Intermediate Care

Context

Review of intermediate care undertaken in 2015/ 16 to;

Analyse performance of the current intermediate care system.
Clarify local need for intermediate care.
Identify key elements required in the future service model for Doncaster.

Range of activities, including;

- In depth study of the needs of statistically significant sample (1027) of people referred to intermediate care in 2014.
- Visits to current services and 51 interviews with key stakeholders
- Desktop analysis of data relating to current IHSC services (including benchmarking data from National Audit of IC)
- Interviews with 58 people using intermediate care services about their experiences.
- Findings from the hospital discharge pathway study.

Key findings;

Current services too complicated and difficult to navigate.

Lots of duplication- Similar services doing similar things to support people with similar needs.

Not enough step up support to prevent admission and maintain people at home.

More bed based services than in other areas.

Most people who use intermediate care are over 80 and have complex, health and social care needs- need integrated, flexible services to meet this need.

Not all teams could work with Dementia and Cognitive impairment- despite growing need.

Don't routinely address low level mental health, loneliness and social isolation.

Commissioning and contracting arrangements contribute to complexity and disjointed provision.

Project Description (Scope)

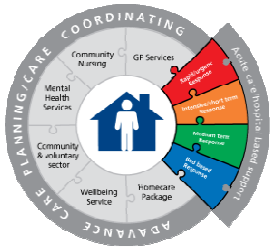
Intermediate Care is **a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living**

National audit of Intermediate Care 2015. NHS Benchmarking

The Doncaster services currently in scope;	Provider	Commissioner
Community Intermediate Care (CICT) & Unplanned Care Team	RDASH	DCCG
Short Term Enablement Programme (STEPS)	DMBC	In-house
Home from Hospital Service	AGE UK	DMBC
Positive Steps	DMBC	In-house
Hazel and Hawthorn wards	RDaSH	DCCG
Fred & Ann Green Rehab Centre (general rehab beds)	DBTHFT	DCCG
Integrated Discharge Team (IDT)	DBTHFT/ DMBC	
Rapid Assessment and Prevention Team (RAPT)	DBTHFT	DCCG
OPMH Liaison	RDaSH	DCCG
Emergency Care Practitioners (split to be determined)	FCMS	DCCG
Community Geriatrician Service	DBTHFT	DCCG
Evergreen Falls Service	RDaSH	DCCG

The financial envelope for the services included in the redesign is understood to be around £17.6 million. (work underway to confirm this)

Commissioners have been working with current providers to develop and test a more streamlined, integrated physical. mental health and social care service model that can provide a more even balance of step up and step down support. In the future Intermediate Care needs to offer;

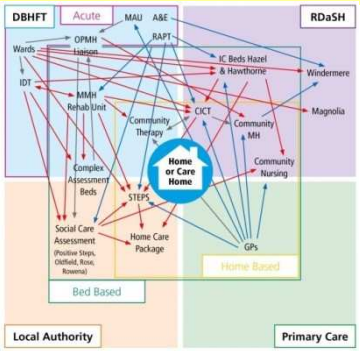


- **single point of access and assessment,**
- rapid response and short term interventions,
- medium term rehab and reablement in the community
- a smaller but integrated health & social care bed base.

The aim of the next phase is to facilitate full implementation of a new integrated model.

Intermediate Care

Case for Implementation



- **Complexity of current services**

Intermediate Care is commissioned by two organizations, provided by four with several teams delivering services. (see diagram on right). There are multiple referral routes and different assessment processes . Patients and carers tell us how complicated it is to navigate and how they feel they are assessed repeatedly (patient interviews). Health and Social Care professionals also find it difficult to understand when to refer to one service over another. This is further complicated by multiple IT systems that can not talk to each other.

Current Commissioning and Contracting arrangements add to this complexity: An integrated commissioning and contracting model across health and social would help to facilitate the development of a simpler, integrated service offer.

- **Duplication**

The needs review clearly identified that there are similar teams doing similar things with people with similar needs. For example CICT the health reablement service and STEPs the social care reablement service. When the needs of people referred to these two services were reviewed there were very similar profiles across both teams and little difference in terms of the purpose of the services. However access to certain skill sets was restricted dependent on which service a person was referred to.

- **Complex physical, mental health and social care needs**

Most people who require intermediate care services present with a fluctuating mixture of physical health problems, social care needs and often mental health needs. (needs review) The current configuration of services (ie separate health and social care teams and units) makes it difficult for these needs to be met in a flexible and patient centered way and a lot of time is wasted assessing people to slot them into the correct box only for their needs to change once they access the identified service. There is a clear case for developing an integrated offer to dissolve some of these boundaries to enable more flexible working. Not all teams are set up to support people with Dementia and this must be a priority with an increasingly aging population.

