care, primary care and other relevant professionals; community equipment services.

2.1.6 Transforming the Quality of Dementia Care

The Department of Health Consultation on a National Dementia Strategy has now published its initial findings and recommendations, and has requested responses by mid-September 2008. The emphasis within this document is on improving awareness
of dementia both amongst the general public and care professionals; ensuring the condition is diagnosed as early as possible and delivering high quality care and support.

Recommendation 10 of the consultation is to ensure that ‘Intermediate Care is made accessible to people with dementia to meet their needs.’ It describes a situation in which exclusion from intermediate care services on the grounds that somebody has dementia will no longer be acceptable. There should be no exclusion on the grounds of exceeding the normally defined 6 week period, because people with dementia may need longer to benefit, and no presumption that people with dementia would not benefit from rehabilitation.

The report states that ‘there is good evidence that people with physical rehabilitation needs in addition to mild or moderate dementia do well if given the opportunity, while people with severe dementia may need specialist services better geared to meeting their mental health needs as well as providing physical rehabilitation.’ To achieve this, staff working in intermediate care need core training in dementia and access to advice and support from specialist mental health personnel.

2.2 What works – research and best practice

The original intermediate care planning targets for England (set in the NHS Plan, 2000) have been met, but it is unclear whether the strategic aims for these services have been achieved. For example, there is evidence that many intermediate care services are too small, inadequately targeted or insufficiently integrated to achieve a whole system change to the care for older people. The wider dissemination of the intermediate care functions could be achieved by incorporating its principles (multi-agency working, comprehensive assessment and enabling/rehabilitation approach) into service specifications for jointly commissioned locally based health and social care services.

Whilst the general lack of a single, clear definition for intermediate care/services makes robust evaluative studies difficult there is some evidence for interventions that appear to work\(^1\), including:

- Early supported discharge works to decrease hospital length of stay involving support to address medical rehabilitation and long term planning needs. Benefits can be observed for functional status, well-being and individual satisfaction;
- Geriatric Orthopaedic Rehabilitation – mixed evidence in reducing lengths of stay. However, it is most effective where interventions focus on early mobilisation and intensive rehabilitation;
- Specific interventions – staff education in delirium, transitional care and residential rehab, has significant impact on hospital length of stay;
- Disease management for older people with heart failure reduces hospital admissions and increases other benefits (COPD, Cancer, myocardial infarction). Multi-disciplinary and patient management continued with the patient and family education.
- Homecare re-ablement (CSED study) has been shown to result in a 28% reduction in commissioned hours of domiciliary care after the intervention for those undergoing a phase of re-ablement when compared to a control group.

\(^1\) A fuller set of presentation material has been provided that fills out the evidence base.
Building on the research evidence it is suggested that an effective intermediate tier service should seek to achieve the following broad objectives:

- Building up mainstream community capability and capacity to ensure robust responses to need that can be met in community settings as opposed to hospitalisation;
- The development of inter-dependence between areas of service provision and thereby enabling the most effective and efficient provision of care;
- Developing ways of working in the intermediate tier that complements and dovetails with emerging models of case management and potentially integrated health and social care teams;
- Promoting the development of an appropriate range of health, social care and housing services that emphasise support at home in line with the objectives of a well-being strategy;
- Furthering the continuing debate about the relationship of mental and physical ill-health in older people and its implications for the integration of other service elements;
- Integrate the provision of housing and appropriate support functions to maintain individuals in the community.

Some of these characteristics have been identified in examples of good practice from elsewhere. These can be used to inform the local development of services and include:

- **Croydon’s virtual ward** concept which is linked closely to predictive modelling and case finding in the community;
- **Bolton’s Primary Care Assessment Unit** which provides for significant diversion from hospital from its hospital base and primary and community care facing staff;
- Examples of **joint assessment and care management teams** particularly for people with complex needs such as continuing NHS healthcare;
- **Medway PCT’s** iterative assessments of need that have identified the balance of need between bed and home based care;
- The **Rotherham CARATs** rapid response falls team that has seen success in reducing hospital admissions for this client group;
- The **Sunderland** model which encapsulates a partnership approach between the Council, PCT and health providers including a team of reablement assistants working across all aspects of the intermediate care service.

