Appendix 7a

Blackpool Intermediate Care Review (July 2015)

Blackpool Council

NHS
Blackpool
linical Commissioning Group

Contents

Preface

Blackpool CCG and Blackpool Council have completed a commissioning review for intermediate care to ensure the health economy has an outcome based whole systems model of 24/7 integrated intermediate care services.

Commissioners from Health and Adult Social Care have worked with key providers involved in the existing patient pathways to analyse the current picture of service provision and to consider where this works well, and where the is scope of improvement to benefit the patient.

Background to the Review

The Care Act (2014) places a duty on local authorities to promote the wellbeing of individuals. They are required to provide or arrange for the provision of services, facilities or resources which will prevent, reduce or delay the development of people's need/s.

Local authorities must exercise their functions with a view to ensuring the integration of care and support provision with health provision and health related provision where it considers this would meet the overarching wellbeing principle and improve the quality of care and support for adults and their carers.

NHS Blackpool CCG (with support from NHS England) has commenced working with external support on developing new models of care. This work is based on international best practice to build on our existing progress in transforming and integrating local care delivery. The new system will be radically different, with clusters of GP practices working together, supported by appropriate services coordinating care in their 'neighbourhoods' closer to patients' homes.

The Fylde Coast neighbourhood models of care have been recognised by NHS England as one of 29 'Vanguard' sites chosen to lead on transforming care for patients.

As part of the Better Care Fund NHS Blackpool CCG and Blackpool Council aim to implement the recommendations from benchmark intermediate care review to ensure sufficient capacity within residential rehabilitation and community therapy, and consider development of plans to integrate bed and community based rehabilitation services

The 'Healthier Lancashire' Out of Hospital Care programme seeks to improve outcomes for patients who no longer require an acute hospital bed but who would benefit from further treatment or therapy delivered in a non-acute setting. The project would seek to provide health and social care support that cannot be provided in a person's own home. It will address the longstanding problem of hospitals (physical and mental health) being unable to discharge patients who require further rehabilitation, therapy or intermediate care in a timely fashion due to lack of suitable alternatives.

This commissioning review considers these duties and seeks to support the national drive to ensure that local intermediate care services are resilient and able to effectively contribute to timely hospital discharges and prevent avoidable hospital admissions by providing intermediate support in the most appropriate care setting.

Commissioning Intentions

Intermediate care services, including rehabilitation and re-ablement, have the potential to reduce the number and length of admissions by facilitating a stepped pathway out of hospital (step down) and by responding quickly to changing needs in the community (step up).

Blackpool Commissioners believe that good intermediate care should be easily accessible and seek to reduce, minimise or reverse deteriorating situations and conditions which might otherwise lead to a hospital admission.

The development of a whole system model of Intermediate Care, where there is real integration of services designed to support people to gain and regain independence and control is seen by Blackpool Commissioners as essential to the transformation of health and social care and to maximising people's independence.

There is an array of good intermediate care services commissioned by Blackpool health and social care. However this commissioning review has identified issues around the complexity of the current model including areas of duplication and gaps in provision. Many of these issues were previously identified by the Fylde Coast Intermediate Care Review (2013). For example:

- there are a number of entry points and pathways to services which are badged as intermediate care
- there is no single point of coordination
- there is limited 'at home' provision for intermediate care
- there is limited tailored support for people with mental health needs including dementia
- patients experience varying access to specialist equipment, medical or therapeutic supports.

This commissioning review has explored existing and potential service delivery models, drawing on the knowledge and experience of a range of professionals across a number of authorities including Blackpool and seeks to address these concerns.

It identifies the key intermediate care functions which best meet peoples' needs and promotes their independence across a continuum of care from hospital to home through bed based or community based support/s including; rehabilitation, re-ablement and resettlement supporting care closer to the person's home wherever possible.

The review presents options and makes recommendations on potential areas for development including; pooling of resources and invest to save opportunities to secure positive outcomes for people accessing intermediate care services and to deliver maximum value for money.

Aims and Objectives

This report aims to identify what kind of intermediate care services are needed and how these will work together to best effect and to describe a model which: -

- Promotes independence and wellbeing and prevent, reduce or delay the onset / development of need/s
- Supports care closer to the person's home
- Simplifies intermediate care pathways to provide effective and accessible integrated services
- Prevents people attending or going in to hospital unnecessarily
- Prevents people from having to move in to residential care or nursing care until they really need to

For the purposes of this review the definition of intermediate care is provided by the Department of Health (Section 2 Care Act Guidance 2014)

"*Intermediate Care" services are provided to people, usually older people, after they have left hospital or when they are at risk of being sent to hospital. Intermediate care is a programme of care provided by a limited period of time to assist a person to maintain or regain the ability to live independently. As such they provide a link between places such as hospital and home and between different areas of the health and social care support system i.e. community services, hospitals, GPs, care and support.*

Strategic Relevance

There are considerable health challenges in Blackpool which contribute to significant differences in life expectancy for local residents compared with national and regional averages[1]:

- Male life expectancy at birth (74 years) is the lowest in England.
- Female life expectancy at birth (80 years) is 2.9 years below England & Wales and 1.7 years below the North West female life expectancy
- Not only do people in Blackpool live shorter lives, but also spend a smaller proportion of their lifespan in good health and without disability.