- **More emphasis on facilitating discharge (step down) and less on preventing admissions to hospital (step up):**

Only 30% of all referrals made to IC in the year of the review were for step up compared to 62% nationally. (benchmarking). However over 50% of the over 75 year olds reviewed who were admitted to hospital could potentially have been supported at home with different intermediate care services. (needs review by MDT panels). Services are currently configured to respond quickly to support discharge but are not so responsive to step up referrals- for example one team's average response time was over 6 days compared with 1 day for step down. (data analysis). The majority of patients and carers interviewed as part of the review and in subsequent engagement have stated a prefernce for being supported at home and there is a growing body of evidence that hospital is not the best place for frail older people and extended stays can result in significant loss of function. In the future there is a need to develop the intermediate care offer so it is more responsive and does more to prevent admissions as well as stepping people down.

- **More bed based activity than home based;**

49% of referrals to IC were for bed based IC services in the review compared to just 8% nationally. (benchmarking). Of those admitted to a bed base service the panel identified that 86% of these could have been supported by home based IC services (needs review) which is closer to national picture. Doncaster also has approximately 20% more IC beds per 100,000 weighted population than the national average.
Bed based services are significantly more expensive than home based IC services (national audit of IC) In Doncaster community services account for approximately 51% of the total number of referrals into intermediate care however it is estimated that just over 13% of the total spend on intermediate care goes on these home based services (initial local costings). So there is potential to do something different within existing financial envelope.

For full case for change see http://www.doncasterccg.nhs.uk/wp-content/uploads/2016/05/DCCG-Case-for-Change-Final-HR.pdf

Intermediate Care

Assumptions

- By utilising the bed base resource differently more people could be supported at home in order to reduce activity in acute care and care homes.
- Reducing the number of separate teams and simplifying services will result in efficiency savings,
- All partners are signed up to the aspiration for integration as articulated in the Doncaster place plan, as this will require current providers to work together to move some of this activity and associated resource across the system.
- In order to transition to a new model the community and step up offer needs to be enhanced before a reduction in the intermediate care bed base is possible. To achieve this there will be some double running costs. An initial BCF business case was successful to support the first phase of testing. Will need to consider how ongoing transition costs are funded.
- There will not be a significant reduction in the intermediate care envelope while the new model is implemented (year 1). However any recurring costs from the double running/ transitional costs will need to be absorbed through the service redesign and the efficiencies released.

Exclusions

There are a number of services that provide an element of intermediate care and could be included in scope for example;

- Windermere
- Magnolia
- Community Therapies
- CAP Beds

These have been reviewed and it has been identified that further work is needed to understand these services and their costs before they can be included in the redesign. Therefore it is proposed they are in scope for year 2.

Expected Benefits

- Services designed round the needs of individuals rather than organisational structures.
- Integrated care is associated with improvements in patient/ user experience and higher levels of satisfaction.
- More people living independently for longer.
- Reduced need for more expensive/ higher intensity services
- Increased efficiency by reducing duplication.
- More flexible workforce.
- Simpler pathways that are easier for everyone to navigate.
- Whole system view of estates – reduce need for cross charging, opportunities for co location.
- Shared outcomes and KPIs across a number of organisations
- Simpler funding and contracting arrangements to increase flexibility for shared solutions.
- Integrated contract management, performance monitoring and governance processes across a pathway.
- Improved staff satisfaction.

Intermediate Care

Outcomes for an integrated intermediate care service (DRAFT)

More people are enabled to maintain their independence, live at home and be part of their community for as long as possible.

People have their physical, mental health and social care needs met by access to an appropriately skilled and flexible workforce.

People are offered responsive assessment and time limited support as early as possible to promote faster recovery from illness and avoid major disruption to a person's daily life.

When needed intermediate care is simple to access and experienced as one seamless service.

People will be offered care in the most appropriate setting to safely meet their need exploring all options to safely support someone in their own home environment first before escalating to a bed based or more intensive service offer.

KPIs

- Reduced A&E attendances for people aged 65 and over
- Reduced emergency admissions for people aged 65 and over
- Reduced ambulance conveyance to A&E for people aged 65 and over
- Reduction in excess bed days and delayed transfers of care.
- More people remaining at home following discharge from an acute bed.
- More responsive (2 hour, 4 hour, 24 hour and within 2 days responses)
- Increase in community based intermediate care activity (linked to reduction in bed based activity and ultimately less beds)
- Fewer people discharged to care homes.
- Patients and carers report positive experience of using services.
- Appropriate Patient Reported Outcome and Clinical Outcome Measures being considered.
- People achieve their goals and maintain connections with their home and community environments.
- Proportion of people who use services that say that those services have made them feel safe and secure
- More people remaining at home following discharge from an acute bed (91 days after discharge into rehab/ reablement).
- Reduced short term admissions into emergency respite for older people with Dementia.