### 3 Where do we start from?

#### 3.1 The needs of the people of Warrington

Warrington’s population of c200,000 people are fairly typical of the average for England in terms of health related indices. However, emergency hospital admissions represent 46% of hospital episodes compared to 36% nationally. This suggests that a key part of the system is not operating effectively or to optimised capacity, for example over 1,000 people over the age of 65 had 2 or more emergency hospital admissions in 2005/06. Moreover, given the increase in the numbers of older people hospital admissions would rise by c.18% between 2008 and 2020 if nothing were to change.
3.2 Current services

Information about the Warrington Services was gathered as part of this review. The key components identified as being core to the existing service are illustrated in Figure 1.

![Current service map](image)

**Figure 1  Current service map**

This review has found a consistent set of messages about current services that can be summarised as:

- Padgate House has both a step-up and a step-down function. However, the assessment and admission processes are different, occupancy levels vary and there is no overarching management information that can accurately determine the use of this facility;
- Houghton Hall is a short term (18 month) bed based unit that will also have step-up and step-down capacity, although with a focus on the latter and therefore with enhanced nursing level support;
- The Community Services Rapid Response Team is based at Padgate House and has been in place for about a year. It has admitting rights to Padgate House and has a social worker as part of the team, although securing packages of care for discharge to the community remains a challenge;
- The Home Support Team who provide rehabilitation in people’s own homes to ensure that people reach their maximum independence and therefore reduce the size of ongoing packages of care;
- The Community Services Intermediate Care/GP liaison team is also based at Padgate House and focuses on preventing hospital admissions. The service has found it difficult to secure referrals from the community;

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2 A full set of presentation material has been prepared that provides more detail for these services.
The ‘single point of access’ supports the management of unscheduled care admission to hospital. The service commenced in November 2007 but still has relatively limited capability, for example having no assessment or diagnostic function and without referral rights to mental health teams; A discharge function within the acute hospital to ensure appropriate pathways from hospital.

3.3 Development potential and gaps in services

The views expressed throughout the review in one-to-one or larger group discussions have been consistent with the emerging evidence base and examples of best practice. 16 people were interviewed individually during the process\(^3\) and approximately 40 people attended the stakeholder workshop. Together they concurred with views that can be summarised as:

- A recognition of the work of the Intermediate Care Strategy Group – but also the sense that there remained a lot to do and that with the policy and organisational changes now taking place change was inevitable;
- That there needed to be a renewed clarity of vision and strategy, with a focus on improved and easier access to the service, ensuring dignity and choice for service users;
- That the service should be based on ongoing assessment and should have access to a range of flexible responses according to somebody’s need;
- That the future of services should be one of integration, single assessment and improved access how, when and wherever the patients needs dictated;
- Skills within the service need to match needs and therefore reflect a range of specialist inputs, such as assessment, therapy, medical, prescribing and mental health, whilst not diminishing the role of generic workers such as reablement assistants;
- Finally that people saw the need for the intermediate service to have strong and united leadership with, as far as possible an integrated management arrangement that optimised integrated working.

In the light of the policy context and examples of good practice Warrington Intermediate Care Services would benefit from a number of additional functions or integrated services as illustrated in Figure 2.

The key potential for development lies in:

- Multi-disciplinary intermediate care teams to support people at home with a package of care;
- A consistent set of eligibility and assessment criteria for intermediate care across the system;
- Sufficient staff with the skills to undertake Mental Health assessments within intermediate care;
- Mental Health component of ongoing care and rehabilitation within delivery of intermediate care for people with mild to moderate mental needs;
- Active case finding to anticipate rehabilitation needs (in hospital and at home);

\(^3\) Sheila Williamson of Dearden Consulting undertook these interviews and provided a comprehensive report, available separately, on which parts of this report are based.
- Speedy access to equipment;
- Referral routes from community (e.g. community matrons) to intermediate care.

![Diagram of service gaps]

**Figure 2** Service gaps

### 4 The future service model

#### 4.1 Description of the model

The future service model for intermediate care in Warrington will reflect the definition and characteristics set out in section 1.2 of this report. However, a comprehensive service model also needs to have clear pathways and access points. Figure 3 illustrates such a systems map and identifies three pathways: urgent, planned and through screening and case finding. The identification of three pathways should not imply segregation but rather speed and nature of response. The development of a single point of access and consistent assessment criteria are fully consistent with this approach. Each pathway will need to operate to one set of criteria, although triggers for referral may differ slightly in view of the individual's circumstances.