The causes of death contributing most to Blackpool's low life expectancy are:

- Diseases of the digestive system (Inc. Cirrhosis)
- Circulatory Diseases including Heart Disease and Stroke.
- Cancers (especially lung cancer)
- Respiratory diseases including bronchitis and COPD
- Accidental overdose and poisoning and self-harm amongst men

Intermediate Care, delivered promptly and effectively, can have a significant impact on the quality of life of people with long term health conditions.

[1] Source: Blackpool Joint Strategic Needs Assessment. Core document - Chapter 2 - Health and Wellbeing in Blackpool (August 2014)

Future Needs

- The biggest % increases in adult population are projected to be in the 70-74 and 80-90 age groups.

- By 2020, the number of people aged over 65 is estimated to increase to over 29,000 people and increase by 5%.

- The older age group, those aged 80 and over is predicted to increase by 10% as people live longer.

- Between 2001 and 2011 the number of people providing unpaid care increased by 0.62%.

- As at 2011 the number of people providing unpaid care was 18,330 which equates to nearly 13% of the population.

  According to the JSNA, it seems inevitable that rising numbers of people will be seeking assessment and support from health and social care services.

  Work stream six of the Fylde Coast Unscheduled Care Strategy refers to 'Seamless wrap around health and social care services in the community.' This coupled with the Care Act 2014, seek to support people in the community, in their own homes where possible for longer.

  The likely impact of this trend will be increased demand for health and social care assessments, appropriate housing options, high rates of mobility, personal care and domestic needs, and increasing demand for services to support people with dementia.

Review of Existing Intermediate Care Provision

The Intermediate Care Review scoped the existing health and social care services for intermediate care and their current capacity. A range of stakeholders were engaged to identify what works well, or not so well in order to reach a clear understanding of the current care pathway, blockages, areas of duplication and where gaps exist. This included consultation with a small number of people who have used these services. A summary is attached.

The service redesign for intermediate care has also considered the Patient Pathway reviews currently being completed including falls, stroke and respiratory.

Current Issues Relating to Intermediate Care Provision

There is no single point of access for intermediate care services. There are a number of points in the 'system' at which assessments for intermediate care are carried out with patients experiencing multiple assessments. This results in significant duplication, fragmentation and a lack of consistency in approach.

Referrers are unsure of the availability of intermediate care services, and the criteria for accessing these services.

The A&E admission avoidance Integrated Assessment Team (IAT) is effective in supporting the rapid return home of patients before admission. Significant benefit would be gained by improving how the IAT team integrates its working practices with the new recommended Intermediate Care in the community model.

There is no identifiable health, multi-disciplinary 'Intermediate Care at Home' team in Blackpool unlike the case in the majority of health economies, with the exception of the social care re-ablement team. Until recently the vast majority of the intermediate care at home function (other than re-ablement) has been incorporated into the district nursing team, community matrons and community therapy teams with limited interaction between these services.

In April 2015 the Enhanced Supported Discharge service (ESD) commenced pro-actively identifying patients in hospital who require rehabilitation which could be delivered at home.

Existing intermediate care services have developed their own assessment documentation which potentially leads to a lack of a consistency in approach and people not receiving the intermediate care service which best meets their individual needs.

Medical cover, in some services, is reactive and temporary. There appears to be little in the way of formal medical cover arrangements within some service specifications; for example, medical cover for bed-based patients in the Assessment and Rehabilitation Centre (ARC) are based upon temporary registration of patients with local GP practices on an ad hoc basis.

Intermediate Care at Home Provision

Reablement Care at Home *(Blackpool In- House Provider Services)* delivers outcome focused support to people through a social care programme of time limited intensive rehabilitation to enable them to regain their independence following a period of illness, injury or surgery. The interventions offered are short term helping people 'to do' rather than 'doing to or for' people and normally last up to a maximum of 6 weeks.

The service currently delivers an average of 1400 hours of Reablement care per month with people accessing an average of 7 hours of support each week. The service offers some flexibility to 'flex up / down' to accommodate fluctuations in demand.

