OFFICER EXECUTIVE DECISION

SUPPORTING PEOPLE AT HOME - INTERMEDIATE CARE AND REABLEMENT STRATEGY

Delegation from Leader and Cabinet and date:	On 25 August 2015 the Cabinet considered a report detailing the joint Intermediate Care and Reablement Strategy between the Council and NHS Medway Clinical Commissioning Group (Medway CCG). This Strategy set out how Medway intended to commission and redesign Intermediate Care and Reablement Services to meet the needs of Medway residents. It outlined the principles that would guide development and implementation of the strategic direction and also set out aims and objectives, and plans for delivery. It was noted that the Strategy would also be considered by the Medway CCG Governing Body and the Health and Wellbeing Board. The Cabinet therefore agreed to delegate authority to the Director of Children and Adult Services, in consultation with the Portfolio Holder for Adult Services and the Chief Operating Officer of the Medway Clinical Commissioning Group, to make minor amendments to the Intermediate Care and Reablement Strategy following consideration by the Health and Wellbeing Board and the NHS Medway Clinical Commissioning Group Governing Board. A copy of the report and Record of Decisions is available via the following link http://democracy.medway.gov.uk/ieListDocuments.aspx?CId=115&MId=3161&Ver=4
Decision:	The Supporting People at Homes – Intermediate Care and Reablement Strategy was submitted to the Medway CCG Governing Body on 26 August 2015 and the Health and Wellbeing Board on 15 September 2015. A number of minor changes were made to strategy following the Medway CCG Governing Body. A copy of the final document is attached.
Reasons for Decision	Commissioners from Health and Adult Social Care have worked with the key partners involved in the patient/user journey to analyse the current picture of service provision, review current and future needs, and learn from best practice elsewhere, in order to identify the changes necessary to improve the quality, effectiveness and efficiency of future service provision throughout Medway. The Intermediate Care and Reablement Strategy is a joint health and social care strategy which details how Medway intends to commission and redesign Intermediate Care and Reablement

	Services to meet the needs of Medway residents. It outlines the principles that will guide development and implementation of the strategic direction and also sets out aims and objectives, and plans for delivery.
Date of Decision:	16 September 2015.
Details of any other options considered and rejected:	The options were considered within the Cabinet report. A number of minor changes were made to strategy following consideration at the Medway CCG Governing Body.
Lead Officer:	Lance Douglas , Interim Transformation Lead Adults lance.douglas@medway.gov.uk
Conflicts of Interest:	Not Applicable.

MEDWAY INTERMEDIATE CARE AND RE-ABLEMENT STRATEGY 2015 -2018 – Supporting people at home

Resilient individuals and resilient communities

VERSION 11

Contents

1. Executive Summary

This is a joint health and social care strategy which details how Medway intends to commission and redesign Intermediate Care, which includes Reablement services to meet the needs of our Medway residents. It outlines the principles that will guide development and implementation of the strategic direction and also sets out aims and objectives, and plans for delivery. Commissioners from Health and Adult Social Care have worked with the key partners involved in the patient/user journey to analyse the current picture of service provision, review current and future needs, and learn from best practice elsewhere, in order to identify the changes necessary to improve the quality, effectiveness and efficiency of future service provision throughout Medway.

Our vision for the future of intermediate care in Medway is:

We will develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, that enables individuals and their carers to remain as independent as possible, for as long as possible.

This strategy aims to improve the experience of people who find themselves in hospital when they really do not need to be there and would rather be treated for non-urgent care in surroundings they know and understand. We know that more than 50% of those over the age of 75 who end up being admitted to hospital could be better serviced by remaining at home or in a place they know and understand and receive their care in that setting. We also know that people deteriorate while in hospital and the best place for people to receive non-medical care is in a setting they know and understand, this is particularly important for those who are vulnerable or may have dementia or emotional health and wellbeing challenges: Creating a process which quickly returns them to their own home or known place of safety will enhance their ability to retain their existing resilience and capacities.

When people present to emergency and urgent care centres it is important to quickly identify those people who can safely be returned to home with appropriate support so an assessment of their future needs can be completed there rather than in hospital. This approach employs the ‘home to assess’ rather than the ‘decide to admit’ principles on their initial arrival at the hospital. Once the acute team has identified, stabilised and treated any acute illnesses the person will be referred back out to a ‘wrap around’ community team which can complete an assessment and organise support from the person’s own home or registered place of safety.

A set of high level aims have been developed that describe what the Intermediate Care Model will deliver for Medway. These aims align closely with the Department of Health guidance ‘Intermediate Care - Half Way Home’.

Our aims are to:

- Support people at home
- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to Long Term Residential Care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce

From our engagement with patients, carers and staff who provide services, we have developed a set of objectives and supporting activities, which we believe will help us to achieve the above aims for the people of Medway.

Finally, we intend to measure our success over the next three years through the suite of metrics developed to report upon the Better Care Fund which include the programme to develop Intermediate Care, Rehabilitation and Reablement Services.

The key strands to the strategy are to:

1. Develop more community based services to support people at home including the following actions
    a. Make more use of and develop better reablement services
    b. Develop a responsive Integrated Community Equipment service
    c. Develop Telecare services
    d. Work with the Voluntary Sector to maximise the contribution the Voluntary Sector can make to supporting more people at home and to self help and community resilience
2. Develop a Home to Assess scheme to keep people away from hospital and get them back home sooner
3. Place the care around the individual in the setting they choose which will usually be their home
4. Shift the balance of care away from institutional settings towards supporting more people at home

2. Introduction

Different interpretations have emerged and evolved nationally and locally regarding the definition of 'Intermediate Care' and its links to 'rehabilitation' and 'reablement'. In Medway, partners have worked together in order to review national guidance and agree a clear set of definitions for intermediate care, rehabilitation and reablement.