The three responses reflect:

- An **urgent** need where an appropriate response by intermediate care rapid response or similar, within 24 hours, can result in avoiding hospital admission. Close working/integration with a Primary Care Assessment Unit at A&E will be important to make this function work. Specialist assessors and care managers responding to this urgent need will be part of the core integrated specialist intermediate care team proposed in the service model.

- A **planned** need, typically where people have been identified in hospital as needing an episode of intermediate care on discharge, or possibly as a result of significant and anticipated deterioration for somebody at home or in a care home – normal criteria of the ability to benefit from such an episode will still apply. Such episodes of intermediate care will be initiated
through assessment by the specialist intermediate care team but may be delivered by locality intermediate teams including reablement assistants.

- **A case finding** approach where community health and social care teams identify people with the need for enhanced support for a period of time to delay or reverse deterioration of functioning. This part of the service will need to work particularly closely with the reablement approach of the Local Authority with acceptance into the intermediate care service based on people’s need for a health and/or therapy element of their support.

Wherever possible the service model will reflect a locality or neighbourhood footprint and will increasingly be responsive to both locality/GP commissioning and community needs.

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**Figure 3**  System map for future intermediate care services

### 4.2 Capacity requirements

During the course of the review an initial assessment of future capacity requirements was made using a systems modelling approach. The approach ‘scaled’ the systems model to the local Warrington demographic, including current rates of unscheduled admissions to hospital for people over the age of 65.

Key assumptions on which the model has been based have been derived from the evidence base, in particular:

- That there is good evidence that chronic disease case management, home support and specialist nurse (COPD, DVT, Heart Failure) care in the community can reduce emergency admissions;
- Admission avoidance schemes for older people can reduce attendances at A&E, however, they tend to actually ‘avoid’ only about a third of admissions with the rest unlikely to have been admitted to an acute hospital in the first place;
- Various studies have estimated c.20% minimum of hospitals admissions could have been avoided;
- Medway PCT’s needs assessments that have suggested that most care could be provided at home (80%);
- That a saved admission is likely to save approximately £285 per case and that a hospital discharge to intermediate care is likely to cost an additional £189 per case (based on whole system costs rather than just tariff).

The system model reflects a simple, high level pathway and simulates the anticipated capacity requirements for intermediate care based on these and related assumptions (all these assumptions are able to be modified in the light of local expectations which will be fully tested with clinical input during the business case development).

An **illustrative** output has been generated based on:

- 24% hospital divert;
- 20% of people staying beyond 7 days in hospital and medically fit are discharged to IC;
- Demographic impact is included;
- Ratio of community to hospital step-up is 2:1;
- Percent of referrals to IC who need a bed is 20%;
- IC bed occupancy of 90%;
- Caseload of a Community Professional of 10.

On the basis of these assumptions future capacity requirements for Warrington would be:

- Between 45 and 55 Intermediate Care beds and approximately 25 community based professionals undertaking the specialist assessment and complex case management function, plus support staff;
- Approximately 350 referrals to the Intermediate Care service each month suggesting the need for locality responses;
- Potential savings using national research of c.£300k pa but additional costs and benefit from additional community step-up referrals are not factored in at this stage and are likely to outweigh these savings.

Future use of this systems model to refine capacity requirements will be undertaken in the next phase of implementation for this strategy.

### 4.3 Commissioning intentions

In order to achieve the desired service model Warrington PCT will work with the Council and local GPs to commission services that reflect the service model in section 4.1 and the characteristics outlined in section 1.2 of this report. The pooling of budgets and joint arrangements for procurement, contracting and performance management should be explored.

It is the intention in particular to commission (with the expectation of these services being in place by the Autumn of 2009) the following key Intermediate Care services:

- An integrated, singly managed, multi-disciplinary (including OP CPN) **assessment and care co-ordination team** that will work across all intermediate care settings and directly support the most complex cases;
- A hospital-based (A&E) primary care facing unit to manage and quickly secure alternatives to hospital where appropriate (*Primary Care Assessment Unit*);
- Integrated **locality based teams** to directly support those with a non-complex intermediate care package (therapy, nursing, social work, CPN's and reablement assts) operating predominantly in the community and providing the key links to primary care, community matrons and local statutory and voluntary sector organisations.