In 2014 - 2015 the average reablement care at home package lasted 29 days

Blackpool Equipment Service – A number of health professionals across the Hospital Discharge, Spiral CIC, Early Supported Discharge, and Rapid Response Teams together with the colleagues across Intermediate Care assess and prescribe equipment to patients at the point of referral in to intermediate care services. 1,698 items of equipment were provided in the period (01/12/14 – 31/05/15).

The value of equipment prescribed in the period was £65,945.00 (Equivalent £132,000k per year). *Source: Community Equipment Service Database (June 2015).*

Increasing the flow of patients returning home from hospital sooner and with higher levels of need may lead to an increased draw on the community equipment budget as people returning home sooner, with greater needs are likely to require more equipment and support which may have otherwise been available in another setting.

Broadly speaking the overall numbers of people accessing the new Intermediate care service in the short term should remain approximately the same. However, in light of the proposed reduction to intermediate nursing bed capacity and residential intermediate care beds (53 reducing to 33) combined with increases in the local population anticipated by the (JSNA) and rising demand for services anticipated over the next five years, the focus of intermediate care services will need to shift toward supporting people to remain at home or return to their homes sooner to complete their rehabilitation.

NHS Blackpool CCG and Blackpool Council also commission the Keats Community and Day Care service for residents of Blackpool with enduring mental health problems. This service is a specialist daytime support service providing intermediate care in the community.

Intermediate Bed Provision

The current bed provision for intermediate care is as follows:-

ARC *(Assessment and Rehabilitation Centre)* is a jointly commissioned (Blackpool Council and NHS Blackpool CCG) Social Care led service providing 33 intermediate care beds with health and therapy input. Therapy staff at ARC are commissioned by NHS Blackpool CCG from Blackpool Teaching Hospitals NHSFT. The ARC is partially funded through £591k Better Care Fund (Community Contract - £91k and Section 26 - £500k).

Admission to the ARC is dependent on a referral from a social care or health professional. This referral will determine whether the access criteria is met. Some admissions are made and it is found that incomplete or inaccurate information on the referral means that access criteria are not met, but as the patient is by this time in the service, this can be a challenge to manage.

In 2014 -15 the ARC admitted approximately 250 people for up to 6 weeks of intermediate residential rehabilitation.

Patients cared for at ARC tend to have a variety of health, social care and housing related issues. The ARC does not decline referrals based on diagnosis of mental health problems or life limiting conditions, but the person must be able to benefit from a period of residential reablement. On average 5.3 residents a month were readmitted to the acute hospital.

People accessing residential intermediate care services at ARC receive multi-disciplinary assessment and support typically for 6 weeks before returning home. Following admission, a planning meeting takes place, usually around the end of week two. This meeting is attended by the person and the Multi-Disciplinary Team and is the point at which the individual's initial assessments and planned rehabilitation programme is agreed. Family and carers are encouraged to participate with the person's consent. All parties are involved and encouraged to contribute the formulation of a care plan.

Part of the role of the ARC is to support people who are considering residential care to ensure that all options of support in the community have been exhausted before a long term decision is made.

Discharge planning at ARC typically does not begin until around week four of rehabilitation. The review found that environmental visits are not routinely completed and on occasions when home visits are completed, they rarely take place before the end of the rehabilitation period. Consequently opportunities to identify and address issues early on that may later affect discharge home are lost resulting in avoidable delays.

There is little transitional support available during the rehabilitation period to help people prepare to return home. Some residents at ARC will have experienced 24 hour support in a hospital setting followed by an extended period of residential rehabilitation and are understandably cautious about returning home, often alone and with significantly lower levels of daily support and oversight.

People discharged home from ARC tend to go on to receive a further package of intermediate

reablement care at home for up to a further 6 weeks.

A multi- disciplinary review of patients present at the ARC on a given date in June 2015 showed that of 29 patients, 12 could have remained at, or been discharged straight to their home if there had been suitable community support, 9 could have been discharged from ARC within 5 days after an intensive period of assessment if there had been suitable community support to continue a rehabilitation program at home and 7 required a stay of up to 14 days due to more complex issues. 2 patients were not suitable for a community rehab service and their needs would be more appropriate for longer term care settings.

Spiral CIC is a Nurse-led, sub-acute unit at Bispham Hospital. This unit has 20 beds. Spiral is a Community Interest Company (CIC) and their service is sub-contracted by Blackpool Teaching Hospitals NHSFT to provide nurse-led intermediate care along with some specific programmes of care for cardiac patients being discharged from the acute hospital.

In the financial year 2014/15 admissions to the Bispham Spiral site were calculated at 480. On average 3.8 patients a month were readmitted to Blackpool Victoria Hospital approximately 9.5% of overall admissions.