What is Intermediate Care?

As stated in the Department of Health document – "Halfway Home", integrated care should ensure the development of :

'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'.

This range of services is often described as those services that do not require the resources of the acute trusts, but are beyond the scope of the primary care team, and are offered on a short term basis at home or in nursing or residential settings for those people who need some degree of rehabilitation or recuperation at times of transition in their health, social care or housing needs.

The core service should generally be provided in community-based settings or in the person's own home. Intermediate Care should incorporate a range of services, including nursing or residential care beds in Residential Care Home, Nursing Home or Community Hospital settings, some with nursing care. Intermediate Care may include a rapid response team to provide assessment or immediate intervention in people's homes to reduce inappropriate admissions to hospital. The service could also include more intensive support and treatment at home to prevent avoidable admission or to facilitate discharge. This type of service is sometimes described as 'hospital at home'. Part of the service should be available on a 24 hour, seven days a week basis, with access to assessment.

What is Reablement?

Reablement is one service on a continuum of Intermediate Care. Reablement is a range of services focused on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and confidence to live at home.

The agreed definition of reablement services funded by Medway Council and Medway CCG is that it:

- is about helping people to do things for themselves, rather than doing things to people
- is time limited
- is outcome focussed
- is about helping people to get more independent within their community
- seeks to increase a person's independence, choice and quality of life
- requires active involvement from the person, because it is about working with someone to help them toward positive changes

What is Rehabilitation?

'The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce, Rehabilitation usually requires a mixture of clinical, therapeutic and social interventions that also address issues

relevant to a person's physical and social environment. Effective rehabilitation needs to be responsive to a user's needs and wishes, to be purposeful , involve a number of agencies and disciplines and be available when required.'

[Audit Commission 2000. The Way to go Home – Rehabilitation and Remedial Services for Older People]

3. Policy and Local Context

The Strategic Direction has been developed in response to and influenced by a range of National Health and Social Care policies and strategies, including:

- Our Health Our Care Our Say: A New Direction for Community Services (2006)
- The Local Government and Public Involvement Act 9 (2007)
- Transforming Community Services: Enabling New Patterns of Provision (2009)
- Think Local, Act Personal – Next Steps for transforming Adult Social Care (2011)
- National Dementia Strategy (2009)
- Valuing people now: a new three year strategy for people with learning disabilities (2009)
- Healthcare for All (2008)
- Recognised, valued and supported: Next steps for the Carers Strategy (2008)
- Caring for our Future : reforming care and support (2012)
- Equity and Excellence: Liberating the NHS (2010)
- The Health and social Care Bill (2011)
- The Care Act (2014)
- Department of Health – Intermediate Care, 2001 Health service/Local Authority Circular 2001/001
- Department of Health – National Service Framework for Older people (2001)
- Department of Health – Intermediate Care – Halfway Home (2009)
- Department of Health – Personal Care at Home Act (2010)
- The Health and Social Care Act (2015)

'Think Local Act: Personal' provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. Using this framework for Intermediate Care allows for the development of services that are tailored to meet individual needs, rather than provision of a range of targeted specialised services.

The national policy drivers provide a framework for the further development of health and social care in Medway and the implementation of a coordinated approach to the personalisation of services across health, social care and partner agencies.

The Intermediate Care and Reablement Strategy for Medway is aligned with and includes a range of local strategies which aim to support Medway residents to live independently and to stay in their own homes for as long as possible.

Medway Joint Strategic Needs Assessment

Medway's resident population is 271,000. Projections from 2011 to 2021 suggest that the proportion of the population aged 65 years or over will increase from 14% (37,200) to 16.4% (47,700). The equivalent change in those aged 85 years and over is 1.7% (4,400) to 2.0% (5,700). The number of those over 65 years with a limiting long term illness is expected to increase by 31% (the same as national figures) from 2009 to 2020 and this will have a significant impact on the demand for health

services for the management of long term conditions such as dementia, heart disease and diabetes as the incidence of these conditions increases with age.

An ageing local population is likely to result in a substantial increase in costs to the health and social care system and primary and secondary prevention of conditions such as diabetes, Chronic Obstructive Pulmonary Disease and heart disease. Combined with improved care for people with conditions such as dementia, it is essential to reduce or limit the numbers of high intensity users of services and reduce the costs to the health and social care system.

Nationally, mental ill health represents up to 23% of the total of ill health in the UK – the largest single cause of disability. In Medway it is estimated that 29,600 people aged 16-74 have 'a neurotic disorder' and 2,390 people aged over 65 have dementia.

Medway's Better Care Fund Plan

The Spending Review at the end of June 2013 announced the establishment a £3.8 billion pooled budget across health and social care known as the Better Care Fund (BCF) that will be available to Local Authorities nationally from 2015/16. This funding is not new money and is already allocated to support a number of services. Joint plans contained with Medway's Better Care Fund Plan were agreed in December 2014 and were given the highest possible rating. These plans include a joint fund of £17.6m to be used to continue to fund existing services but change some of these in order to meet our objectives of supporting more people at home and reducing the number of people in hospital within the context of a shrinking resource base.