It is also intended that the commissioning group that will be part of the future arrangements for implementation will undertake specific work (in partnership with services users and carers and current providers and other stakeholders) to:

- Develop an outcomes based evaluation framework that will run in parallel with service change and provide active and regular feedback into the redesign process – potentially seek research partner to undertake this.
- Develop a performance framework that identifies anticipated throughput and capacity requirements to inform the development of specifications and levels of necessary investment and ensure this ‘fits’ with the respective commissioners performance requirements.

5 **Recommendations and next steps**

5.1 **Recommendations**

The following recommendations now need to be considered, adopted and integrated into relevant workstreams:

1. To adopt this statement of strategy and commissioning intent and to develop and put in place regular communications about existing and future plans for intermediate care as the programme rolls out.

2. To develop service specifications for the key service elements outlined in the commissioning intentions above and business cases, including a review of options to secure best value.

3. To develop ongoing involvement and governance arrangements including a project group, joint commissioning group and engagement mechanisms.

4. To form, or build on, an existing service user and carer reference group to advise on the implementation of the strategy on an ongoing basis.

5. To appoint or identify capacity to undertake the Programme Management for the implementation phase for a limited (2yr?) period answerable to the Joint Commissioning Group.

6. To review the functioning and location of intermediate care beds in the light of the developments above as a precursor to re-specifying the bed requirement from Spring 2010.

7. To undertake a market analysis of the care home market to inform future requirements for intermediate care beds.

8. To review and re-energise the development and adoption of the Single Assessment Process.

9. To develop clear and consistent assessment and eligibility criteria based on need including ‘triggers’ for referral from mainstream services, and require it’s adoption in line with the development of services.
10. To review the functions and integration of the hospital discharge function and the hospital social work team to ensure they contribute to the development of the intermediate care model described in this report.

11. To develop options for the (re-)design of the single point of access to support consistency of access.

12. To develop active case finding in partnership with community matrons, social workers and CPNs in the context of the development of long term conditions management both in hospital and in the community.

13. To establish and/or strengthen links with housing providers and equipment services to ensure speedy response to comprehensive needs.

14. To use the initial systems model to explore capacity requirements based on assumptions informed by practitioners within the local system.

5.2 Implementation steps

The following key steps have been identified to frame a more detailed implementation plan:

- Produce a strategy and commissioning intentions (this document) with an outline implementation plan to the PCT unscheduled care board by mid December;
- Establish new project arrangements including a Joint Commissioning Group by mid-January with it's own development programme;
- Commence team building, joint training or other activities to build understanding, awareness and joint working at an operational level by Feb '09;
- Complete service specifications by the end of February and business cases by the end of April '09;
- Identify the most appropriate procurement approach to secure the desired service model;
- Agree ‘quick-wins’ with providers for implementation from 1st April '09 that are cost neutral and support the overall direction of travel, e.g. ways of working, development of systems etc;
- Identify or appoint a Lead ‘Programme Director/Manager’ to be in place from 1st April '09 at the latest;
- Produce integrated (timed and costed) implementation plan by the end of April '09;
- Begin the procurement process to secure key elements of the enhanced and redesigned service as defined in the agreed implementation plan by May '09, to be operational from Autumn '09.

An outline implementation plan building on these steps is contained in Appendix 4 to this report.
INTERMEDIATE CARE STAKEHOLDER WORKSHOP
18TH NOVEMBER 2008, 1.00 PM-4.30 PM,
ROOM 4 CONFERENCE CENTRE (SITUATED JUST OFF THE
A580, CLOSE TO THE M6 J23)

Event Objectives:

- To share the work that has happened so far in the review;
- To get your views and input on how to develop the ‘best approach’ in delivering intermediate care for Warrington.