Based on review, design work, engagement activities with co- create and dashboard development

Intermediate Care

Example from Rapid Response and testing an integrated pathway.

Joan is an 87 year old who lives alone. Fell and her neighbour called 999. Ambulance attended and she had no major injury but there were some concerns about her managing safely at home. This was her second fall in a few days, the last one had resulted in an admission to hospital where she was found to have a urine infection.

Previously →	What happened instead? →	Outcomes
The ambulance service would have had to phone **three** different numbers to arrange for this type of follow up at home and **none** of the services would have been able to respond immediately. It would have been safer and easier to transport Joan to A&E to get an assessment in hospital. *Once in hospital she is more likely to be admitted hospital, end up in a bed based service and from there a care home.*	**ONE number**. YAS called while with Joan and spoke to a triage practitioner. Agreed that a response was needed and agreed to send a therapist and social care worker out within 2 hours. Co ordinated multi agency, rapid response provided instead of transporting to hospital, including; • Full assessment by therapist, • Provision of equipment immediately and a pendant alarm to be provided. • Arranged for short term social care reablement at home (one call a day) for few days as she was struggling with personal care. • Review with GP arranged and community nursing followed up to review blood pressure and monitor bloods. • Falls prevention advice to Joan and her family and exercise programme to improve strength and balance given by therapist.	Joan was supported to remain at home and was able to regain her confidence and independence with some support for a couple of weeks from the STEPs team (re ablement). The staff have been friendly and allow me to do as much for myself as I possibly can. I feel lucky to have services within my reach that could help me at such short notice so I could stay at home. 

EY

Intermediate Care

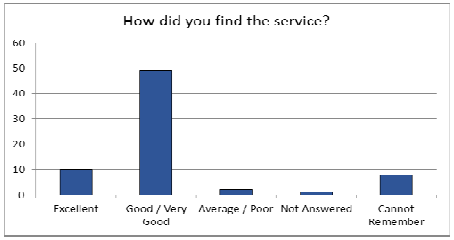
Early benefits of testing integrated approach to rapid response

Doncaster Residents

"Very good as I wouldn't have known where to get help and the rapid response service sorted it all for me."

" I found the service very good, fell a bit before that and was taken to hospital. This time felt it was better than having to go to hospital and get sorted at home."

High level of satisfaction*



Helping people stay independent

Do you think the service has helped you stay safer at home?

84% said YES*

Staff

Referrer feedback;

I feel reassured that I know exactly when someone is going to turn up. In the past, there would have been a chance we would take someone to ED as we wouldn't know for certain if they could be safe if things got worse. Also, the team seem quite flexible in the help they can offer and the type of patient they are willing to see. (YAS crew)

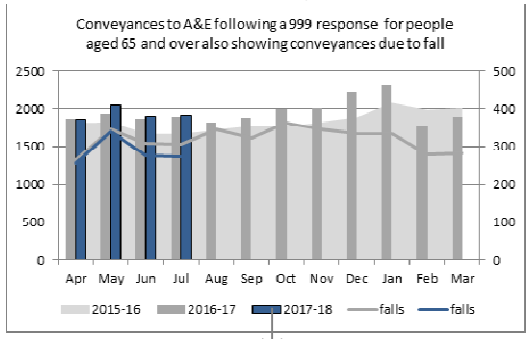
Staff feedback

What words would you use to describe your experience of working with partners?

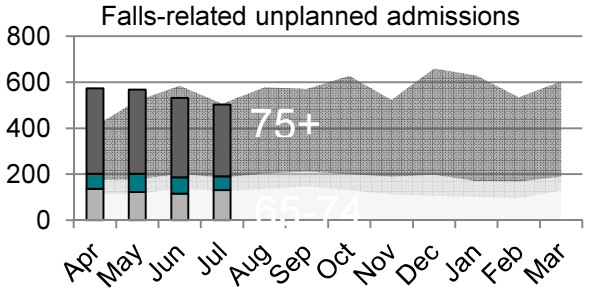
Activity

83% of those accepted to rapid response supported at home

Reduction in AE conveyances due to falls,



Falls related unplanned admissions are starting to reduce



Finance

Savings made as a result of the reduction in conveyances due to falls YTD = £10,998

Which is above the YTD QUIP target of £5,059

Work to identify other savings is underway.

* *Data from 70 follow up calls*