The cohort of intermediate care patients cared for at Spiral would not typically be classed as 'sub-acute'. The average length of stay of this cohort of patients is 13.7 days, which suggests many of these patients could be cared for by an 'intermediate care at home' team, were one available. Sub-acute patients generally have complex needs, existing co-morbidities and require high levels of nursing input and potentially some medical review / input to ensure their multifaceted, complex needs are met.

In 2014 -15 Bispham Spiral admitted approximately 480 people

The assessment for Spiral is undertaken by their own trained Nurse Assessor, in the hospital setting, who liaises directly with ward staff to identify suitable patients for assessment and transfer to the Unit. The Hospital Discharge Team does not appear to be involved systematically in this process. Spiral has developed its own assessment documentation.

Social Services are not as involved in supported discharge as would be expected in a sub-acute unit. A dedicated social work assessor attends the unit when a referral is received from Spiral ward staff. However, Social Services report receiving low numbers of referrals from Spiral.

In the financial year 2014/15 the average length of stay at Spiral was 13.7 days.

A review of recent referrals to Social Services from Spiral and subsequent assessment outcomes suggests that the service tends to be occupied by people who have few nursing needs and who could potentially be supported to return home either straight from the acute hospital, or much sooner with more appropriate intermediate care services.

A Public Consultation exercise was recently undertaken to understand older people's needs and the capacity of rehabilitation services across

the Fylde Coast: Fylde Coast Intermediate Care Review and Recommendations (2013).

With regards to access to beds the report concluded that '*the future need for services based at Bispham is being reviewed as part of the unscheduled care plan. Just like other services, the new model may enable the current Spiral health staff to benefit from new ways of working and meeting local needs...'*

Spiral does not accept patients with a mental health need or people who reside in care homes. 'Halfway Home' specifically makes reference to intermediate care services being inclusive and that patients should not be denied services on these grounds. Nationally, the intermediate care patient cohort comprises frail older people with a number of long-term conditions, including dementia. Wherever possible, this client group in particular would most benefit from least time in in-patient care with maximum intermediate care at home.

Clifton Hospital is a 72 bedded unit. The unit has 3 wards which provide slower stream medical and orthopedic rehabilitation and complex discharge planning to patients with complex health and social care needs and long term conditions. This includes patients with moderate to severe dementia and patients requiring assessment for Continuing Health Care.
This service provides 'in patient' rehabilitation services, and people supported in this environment are assessed as continuing to require consultant led care.

Each Ward is support by a multi-disciplinary team made up of consultants, doctors, nurses, physiotherapists, Occupational therapists and a speech and language therapist. In addition there is a Chaplaincy Team that can provide spiritual and pastoral care to patients and their carers.

Other facilities on site include a patient gym area and an activity of daily living room.

Consultation Exercise

The Commissioning Review carried out a telephone survey in July 2015 to ascertain what patients and service users felt about the care they received, particularly around how involved they were made to feel in decision making. The survey consisted of a mix of closed and open-ended questions intended to extract relevant information from patients in relation to their care, how they were included in decision making and how they have coped following the end of their intermediate care.

The survey was carried out jointly by the Clinical Commissioning Group and Blackpool Council's Adult Services. There were 124 individual cases identified to take part in the survey, these were split between the CCG and Adult Services and included a range of service areas including Rapid Response Plus, Reablement and the Assessment and Rehabilitation Centre. Taking all of the responses together:

Most respondents first came into contact with the service through a hospital admission. There was a mixed response as to whether or not people felt they had been given all the options available to them; some felt included in the decision making process whilst others said they felt that they had had no say in the matter. There was a mixed response as to whether or not patients had goals discussed and set for them and most respondents felt that there was nothing more that could have been done to

enable them to return home any sooner. However, a few respondents did feel that equipment / support could have been put in place sooner to allow them to return home earlier.

Consultation Findings and Conclusion

The findings of the survey show that there were inconsistencies in how the respondents felt about their experiences of the intermediate care service. Due to the low response rate, 28 responses out of a total of 124 calls made, the data did not lend itself to qualitative analysis and therefore no conclusive findings can be made.

The inconsistencies in the experience of patients may suggest that a more robust exercise is required to gain a more in depth insight into why people have mixed opinions about the service.

The Future of Intermediate Care

The commissioning review anticipates that significant improvements could be achieved to the provision of intermediate care by moving away from the current collection of services which often lead to duplication, fragmented and uncoordinated care. Designing an integrated service which most effectively meets patient/service user needs and makes the most effective use of available resources is paramount.