Outline Programme:

   Lunch is provided from 1.00 pm

13.30 Welcome, Introduction and Workshop Objectives - Dr Sarah Baker, NHS Warrington
13.40 What have people said about Intermediate Care Services in Warrington
   - Sheila Williamson, Dearden Consulting
14.00 Group work
14.30 Plenary feedback and discussion to identify common themes
14.45 BREAK
15.00 Local Services, best practice and future needs – Peter Lacey, Whole Systems Partnership
15.20 Group work
15.50 Plenary feedback and discussion to identify common themes
16.00 Panel session
16.20 Next steps – Dr Sarah Baker, NHS Warrington
16.30 CLOSE
### Appendix 2: Stakeholder Workshop comments

<table>
<thead>
<tr>
<th>Area</th>
<th>Confirm – which comments do you think are particularly important</th>
<th>Challenge or qualify the comments made</th>
</tr>
</thead>
</table>
| **Strategy**    | • Need to resurrect shared vision/definition – respite? And transitional? X13  
• Build on existing resources X4  
• Assessment X4  
• Criteria  
• Health and Social Care model - More than beds X6  
• Set direction for 10 years  
• Involve Social services X2  
• Needs a whole systems approach  
• Be close to persons home  
• Currently of shared vision, areas precious and not thinking of patients  
• Prevention of admission? X2  
• Support discharge X2  
• It’s about people – less use of the word “beds”  
• Joint leadership  
• Mental Health?  | • Need to revise and publish shared vision X3  
• Paperwork  
• Barriers – Finance, Funding and costs X3  
• Barriers – Roles x3  
• Professional values and extra responsibilities x2  
• Roles - Task orientated and holistic approach  
• Criteria  
• Virtual beds/wards  
• Respite part of IC?  
• Prevent unnecessary admissions missing from strategy x6  
• Proactive support needs to be explicit ie discharge planning commenced on admission x2  
• It’s about patients/people not beds  
• Proactive support for discharge with equipment/support/medically fit to prevent re-admission X2  
• Not whole system approach at present – complex issue  
• Strategy needs agreeing at organisational level  
• Enabling the patient to access optimal treatment  |
| **Structure**   | • SAP x3  
• Need for ongoing crucial, holistic, robust assessment criteria x8  
• Multi-disciplinary team  
• Specialist assessment  
• Regular review X5  
• Review should not be medical x2  
• Early identification and referral X6  
• Flexibility in assessment and admission to step up/down x3  
• Speed discharge/target discharge date  
• No capacity for 6 months  
• Practice boundaries  
• Joint funding  
• Management structure to lead  
• Teamwork  | • Team  
• Training of staff X3  
• 24/7 service X2  
• Rapid response X4  
• Need knowledge of resources  
• Need for Mental Health assessment? X2  
• Procedures for admission  
• Early identification at A&E  
• Shared budgets  
• Where do you support people to “become fit” for rehabilitation? X4  
• Definitely but must be robust  
• Flexibility but doesn’t mean “one size fits all”  
• Social worker/carer assessment x8  
• Continence and Cather care not additional, but core x4  
• Need accessible services  
• Links between assessment and provision is crucial  |
<table>
<thead>
<tr>
<th>Area</th>
<th>Confirm – which comments do you think are particularly important</th>
<th>Challenge or qualify the comments made</th>
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<tbody>
<tr>
<td><strong>System</strong></td>
<td>• SPA X3&lt;br&gt;• Integration X2&lt;br&gt;• GP hours&lt;br&gt;• 24/7 service (including equipment service) X9&lt;br&gt;• Communications x2&lt;br&gt;• Jointly managed service – Head of IC x2&lt;br&gt;• Agree it’s more than beds!&lt;br&gt;• Shared Budget&lt;br&gt;• Rapid response team – essential&lt;br&gt;• People in crisis</td>
<td>• How to incorporate Mental health? X3&lt;br&gt;• Computer system&lt;br&gt;• 24/7hour service X4&lt;br&gt;• Shared Budgets X5&lt;br&gt;• Rapid response missing x2&lt;br&gt;• Used to be hospital OT who referred to SSD&lt;br&gt;• Initiate discharge planning – this is not happening&lt;br&gt;• Patients get passed from service to service x2&lt;br&gt;• Friday is normal time for discharge – needs 7 day service&lt;br&gt;• Accessing equipment</td>
</tr>
<tr>
<td><strong>Shared values</strong></td>
<td>• Nurse led model&lt;br&gt;• Comprehensive x3&lt;br&gt;• Shared budgets&lt;br&gt;• Ensure communications around shared values and vision x2&lt;br&gt;• Needs all systems to work together&lt;br&gt;• Communication essential&lt;br&gt;• Disassociate venue from service provision&lt;br&gt;• Organisational boundaries should not affect care x2</td>
<td>• What is IC X4&lt;br&gt;• Pro-active&lt;br&gt;• Shared vision? X2&lt;br&gt;• Rapid response&lt;br&gt;• Access to equipment&lt;br&gt;• Communications vital&lt;br&gt;• Acute and secondary need to communicate to share vision and ensure everyone is involved proactively&lt;br&gt;• Choice</td>
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<tr>
<td><strong>Skills and Staff</strong></td>
<td>• Need trust in one another’s professional opinion&lt;br&gt;• Stops people going into hospital&lt;br&gt;• Trust between services&lt;br&gt;• SAP&lt;br&gt;• Assessments need to be face to face&lt;br&gt;• One assessment process&lt;br&gt;• Terms and conditions&lt;br&gt;• Effective service</td>
<td>• Training&lt;br&gt;• Roles – task orientated “that little bit extra”&lt;br&gt;• Policing from ICT&lt;br&gt;• Social Work assessments/carers assessments&lt;br&gt;• Trust in individuals assessment – avoid lots of duplication x5&lt;br&gt;• Need for just one assessment from health professional – SAP&lt;br&gt;• MH assessment pathway X3&lt;br&gt;• Ensure correct information and nothing is missed&lt;br&gt;• Terms and conditions&lt;br&gt;• Payments</td>
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<tr>
<td><strong>Style</strong></td>
<td>• Need for good leadership x7&lt;br&gt;• Whole system x2&lt;br&gt;• Needs one leader&lt;br&gt;• Needs responsibility for who is leading the service? X2&lt;br&gt;• Trust x2&lt;br&gt;• Engage users X2</td>
<td>• Essential to go forward and make the system work&lt;br&gt;• Clarify leadership&lt;br&gt;• Jointly managed “head of IC”&lt;br&gt;• Single assessment process, avoid duplication x3&lt;br&gt;• Good strong leadership&lt;br&gt;• Other professionals already working with patient should be able to do IC assessment rather than others repeating the process</td>
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## Appendix 3: Outline Implementation Plan