There are a number of national conditions attached to the use of the BCF as well as local targets, together with a performance requirement to reduce non – elective admissions (NEL) by 0.8% (194 less people in hospital) element.

Specialty	Inpatients	Expected length of stay	Actual length of stay	Difference	Potential bed days saving
All	7,465	10.5	11.4	1.0	51,887
General Medicine	3,860	10.1	11.2	1.1	27,110
Geriatric Medicine	954	12.3	16	3.8	9,738
General Surgery	606	9.1	9.3	0.2	3,315
Trauma & Orthopaedics	590	16.3	16	-0.3	4,312
Accident & Emergency	467	9.5	9.1	-0.3	2,942
Cardiology	277	8.6	9.3	0.7	1,480
Urology	246	6	2.8	-3.2	312
Vascular Surgery	128	11.9	12.3	0.3	1,012
ENT	124	4.7	3.5	-1.2	255
Gastroenterology	87	10.5	11.7	1.2	626
Respiratory Medicine	67	10.6	10.9	0.3	450
Clinical Haematology	32	9.5	8.1	-1.4	144
Gynaecology	18	9.4	9.7	0.3	123
Breast Surgery	****	3.5	2	-1.5	0.0
Colorectal Surgery	****	9.1	9.5	0.4	8.0
Endocrinology	****	7.6	14.6	7.0	61
Pain Management	****	23.7	10	-13.7	2.0

Non-Elective admissions to Medway Maritime Hospital for those aged 75+ Jan-Dec 2014.

Potential bed days saving is the number of bed days that could be saved if no inpatients stayed longer than the England median

The following additional measures - effectiveness of reablement; admissions to residential and nursing care, delayed transfers of care - will be central to the success of improving services in Medway. Commissioning intentions will need to ensure that reablement fits with the requirements of the BCF, especially in relation to any potential payment for performance element.

Effectiveness of reablement: The percentage of older people still at home 91 days after discharge into reablement/ rehabilitation (2013-2014)

	Medway	Comparator Group Average	England Average
% all older people	92.5%	85.2%	82.5%
% males over 65	100.0%	85.0%	81.7%
% females over 65	93.3%	87.6%	86.2%
% over 85s	88.2%	83.3%	80.2%

From DH statutory ASC-CAR return 2014

Effectiveness of reablement: The percentage of older people offered reablement services on discharge (2013-14)

	Medway	Comparator Group Average	England Average
% all older people	2.5%	3.6%	3.3%

From Hospital Episode Statistics 2014

Medway's latest performance (2013-14) is better than the national average with 92.5% of older people discharged to reablement/ rehabilitation still at home 91 days later. However, Medway has relatively few people accessing these services compared to the national and comparator average. The BCF plan has identified approximately £900,000 of potential avoided costs in on going residential care and home care packages by maintaining the success rate but increasing the number of people receiving reablement after discharge from hospital by approximately 30% (another 164 people).[1]

Admissions to residential and nursing care: Admissions per 100,000 population

	Medway	Comparator Group Average	England Average
65+	626.5	727.9	668.4

From DH statutory ASC-CAR return for period April 2013 – March 2014

[1] The benefits realisation plan for the Better Care Fund compares potential costs avoided for those people who remain in their own homes without the need for ongoing care after a spell of reablment compared to the possible costs of providing ongoing care in residential care or as a home care package. It assumes that another 164 people discharged from hospital over 2015-16 could benefit from reablement based upon a 1% planned increase in performance of those discharged from hospital to reablement.

In 2013-14, Medway had a relatively low rate of permanent admissions to residential and nursing care for older people compared to the national and comparator average. The BCF plan has identified potential cost avoidance of approximately £300,000 by maintaining this low number of admissions by 2015-16 against the expected rise in population.[2]

Delayed Transfers of Care in Medway[3]

	Days delayed attributable to NHS	Days delayed attributable to Social Care	Days delayed attributable to both	People delayed attributable to NHS	People delayed attributable to Social Care	People delayed attributable to both
Acute	5433	82	0	189	4	0
Non-Acute	701	1371	88	26	55	3
Total	6134	1453	88	215	59	3

From DH Delayed Transfer of Care statistics for 2014-15

Reason for Delay	Days delayed attributable to NHS	Days delayed attributable to Social Care	Days delayed attributable to both	People delayed attributable to NHS	People delayed attributable to Social Care	People delayed attributable to both
Completion of assessment	731	123	8	30	5	1
Public Funding	203	127	61	3	5	2
Further non acute NHS	1097	0	0	34	0	0
Residential Home	701	319	0	28	14	0
Nursing Home	1254	703	19	40	27	0
Care package in home	92	74	0	5	4	0
Community equipment	125	0	0	5	0	0
Patient/ family choice	1300	107	0	48	4	0
Disputes	70	0	0	3	0	0
Housing	561	0	0	19	0	0
Total	6134	1453	88	215	59	3

From DH Delayed Transfer of Care statistics for 2014-15

Joint Health and Wellbeing Strategy 2010-2015

The Intermediate Care and Reablement Strategy supports the outcome in the Joint Health and Wellbeing Strategy of enabling Medway's older people to live independently and well. The delivery of reablement services supports the objective of improving physical and mental health and wellbeing and the underlying principles of a commitment to an integrated systems approach and partnership working via the Partnership Commissioning Team commissioning services across health and social care.