This commissioning review has identified a set of principles which should underpin any new model. These are: –

- The support model should be to enable people to be at home as soon as possible.
- The model should be inclusive, but targeted at those people who will benefit from a tailored intervention.
- The model should be cohesive, with services and professions working together seamlessly to support progression through a clear pathway of reablement.
- Any residential element should be short term with intensive support, aided by a team who are able to solve problems which are barriers to the person returning home, whether they be health, social care or housing related.
- The staff within the model should feel part of a larger intermediate care team with common aims irrespective of the area of the service they work within, and the patient journey should not feel fragmented.
- There should be a single point of referral, where experts from the intermediate care team support positive decision making with the patient about their individual pathway.
- Group work with patients is recognised as important, but should be done wherever possible in a more localised community setting close to the person's home.
- Intermediate care services should support people to build up their knowledge of self-management of long term conditions and health risks, and support them to be resilient to further changes in their health the future to reduce the dependency on health and social care services.
- There should be strong and effective links with new models of care.

Summary of Findings

A greater number of people could be supported to return home sooner if the intermediate care pathway operated more efficiently. The following outlines the high level conclusions of the review:-

- **A service redesign for Intermediate care is essential** in the strategy for managing the projected rise in the older population and the increased numbers of people with long term conditions living longer with more complex needs. The challenge facing the Local Authority and the NHS is to commission a high standard of care and support within the current financial constraints and growing demand.

- **A key aim of the local intermediate care offer should be to provide rehabilitative care closer to peoples' homes**; reducing the level of unscheduled care presentations, admissions and readmissions. Also reducing the length of hospital stays, delayed transfers of care and the level of admissions to residential care; including admissions to residential care from the acute hospital.

- **A service re-design should deliver improved patient / service user and carer experiences and an enhanced multi-disciplinary response to individual needs.** A change in organisational cultures and approaches will be key to delivering integrated health and social care services which have traditionally been delivered to people either as in-patients or residential setting rather than at home.

- **Commissioners should seek to develop a quality and cost effective local intermediate care offer delivering a spectrum of intermediate care services in line with the 'Halfway Home'** recommendations; establishing integrated re-ablement services at home alongside bed based provision.

- **Financial reconfiguration will be necessary to develop appropriate levels of at home and closer to home based services** which encourage and support patients / service users to be independent and maximise their opportunities for recovery and wellbeing.

- **There is potential for a moderate increase in demand on the community equipment budget** as greater numbers of people with complex needs are supported to remain at for home longer or to leave hospital sooner. The new service will promote independence and explore alternative options and appropriate solutions.

- **Environmental / home visits are a key opportunity to identify potential barriers to returning home.** Conducting visits early on in the rehabilitation process ensures issues can be addressed more quickly and may reduce the length of a person's requirement for support.

- **Reducing overall intermediate bed capacity will lead to an increase in demand for alternative services** such as: nursing at home, therapy at home, re-ablement at home, care and recuperation at home, and residential recuperation. Failure to properly resource community based intermediate care services will result in people falling into crisis and re-presenting at A&E or being re-admitted to hospital.

Review Options

Option A

To continue with the current intermediate service provision, although this option presents a greater risk around achieving national and strategic aims and will lead to continued gaps in intermediate care services.

Option B

To reduce the overall number of residential intermediate care beds and utilise funding to develop and appropriately resource Enhanced Intermediate Care services and develop an improved and more flexible intermediate care pathway and workforce delivering a continuum of intermediate care across the community.

Recommendations

Recommendations are made by the commissioning review are made the context of the following local and national drivers:

Fylde Coast Health Economy Public Consultation: "*The future of older people's rehabilitation services on the Fylde Coast."*
Fylde Coast Unscheduled Care Strategy 2012
Department of Health – "*Halfway Home*" recommendations
Care Act 2014 - prevent reduce delay onset

The commissioning review recommends Option B which delivers one local integrated intermediate care service. A description of the proposed model, broad actions to achieve desired outcomes are included in this report. The model incorporates and encourages new and innovative ways of working to meet local needs, focusing on the rehabilitation and re-ablement of Blackpool residents.

Intermediate care should be regarded as an investment in each individual, supporting them to recover and retain levels of independence for longer. Investing in intermediate care services closer to home is seen as a way of supporting people to be more resilient. Ensuring appropriate levels of 'wrap around' care at home or in a residential rehabilitation centre will be critical to the success and sustainability of the strategy.

The service will provide a local integrated intermediate care programme normally lasting up to 6 weeks or less and including a range of multi-disciplinary supports in whatever intermediate care setting. i.e not 6 weeks residential intermediate care followed by a further 6 weeks reablement at home totalling 12 weeks.

Due to the level and pace of the recommended changes certain service areas will remain out of scope for now i.e. intravenous therapy, Acute Rehabilitation service, and Stroke Enhanced Supported Discharge but will be considered for future service development.