<table>
<thead>
<tr>
<th></th>
<th>Jan 09</th>
<th>Feb 09</th>
<th>Mar 09</th>
<th>Apr-Jun 09</th>
<th>Jul-Sept 09</th>
<th>Oct-Dec 09</th>
<th>Jan-Mar 10</th>
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<tbody>
<tr>
<td><strong>New project arrangements</strong></td>
<td>Convene first Commissioning Group and establish pattern of mtgs</td>
<td>Hold broader project team to refine capacity assumptions</td>
<td>Ongoing programme of commissioning and engagement/communication events plus task specific work in line with procurement path below. Detailed Implementation Plan in place by April 1st at the latest with capacity agreed to deliver.</td>
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<tr>
<td><strong>Procurement path</strong></td>
<td>Development of business plans including review of capacity assumptions and options</td>
<td>Agree specifications (end of April)</td>
<td>Tendering (commence in May/June)</td>
<td>Services in place and ongoing review</td>
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<td><strong>Service redesign &amp; development</strong></td>
<td>Work with providers to identify ‘quick-wins’</td>
<td>Instigate joint training with a focus on access criteria and joint working</td>
<td>Quick-wins in place and being evaluated</td>
<td>Ongoing programme of joint training to be developed in detail</td>
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<tr>
<td><strong>Monitoring and evaluation</strong></td>
<td>Use service user engagement to support the development of an outcomes framework</td>
<td>Draft and pilot new performance and evaluation framework based on outcomes framework</td>
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<tr>
<td><strong>Current service evaluation</strong></td>
<td>Develop and deploy integrated monitoring arrangement for the use and benefits arising from the existing intermediate care beds.</td>
<td>Undertake a market analysis of the care home sector</td>
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<tr>
<td><strong>Integration &amp; partnership</strong></td>
<td>Establish links and potential pathways with key partners including housing and mainstream community health services</td>
<td>Refine and integrated proposals with partners into the roll out of the service</td>
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