[2] BCF plan benefits realisation plan assumes 23 admissions avoided in 2015-2016 by maintaining performance against a predicted population increase of 9.2%

[3] Delayed Transfers of Care data subject to improvement programme

Medway CCG ICommissioning Strategy 2014-2019

The CCG strategy focuses heavily on integration and streamlined care co-ordination in order to reduce hospital admissions and length of stay, and aligns to the Better Care Fund. It is underpinned by delivery strategies which are proactive and not reactive; empowering the patient and carer and delivering care coordination across a range of collaborative provider networks.

The Health and Social Care Act 2015

The Care Act brings care and support legislation into a single statute. It is designed to create a new principle where the overall wellbeing of the individual is at the forefront of their care and support. The Act requires the promotion of integration of care and support with local authorities, health and housing services and other service providers to ensure the best outcomes are achieved for the individual. The Better Care Fund (BCF) will support the agenda of integrated services across Health and Social Care.

Dementia Strategy

Medway Council and Medway CCG's joint Dementia Strategy aims to support people to maintain their existing quality of life for as long as possible. The Alzheimer's Society use the phrase 'living well with dementia' and for a person with a dementia illness and their carers this is the aim of the Strategy.

To achieve this aim it is clear that people should be supported at the earliest opportunity to prevent or delay the potential for a breakdown in the existing arrangements for sustaining quality of life. The Strategy emphasises the need for early diagnosis and support for the person and their carers both before the diagnosis assessment is completed, during the process and afterwards.

With the definition of reablement as it relates to dementia and its effects on people's abilities, services should be designed that support people to rebuild their confidence as they come to terms with the effects on their condition, support people to develop ways to maintain or redevelop existing skills for daily living and engagement, and support to continue to feel that a person's value and contribution to their local community can be retained for as long as possible.

Month	% Dementia Diagnosis Rate	% Target	QOF Dementia Register (Number)	Practice List Size	Adjusted National Dementia Prevalence Rate	67% Target	Gap
Mar 15	55.0%	67%	1,575	292,491	2,862	1,918	343
Mar 15*	63.1%	67%	1,575	292.491	2,498	1,674	99

*National target is for 67% of the estimated number of people with Dementia to have a diagnosis by the end of March 2015. *Denominator for Dementia diagnosis amended by NHSE for all CCGs, impact on Medway CCG was a reduction in the estimated prevalence therefore this is an improved diagnosis rate*

Needs Analysis and Audit

The OAK Group carried out a point prevalence study in Medway NHS Foundation Trust (admissions and beds) and within the intermediate care bed facilities in the community - St Bartholomews, Frindsbury Hall nursing home and Platters Farm residential care home. FUSION Health Care were employed by Community Health Partnerships (CHP) on behalf of Medway CCG and Medway Council to look at modelling Community beds in Medway. The work shows there is an over provision of beds in Medway.

The FUSION study, the Oak audit and the needs analysis work to date shows the following in respect of community beds:

- Under use of the beds for intermediate care
- 1/3 of admissions (27%) unqualified[4]
- 53% of unqualified* admissions could have been prevented by providing a variety of services at home
- 63% unqualified* bed days
- 66% of all unqualified* continuing days of care could have been provided at home with a variety of services for the Medway CCG

4. Areas of Development

The work on Intermediate Care and Reablement has considered the following areas for development including:

- The need for step-up and step down provision
- Consider the service user / patient journey and link the work to the frailty pathway and the need to keep more people out of hospital and at home
- Configure an effective Community Rehabilitation Service
- Develop services with an enabling ethos
- Support the workforce to develop its skills to meet the emerging needs of older people

The main aim is to change the shape of health and social care services in the future to focus on:

- Prevention and promotion of health and wellbeing and away from an emphasis on ill health.
- Active identification of individuals at risk of developing illness, deterioration or crisis providing early intervention such as reablement and case management to support individuals to remain at home and avoid hospital admission.
- When people do need care and support, ensuring this is high quality and provided in the right setting at the right time, as close to home as possible
- Providing services that are personalised to meet needs so that individuals have choice, flexibility and control over the care and support they receive.

The strategic shift in services and resources that we aim to achieve through implementation of our wider health and social care strategies is:

[4] *Unqualified refers to care which can be provided in alternative setting usually providing lower levels of care, sometimes at home.

A Move 'From'

- Low emphasis on prevention
- Dependence on hospital care
- Dependence on residential and nursing care
- Variation in quality and provision
- Poorly connected services in community

And Move 'To'

- Healthier lifestyles and positive behaviours
- Increased self care and self management
- Services in the right place, from the right workforce, at the right time
- Effective primary care management of people with chronic disease and risk factors
- Care closer to home - and in peoples homes wherever possible
- Hospital focused on acute care with seamless pathways to community services upon discharge

5. What does Intermediate Care look like in Medway today?

Currently, Intermediate Care services are not commissioned as a specific service, but rather through a series of separate contracts for bed-based and non-bed-based services. Consequently, there appears to be some variation among stakeholders in terms of what is or is not seen as Intermediate Care. This may reflect the way in which Intermediate Care has evolved in Medway, as elsewhere in England. Stroke rehabilitation has been included as part of the Intermediate Care service but is not within the scope of the intermediate care strategy Medway Better Care Fund work as is subject to a Kent & Medway wide reveiw .

At present, the Intermediate Care pathway is accepted as '*those care arrangements focused on getting someone back into the community, or arrangements in the community to avoid someone going into the acute sector*' in discussions with NHS Medway.