It is recognised that some people will have repeat occurrences of intermediate care due to their increasing age and frailty, but it should be a key principle of the model that these episodes are mitigating and prevented wherever possible. At the end of the intermediate care period it is also necessary to ensure robust discharge planning and exit strategies in order that people do not become delayed in the system unnecessarily or access

free intermediate care services longer than is necessary.

In being able to meet these outcomes health and social care will need to deliver care in a way that not only demonstrates clear outcomes for in improving the health and wellbeing of individuals but cost effective and efficient services that demonstrate value for money.

The joint commissioning strategy and service specification will need to monitor and review performance to ensure that intermediate care services meet identified needs and achieve desired outcomes within the defined budget.

Broad Actions to Meet Outcomes

1. **Prevent crisis situations occurring through earlier interventions and joint working; including timely and appropriate access to specialist services, preventing avoidable admissions to hospital and facilitating timely discharges.** *Individuals will receive their care in the right place, at the right time. We will reduce the cost of acute hospital care and manage increasing projected demand.*

- implement an improved patient focused, efficient and effective intermediate care pathway to facilitate joint working, flexible and responsive service delivery for Blackpool

- enable people who have completed periods of intermediate care to 'self- refer' for advice or 'step up' to avoid unnecessary admissions.

- provide open communication pathways in order to develop mechanisms for accessing clinical and social care advice from secondary care for patients, carers and intermediate care staff and vice versa.

- Identify a Single Service accessible to all referrers and which is promoted widely to meet a full range of intermediate care needs.

- Develop a unified assessment process, trusted by all with appropriate information shared between partners.

- Develop the pathway to provide an integrated continuum of service provision. Develop a person centred 'menu based' approach to service provision.

- Redesign Intermediate Care to provide in-reach support to care homes and hospital.

- Review and develop the capacity to provide a rapid response component of the Intermediate Care service to provide urgent community based assessment and immediate intervention in people's homes.

- Increase use of Assistive Technologies and 24/7 response to support people to remain in their own homes.

- Review community equipment available to intermediate care teams

2. **People receive timely and co-ordinated short term care at home or closer to home enabling them to live independently, reducing unnecessary admissions to long term care.** *Assessment and decision making about peoples long term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery.*

- Implement new pathway to ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Reablement.

- Support independent care home providers to manage people who live there to access intermediate care.

- Ensure that individuals with more complex needs (i.e. dementia) have equity of access for assessment and rehabilitation, prior to decisions being made about their longer-term needs.

- Develop clear and consistent referral pathways between intermediate care and Accident and Emergency, the Medical Assessment Unit and Primary Care.

- Facilitate a 'step down' provision via an intermediate care hub that will aim to avoid delayed transfers of care and decrease length of stay by ensuring patients receive the intermediate care that they require in the most suitable environment for them, whether that be at home or in a residential '*Halfway Home'* environment.

- Facilitate a 'step up' provision from the GP neighbourhoods, community services and Extensive Care which aims to reduce secondary care admission by ensuring patients receive the intermediate care that they require in the most suitable environment for them whether that be home or in a residential '*Halfway Home'* environment.

- Reduce the number of residential intermediate care beds for Blackpool from 53 to 33 beds, and increase the flow of people through the pathway by reducing the average length of intermediate residential admissions from 6 weeks to 3 weeks. All admissions should will have an onward exit plan and discharge planning to commence from the day of admission

- Increase Reablement care at home capacity and develop a seamless intermediate support service to 'reach in' and transition people home from the acute hospital or residential rehabilitation settings; promoting independence, building confidence and facilitating timely discharges so that people can continue their rehabilitation programme at home with appropriate levels of support.

- Ensure short term residential care is made available (where appropriate) to people with complex discharge issues i.e. housing, awaiting adaptations, and awaiting CHC assessments. N.B. Assessed weekly charges will be applied.

- Explore potential to develop a small number of temporary sheltered 1 x bedroom flats as part of a local 'Halfway Home' intermediate care offer to temporarily address (up to 3-6 months) specific housing and adaptation issues until more appropriate and permanent solutions are in place.

3. **People have control over their lives; involvement in their care and choice over their treatment.** *Increase patient and service user satisfaction and maximise people's potential to remain independent*

- Strengthen working relationships with specialist and community health services, including Long-term conditions, Falls and Stroke pathways.

- Partner organistions to agree clear eligibility criteria, protocols and pathways through partnership agreements

Option B - Model and Actions

Commissioning an Integrated Intermediate Care Team

Intermediate care functions commissioned by NHS Blackpool CCG and Blackpool Council to deliver health and social care services including bed based or at home provision will become one integrated team. An Integrated Intermediate Care Team service specification will be completed focusing on rehabilitation using outcomes based key performance indicators as a monitoring tool ensuring that the Intermediate Care Team work together as an integral part of the health and social care system with a key aim for rehabilitation will be fundamental to its successful implementation and operation.