There is a rapid response pathway and officers are currently reviewing all services in terms of pathways. There is a sense that the definition of Intermediate Care flexes according to whether or not the system is under pressure.

Based on a stakeholder workshop that occurred in October 2014 and on interviews, it is clear that Intermediate Care is offered in a range of settings including community hospitals, day centres, care homes and in people's own homes. The service is currently primarily composed of:

Adult Rehabilitation Service (St Bartholomew's Hospital, Rochester)

Medway Community Healthcare (MCH) provides a nurse-led bed based service based on short-term rehabilitation needs. Episodes of treatment are focused on the resolution of symptoms, adaptive therapy and crisis resolution leading to either discharge, transfer to the Community Integrated Team or other relevant agencies. Individuals are encouraged to take ownership of their health care and are given education, support and advice accordingly. The service is accessible to anyone over the age of 18 years who would benefit from a short term individualised health related rehabilitation programme following an acute incident/ accident/ illness or exacerbated medical condition and identified as having rehabilitation or nursing need.

All patients must be registered with a Medway GP and have an exit address. There are 35 intermediate care beds in two wards and 15 stroke beds (see below) in a third ward. Twenty-four hour nursing care is provided by MCH, medical cover is provide by local GP practice via a contractual arrangement, and an Intravenous (IV) Therapy service is available.
St Bart's also has the remit of preventing unnecessary hospital admissions through the provision of step up care and enabling early discharge from Acute wards. The aim of the service is to provide short-term comprehensive and equitable care, which is of a high quality and is responsive to the needs of the population.

The building is old and not fit for purpose. It is not suitable for people with moderate or severe dementia, and it is not possible to provide single sex wards in line with the dignity agenda. There are also security concerns at night which make night-time admissions problematic. However, there was no evidence that this prevents night-time admissions from happening.

The Oak Group (details below) in their point prevalence study found that over 60% of all bed days at St Bart's were considered non-qualified (care could be provided outside of this setting). For approximately half of these non-qualified days, the patients in question could have been at home with support services.

Stroke Rehabilitation Unit (St Bart's)

The Stroke service is not within the scope of the intermediate care strategy Medway Better Care Fund work as is subject to a Kent & Medway wide reveiw
The stroke service aims to provide seamless evidence based multi-disciplinary care with the most appropriate care setting to individuals, and their carers, who have had a stroke, so as to optimise the clinical outcome and care experience for both patient and carer.

Stroke rehabilitation services are part of the stroke care pathway and include the 15 bedded Merton ward at St Bart's. The unit provides bed-based rehabilitation to patients who have a primary diagnosis of new stroke, are medically stable, not suitable for rehabilitation at home, aged 16 years and over, and are registered with a Medway GP.

All patients should receive rehabilitation services until they have either reached their rehabilitation potential or have goals set that will empower them to continue rehabilitation in their own. Patients with agreed rehabilitation goals are referred to the Stroke Community Assessment and Rehabilitation Team (SCART).

Integrated Discharge Team (IDT)

The Integrated Discharge Team was established through agreement of the whole system Executive Programme Board. Initially this was through closer working of existing staff focused on hospital discharge with one provider taking a lead co-ordinating role. The team has since expanded through different phases of development to provide additional focused support within the hospital both for admissions avoidance and discharge planning. The drivers for this initiative are:

- Government initiative to encourage and promote integration of health and social care services.
- Nationally, integrated discharge teams have been successful in promoting timely discharge along with other urgent care initiatives which redirects service users away from the acute setting appropriately

As the pressure on urgent and emergency care services has increased over the years, particularly during the winter months, it has been even more evident that patient's timely transfer between services requires joint, multiple agency, seamless admission and discharge planning at each stage

of the patient pathway. Over the three-month period February 2015 to April 2015, there were, on average, 132 referrals to the team, 114 discharges facilitated and 25 care packages arranged. Although we know there are issues with what is being referred through Joint approaches to admission and discharge planning is key to ensuring that people move from and to the most appropriate setting at the point they are medically fit to do so. Work is ongoing in order to improve the discharge process.

The Integrated discharge team's primary purpose is to redirect service users to appropriate community services with regard to admission avoidance and to support and co-ordinate ward staff to discharge patients onto the appropriate community discharge pathway in a timely way.

The team will do this by:

- Adopting a proactive approach to admission and discharge across the hospital, seeking, identifying and advising on approach to discharge, taking timely and appropriate action as required focussing on all wards including ED and the Assessment units.
- Acting as a resource for ward staff and others to enable discharge of complex patients from hospital
- Actively supporting patients who are assessed as requiring time limited services on discharge to enhance the return to their optimum health and well- being.
- Actively supporting patients who have been assessed as having complex needs and require a co-ordinated robust discharge plan including those patients who are reimbursable under the Community Care (Delayed Discharges etc.) Act 2003.

- The integrated discharge team comprises of staff from Medway Council, works with Medway Foundation Trust, Medway Community Healthcare, Kent County Council, Kent Community Health Trust, Physiotherapy and Occupational Therapy and create a 'whole system' fully integrated, multi- agency and multi - disciplinary team. The team also works withA co-ordinator from Carer's First, ensuring that carers of patients with long –term or complex needs are identified and supported anda colleague from the Continuing Healthcare Team who supports fast track/EOL patients and patients that require funding for permanent health care.

The IDT are available 8am-8pm Mondays to Fridays and 8am-4pm Weekends and Bank Holidays.

IDT have access to community respite, rehab and stroke beds within both the Medway and Swale community.

Intake Team Enablement/ Prevention Service

The Intake Team is committed to providing a service that carries out assessments to understand people's needs and gives individuals choice and control, whilst enabling people to remain as independent as possible. This service is for people who are new to Social Care or have been discharged from hospital and require a period of enablement to recover.

The Enablement Service aims to improve the quality of life and choice for individuals. A period of enablement can also prevent the need for 24 hour residential or nursing care and admission to hospital. An assessment will be carried out to identify the needs of the person. Following this, a rehabilitation programme will set realistic, achievable goals with the individual to help them regain their confidence. Over a period of up to six weeks, the team will work closely with homecare agency staff and Trusted assessors so they can support and enable the person to achieve the goals set. The expectation is that the care will be reduced during this time as the person's independence increases. If care needs are ongoing, a review will be carried out following the period of enablement to establish the correct level of need in accordance to the Council's eligibility criteria.

The Prevention Service enables individuals to remain healthy and independent in their own homes without the need for carers. The Prevention Service offers a quick response for people who are having difficulty managing activities of daily living either because they have a deteriorating long-term health condition, or feel they have reached a crisis situation and need support from social care.

An assessment will be carried out and will actively seek to improve the situation with the aim of maximising long-term independence. The service may also prevent the need for premature admission to residential or nursing care homes or formal carers zooming into the home.

In 2014-15, it is estimated that the work of the Intake Team worked with almost 700 clients and saved around £1.5 million in care costs through the provision of enablement and prevention services.

Community Nursing

A community nursing service is provided by MCH.Nurses from the Rapid Response Team deliver an intravenous therapy service in the community and work closely with MedOCC on the cellulitis pathway and with the community integrated teams..

Walter Brice Rehabilitation Day Centre

The Walter Brice Rehabilitation Centre run by MCH is part of intermediate care offer and encompasses the Walter Brice Day Centre facility as well as outpatient clinics that are supported by the staffing establishment of Walter Brice. The service provides patients with a rehabilitation plan, offers social integration and expert patient support. It also provides an initial 'signposting' for the Hoo Community who due to the rural location would be disadvantaged by lack of equitable access to care.

The service provides day rehabilitation to two distinct age groups, adults under 65, and over 65 years, through a multi disciplinary team. The service is primarily for younger people with physical disabilities with longer term conditions but who are still coping at home. The team provides skilled help; support and supervision tailored to individual patients needs in achieving their goals and maximising independence. In 2014-15, the centre dealt with 110 referrals and 2,402 contacts.

Each patient who attends the Walter Brice Centre is offered a multidisciplinary assessment and access to the health care professionals in the team. They are able to participate in social and therapeutic activities and have the opportunity to learn more about their own conditions. The Occupational Therapist can plan a home visit if it is needed, and the team are able to make referrals on to other services, both within the Trust and with its partner organisations. Patients also have access to the lending library and to information files, and the opportunity to try new activities.

Patients who require the Patient Transport Service provided by NSL can attend The Walter Brice Day Centre from 10.00am to 3.00pm, Monday to Friday. It is open from 8.30am until 5.00pm on weekdays, with staff based there allowed access at any time for patients who have their own transport. Patients can phone for advice during these times.

Platters Farm

Platters Farm is a purpose-built residential home and day centre run by Strode Park Foundation and leased from the Council. It provides 16 rehabilitation beds, alongside 27 respite beds. The beds are frequently flexed between respite and rehabilitation. The rehabilitation beds are serviced by MCH Community services and medical cover is provided as and when needed by locally based GPs. Integrated care is provided by a multi-disciplinary team. People with nursing needs receive in-reach nursing care from MCH. The Oak Group Audit showed a high proportion of service users being

"unqualified" or service users wher their care could be provided in an alternative setting including at home..

Frindsbury Hall

Frindsbury Hall is a CQC registered 75 bed private nursing home which is used by Medway Council for rehabilitation.. Social Care and Health (Rapid Response) have the ability to refer a patient/ service user be considered for one of the 8 pre-purchased beds. The decision to admit that patient remains with the Home manager or nominated deputy, under CQC regulations as to whether the patient is admitted. The decision is based on whether that individual patient's needs can be met by the home. There is an expectation that people will stay for no more than 6 weeks. Health and Social care therapists and care managers via rapid response) provide an in-reach service to the unit.

Staffing with regard to the ratio of registered nurses(s) to patients is in accordance with CQC regulations. There is medical cover from a visiting medical officer, and there are discussions about arranging a weekly visit from a consultant geriatrician. An increasing number of people are admitted for end of life care. This increase is related to the home's accreditation for End of Life Care. . The Oak Group Audit showed a high proportion of service users being "unqualified" or service users where their care could be provided in alternative setting including at home.