The new intermediate care pathway will be underpinned by a jointly commissioned NHS and Social Care management and governance structure which will include an overall service manager. The recommended service management post will implement the reviews recommendations in conjunction with partner agencies to realise the delivery of the co-ordinated whole system benefits.

An Intermediate Care Hub will be responsible for both Primary Care and Community (step-up) and Hospital (step-down) admissions allowing an overall view of patient flow, demand and capacity into intermediate care. The integrated service delivery approach and integrated management structures will provide efficiencies, more streamlined pathways for patients and a better patient experience focusing on regaining independence.

Co-ordination of Referrals and Flow

Demand for Intermediate Care Services will be channeled through the Integrated Care Hub which will enable the effective management and operational oversight of capacity and flow in the system. This will facilitate service provision that provides 'wrap around care' for the individual referred to the Intermediate Care Service.

The Intermediate Care Hub will be responsible for reviewing and coordinating referrals. The 'navigator' role will have responsibility for working closely with the secondary care referrers in order to 'Step Down' patients in a timely manner and ensure the most suitable type of Intermediate Care is provided in the most appropriate setting which is tailored to the individual's needs.

There will be an increased requirement for Health and Social Work assessments to meet the rise in the level of referrals. The new team will work closely with Out of Hours care coordination services to develop care plans for 'out of hours' provision to avoid unnecessary admissions. The team will work towards an integrated IT infrastructure with data sharing agreements, currently being developed by the new models of care.

Commission an Enhanced Intermediate Care Service

As part of the service redesign, and as recommended in the Fylde Coast Intermediate Care Review and Recommendations report, the overall number of residential beds for Blackpool will be reduced from 53 to 33 beds. The shift from bed based to home provision will require additional Reablement care at home capacity.

In future Intermediate Care beds will be based at one location in Blackpool. Staff affected by this change will be consulted with a view to TUPE transfer into the new model.

The model will provide 24/7 nursing, therapy and social care provision. Initially ten beds will be allocated for patients requiring nursing input but importantly there will be flexibility to reduce or increase over time in line with demand.

Core hour medical cover will be provided by the patient's own GP practice and practice pharmacists. Additional GP cover will be available over 7 days to complete 'ward rounds' and deal with medication issues. The out of hours medical cover will be provided by the out of hours provider 6.30pm – 8am.

Co-ordinated links will be made to address medicines management issues with Practice and Community Pharmacists.

The model will include nursing or residential beds for patients referred requiring nursing care or a residential care bed but whose potential rehabilitate and to return home is real.

The Intermediate Care team will need to work closely with primary care colleagues to ensure effective discharge information and general advice is made in a timely way. Co-ordinated links will be made to ensure that patient care is not repeated as part of the Extensive Care Service.

Intermediate Care Capacity

Intermediate care capacity will be re-balanced in a phased approach from the current emphasis on bed provision towards intermediate care at home provision in line with intermediate care provision nationally.

An initial increase from the current average of 1400 hours to 2240 hours per month will be necessary to facilitate the support of an additional 10 people per week each accessing an average of 7 hours support per week to return home either from the acute hospital (3) via Early Supported Discharge (2) and to support the increased rate of discharges from residential intermediate care each week (5).

Funding from de-commissioned services will need to be re-channelled in to the Reablement care at home service in order to ensure increased Reablement care capacity.

Close monitoring of demand across an extended period (6 – 12 months) will help commissioners to better understand the effects of the new model locally and to ascertain the actual level of demand and capacity required.

Communication

It is important to ensure messages about the Intermediate Care Review, particularly to staff, are consistent and positively managed. If the proposed model is agreed, a communication strategy will need to be developed and implemented by partner organisations to support implementation of the model and to promote cultural change. Communication specialists from the various partner organisations will be well placed to assist with this work.

Further Expand the Use of Telehealth and Telecare Technologies

The model will aim to further develop use of technologies in clinical triage with patients from the Intermediate Care Hub and primary care services.

Intermediate care provides a timely opportunity for all individuals, using either a bed-based or a home-based service, to review the scope for utilising assistive technology to enhance the individual's ability to maintain their independence at home and maximise the opportunities for prevention of crises in the future.

Telecare and Telehealth maximises the opportunities to support self-care and self-management which fits with the ethos of the new focus on rehabilitation.

To accomplish the above actions, the model needs to include appropriate health and social care specialists and access to timely medical assessment and input, at the triage point and during the intermediate care period.

Financial Information

Current cost of existing intermediate care provision for health and social care in Blackpool:

Current service costs			
Service		**Cost**	**Comments**
BTH	Health	£4,565,000	Includes 1.6 m Spiral funding
Blackpool Council	Social care	£2,860,863	
ARC	£1,328,073		Includes property budget
Equipment	£151,676		Includes 15% staffing costs Approximate overspend M2
Telecare	£250,000*		All provision
Vitaline	£420,000*		All provision
Rapid Response Plus	£126,946		
Reablement	£584,169		Includes urgent bridging care
Total value		£7,425,863	

*Figure is for all provision /units including ongoing care at home

Stakeholders have expressed concern about increasing the flow of patients through the intermediate care pathway, effectively shifting the burden of care at a time when intermediate care services are operating either at or close to full capacity. By seeking earlier discharges from hospital, community based services will in many cases need to deliver much higher and staff intensive community based care packages than would have been the case if the individuals concerned spent a few more days in hospital.

A shift in resources is required to enable community based services and other associated support services to respond appropriately, meet the level of demand quickly closer to the person's home and to sustain flow through the intermediate care pathway.

References

Care and Support Statutory Guidance Issued under the Care Act (2014)

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Fylde Coast Intermediate Care Review and recommendations (2013)

Fylde Coast Unscheduled Care Strategy (2012) available at: http://blackpoolccg.nhs.uk/wp-content/uploads/2013/07/Unscheduled-Care-Strategy-Fylde-Coast-FINAL-.pdf

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Department of Health Intermediate Care – Halfway Home *Updated Guidance for the NHS and Local Authorities* (2009) available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

Glossary

Acute Care	Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.
AssistiveTechnology	The term 'assistive technology' refers to 'any device or system that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed' (Royal Commission on Long Term Care 1999). It is designed to maintain or improve someone's independence such as Telehealth and Telecare. Assistive technology ranges from very simple tools, such as calendar clocks and touch lamps, to high-tech solutions such as satellite navigation systems to help find someone who has got lost.
Care Package	Help people to stay at home with services based upon individual need. Clients can choose the type of support they want.
Care Plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible by the individual in whatever form is suitable to them.
Carer	A carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Commissioning	The means to secure the best care and the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services which: • deliver the best possible health and well-outcomes, including promoting equality; • provide the best possible health and social care provision: and • achieve this within the best use of available resources.

Complex	A term used to describe people who have an intricate mix of health and social care needs. Because of their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long-term institutionalisation.
Holistic	Used in medical terms as treatment which deals with the whole person, not just the injury or disease.
Home	For the context of this strategy references to an individual's home means 'an individual's usual place of residence'. This includes owner occupiers, rented accommodation, sheltered housing, extra care, care homes and prisons.
Integrated Care	NHS and local authority health responsibilities are managed together so that care trusts can offer a more efficient and better integrated service.
Intermediate Care	Integrated services for people that promote faster recovery from illness, prevent unnecessary hospital admissions and maximise independent living.
Long Term Conditions	Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.
Multidisciplinary	A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.
Pathway	The route followed by the service user into, through and out of NHS and social care services.
Personalised	Personalised care is about putting individuals firmly in the driving seat of building a system of care and support that is designed with their full involvement and tailored to meet their own unique needs.
Primary Care	The collective term for all services which are people's first point of contact with the NHS, e.g. General Practitioners, dentists.
Re-ablement	Re-ablement aims to help people accommodate their illness or condition by learning or relearning the skills necessary for daily living - it encourage and supports people to do as much as they can for themselves, doing tasks with individuals rather than for them. For some, it could be supporting them with

	personal care or making meals, while for others it could be helping them to get out of the house and taking part in social activities, or helping them with rehabilitation programmes (e.g. physiotherapy, occupational therapy).
Rehabilitation	Rehabilitation is a goal orientated and time limited process aimed at enabling a person to improve/restore a person's physical, mental and social functioning. It can also aim at providing a person with tools to deal with their loss of and change in function
Secondary Care	The collective term for services to which a service user is referred to by a consultant. Usually this refers to NHS hospitals in the NHS offering specialised medical services and care.
Service Users	Anyone who uses, requests, applies for or benefits from health or local authority services.
Single Assessment Process [SAP]	Process that ensures older people's care needs are assessed thoroughly and accurately.
Telecare	A continuous, automatic and remote monitoring of real time emergencies over time in order to manage the risks associated with independent living
Telehealth	The delivery of healthcare at a distance using electronic means of communication – usually from service user to clinician e.g. a service user measuring their vital signs at home and this data being transmitted via a telehealth monitor to a clinician
Urgent care	"medically necessary services that are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours." In other words, what the medical definition of urgent care means is that an injured or sick person who may suffer from irreversible complications or even death if his injury or illness is not treated in a timely manner is care required immediately or classified as "urgent." So any injury or illness that has the potential to become something more serious, or even deadly, is considered a basis for receiving urgent care.