Average length of stay at Frindsbury Hall and Platters Farm in 2013-14

<1 week	1-2 weeks	2-3 weeks	3-4 weeks	4-5 weeks	5-6 weeks	6+ weeks	Total
27	44	45	43	23	17	33	232

From social care statutory returns 2014

Community Equipment

Medway is developing an Integrated more responsive service to replace the currently separate contract arrangements. The Current services provide the following activity:

Medway Community Healthcare Equipment Loans	**14-15 Activity pro-rata**
Items	18,185
Orders	16,949
Collections	8,717

Community Care and Equipment Services – Bespoke and Electrical Equipment	**14-15 Activity pro-rata**
Users	736
Orders	608
Items of equipment	1,124

Family Mosaic Home Improvement Services – Technicians Service	**14-15 Activity pro-rata**
Total number of referrals	3,192
Of which Hospital Discharge Jobs	621

Total number of jobs completed	2,841

Telecare and Telehealthcare

In 2014-15 the Medway Control Centre provides 4,000 units 350 of which are provided to those meeting social care criteria. It is intended to develop a commissioning strategy for Telecare in 2015/16.

Hospital at Home

This service was developed by MFT aiming to enable a caseload of 20 to 25 people to return home from hospital or avoid admission with medical supervision at home. As the patient remains under the care of the consultant the episode of care is paid for through the standard tariff payment.

The service aims to reduce the pressure on hospital beds, avoid admissions, allow the medical assessment unit to function, improve patient experience, assist bed management and increase the confidence of medical staff in follow-up care. Patients receiving this service remain under the care of a consultant and a team of nurses (5.75WTE) and one physiotherapist. It is expected that length of time with the team will be up to 10 days. There is a daily virtual ward review and the service runs from 8am to 6pm seven days a week. Patients are selected following: a risk assessment, consultant and patient agreement, and a development of a clear management plan with estimated time receiving the service. A more detailed review is required to understand how the pathways work and whether some patients could be transferred to an established community service at an earlier point.

Get Well Stay Well

This service is provided by the Royal Voluntary Service (RVS) and Age UK Medway. It is funded by Age UK Medway. People aged 50 or over who live in Medway and have just been discharged from hospital are provided with 10 to 12 hours of low level support for a period of 4 to 6 weeks. This is the Home from Hospital - Get Well service. Towards the end of the period a review is carried out and if the person wants, they are referred to the Good Neighbours – Stay Well service which provides 2 to 4 hours a week of low level support over an average of 6 months but more if necessary. The service includes: assessment on referral, assistance with shopping and household tasks, assistance with meal preparation, encouragement and confidence building, escort to hospital appointments, signposting to other organisations, and reviews to assess needs.

There are two project managers: one for each element of the service and delivered by volunteers following a formal recruitment process, training and CRB checks.

People with mental health problems and/or substance misuse issues are not eligible for the service.

Frailty Pathway

Because there are far too many older people entering acute care and staying too long once they are within the hospital, one of the priorities within the health and social care system in Medway is the development of an effective frailty pathway which keeps frail older people supported at home, prevents them from being admitted into hospital and discharges them home where possible. Care at the right place at the right time is the prerogative.

The frailty pathway work lead by partnership commissioning consists of three work streams:

- **Front Door** – Improving the initial response to presenting at the hospital to avoid people being admitted in the first place and placing the emphasis upon supporting them back to

their home. The Oak Group STREAM pilot is supporting this alongside Geriatrician Assessment at the front door.

- **Back Door** – how can people be supported to go back home as soon as possible includes IDT and the review of the discharge process with the development of discharge home to assess.
- **Community** – how the various work streams within the Better Care Fund contribute to improve the support people receive to aid the work at the front and back door. The work concentrates upon sharpening the focus within the following projects :
    - Primary Care and Community Services Redesign
    - Intermediate Care and Reablement
    - Community Equipment
    - Self Help and Community resilience – developing the Voluntary sector support

The frailty work has been developed using the national templates by the work of David Oliver (national lead fro Older People Services) and ECIST (Emergency care and Intensive Support Team). At the time of writing the front door pilot using CGA (comprehensive Geriatric Assessment) is showing evidence of improving patient length of stay (LoS) from over 15 days to just over 6 days and improving patient experience (Monday to Friday service). A pilot for 7 day working is planned for late July/ early August and will inform the model going forward.

Home to Assess

The overriding principle here is to enable a rapid pathway away from acute care for this to be successful requires a redesign of existing intermediate care services and the development of a set of responsive community based services based around a patient supported at home. Good practice exemplars confirm this direction such as the scheme at Worcester informing the work in Medway.

An effective Home to assess scheme will allow many more people to be supported at home and reduce the need for institutional services. A proposed Home to assess model for Medway is being considered as part of the Frailty Pathway and Better Care work.

Good Practice –

Worcestershire

The ‘discharge to assess’ model operating in Worcestershire this has 3 pathways

- Pathway 1 - Discharge home to assess with ‘wrap around’ community teams to provide assessment to specify on-going care needs over a 72hr period.
- Pathway 2 – Discharge to ‘bedded’ community resource if the patient continues to require 24hr nursing care, rehabilitation and daily medical review 2- 6 weeks.
- Pathway 3 – Discharge to Care Home for assessment of long term care needs for complex pts who may require CHC assessment and long term placement 4-6 weeks

80% of patients go home in Worcestershire. Stress placed upon Discharge to Assess NOT Assess to Discharge. Wrap around services provided in the community to complement enhanced reablement. Based upon Warwickshire and the national good practice model from Ian Philps and David Oliver. In Worcestershire the scheme is run by a dedicated integrated team consisting of Care assistants (45 employed by the Local Authority), nurses, therapists (OT and Physio) and social work. Worcestershire invested £1.5m in this service partly funded through Winter pressures monies and BCF. This changed the way therapists worked within the Acute Trust as they became community focused. The service is accessed via one number and provides night support and rehabilitation services 24 hours per day, 7 days per week. Patient Transport services need to be

responsive to get patients home. The LoS Length of stay in Community hospital beds is now an average of 21 days.

The urgent Promoting Independence Service in Worcester (ASC)

- Start assessment process within 4hrs of arrival home.
- Coordinates health assessment, night services, number of visits, equipment
- Undertake an assessment of patients needs over first 72hrs
- Coordinate on going care / rehabilitation at home
- Are accessed via One number (WHASCAS)
- 7/7 – 8.30am – 8.30pm
- After 8.30pm – direct access to over night home care service
- Respond within 1hr of the referral
- Initial assessment within 4hrs of pt arriving home

Lessons from Worcestershire

- A champion in the Acute Trust
- An integrated whole system approach
- Responsive Community equipment services
- Pilot the scheme but be careful about how it is rolled out across wards and sites
- Capacity in Domiciliary care is critical as this will have a significant impact on flow through reablement community services and the recovery at home team (pathway 1)
- Left shift of the patient pathway – ie patients moving/ transferring earlier in the pathway
- Cultural shift for clinical staff away from 'beds'
- Trust – relationship building
- Professional protectionism
- Patient transport
- Integration between health and social care community reablement services

Homerton

A whole system visit to Homerton University hospital took place in Feb 2015. In the Homerton area, a population of similar size (but a younger profile) there are 9 intermediate care beds, although it is recognised that the system has progressed change over a number of years to reach this point . This compares to 61 in Medway excluding additional winter escalation beds (of which there are 8 at St Bartholomew's) and excluding 15 stroke beds at St Bartholomew's.

Community Equipment

Supporting people at home requires a responsive good equipment service. As part of the Better Care work Medway CCG and Medway Council are developing an integrated community equipment service by March 2016, replacing the current separate arrangements. This joint service will allow better co-ordinated responsive care.

Telecare

Medway's investment in Telecare could be improved current figure indicate 194 units through the Social care route and 360 through the self funded route. Partnership Commissioning is developing a Telecare commissioning plan.

6. Costs of Intermediate Care

Service	Annual 2013-14	Numbers receiving the service	Unit Cost
Integrated Discharge Team	£687,100		
Adult Rehab service at St Bart's	£3.3m	35 beds	1,814 per bed per week
Walter Brice Rehabilitation Day Centre	£219,077 to be updated	TBC	
Platters Farm	£456,010	16 beds	£548.09 per bed per week
Frindsbury Hall	£313,200	10 beds	8 beds @ £611.06 each per week
			2 beds@ 567.31 each per week
Community Equipment	£1.485m	25,000 pieces of equipment to 8,500 clients	£1.14 per piece of equipment per week or £3.35per person per week
Telecare	£80,000	Social Care Installls 194 Private Installs 360	£222 for social care installs

7. Measuring our Success

Medway Better Care programme proposes using the metrics at appendix 2 to measure the impact and success of the changes to intermediate care. These include:

- Number of delayed transfers of care.
- Length of stay in acute and subsequent placement.
- Occupancy rates
- Number of beds
- Discharge destinations at various intervals.
- Readmission rates.
- Primary or secondary diagnosis of dementia.

Best practice guidance from the British Geriatric Society (2008) suggests that intermediate care services should also have:

- Clear functions (eg admissions preventions and/or post-acute care).
- Incorporate multidisciplinary assessment processes and involve multi-agency working.
- Have a strong focus on enablement.
- Offer time-limited contact in order to distinguish them from other types of provision.
- Clear admissions criteria discussed and agreed locally, along with care summaries on discharge
- A clear whole-systems approach to providing intermediate care with links to primary and secondary care settings
- Strong clinical governance arrangements whereby risk management, clinical audit, critical incident reporting and staff training are regularly monitored

8. What does the future look like for the people in Medway

Medway Council and Medway CCG Commissioners are committed to working in partnership to develop better Intermediate Care Services to ensure people receive the right care in the right place. We recognise we need to shift our investment in some of the institutional bed based services to community based services in order to support more people at home and allow people to go back home sooner. We will do this through our Better Care Fund work we will place intermediate care services into a pooled budget and produce and agree a joint commissioning plan to deliver integrated services.

The recommendations are as follows;

The Need to Develop a Strategic Approach
Key Activities • Develop an Intermediate Care Strategy • Integrate the strategy with the Frailty Pathway • Integrate the strategy with the Better Care work • Develop joint commissioning of Intermediate Care including Reablement • Establish a single co-ordinating function across Health and Social Care • Strengthen and operationalise performance management processes in commissioning

The Emphasis That Should be Adopted Within That Approach
Key Activities • Increase the range of community services around the individual within their homes • Establish single, or at least, simplified access points • Increase provision for people with dementia plus relevant staff training • Increase night sitting capacity • Ensure responsive Community equipment and adaptations • Improve assessment and discharge arrangements • Explore potential for using extra care as an environment for less intensive intermediate care • Develop a Discharge home to Assess service

Specific Recommendations for Change

- Develop more community based services to support people at home
- Develop a discharge home to assess scheme through the frailty work to keep people away from hospital and get them back home sooner
- Place the care around the individual in the setting they choose which will usually be their home
- Shift the balance of care away from institutional settings towards supporting more people at home
- Develop reablement services
- Ensure there is a responsive community equipment service
- Develop Telecare services
- Work with the voluntary sector to maximise the contribution the voluntary sector can make to supporting more people at home and to self help and community resilience