South Kent Coast
Clinical Commissioning Group

Intermediate Care Review Project
Interim report to South Kent Coast Health and Well Being Board

1 Introduction

1.1 This report provides an update to the South Kent Coast (SKC) Health and Well Being Board (HWBB) on the SKC Intermediate Care Review Project. This report sets out progress of the project and includes a high level description for future intermediate care services as agreed by the project. The report also highlights next stages required to complete the project which will result in a final report in August 2013.

1.2 SKC HWBB members are asked to consider the report and endorse the high level future model of care which is aimed at delivering as much care as possible close to or within the patient's own home wherever appropriate.

1.3 This project is being undertaken jointly between the SKC Clinical Commissioning Group (CCG), Kent County Council (KCC) and the district councils focusing on achieving the right model of care for SKC residents. Other stakeholders are involved as part of the project group which was established in March 2013. At the first project meeting the group approved the Project Brief which set out the aims and approach of the project, **see appendix I**.

1.4 This project is a priority workstream within the SKC Integrated Commissioning Plan and is one of several that reports to the Integrated Commissioning Group. This particular project has been led by the CCG on behalf of the group.

1.5 Although all stakeholders signed up to completing all project objectives by June 2013 it was recognised by the group as well as the CCG that it was likely to take slightly longer to ensure the correct processes for engagement could take place before the project could conclude with an agreed future model of care.

2 Project objectives

2.1 The intermediate care project has been an opportunity for multiple partners to work together on assessing the future needs of intermediate care services in the Dover, Deal and Shepway areas to inform the commissioning of an intermediate care model of care which is both innovative and effective at delivering care closer to or within patients own homes whilst responding to changes in the local population needs.

2.2 The project group and the Integrated Commissioning Group approved the project objectives which are as follows:

(a) **An agreed a definition of intermediate care** – to achieve a common understanding of intermediate care to steer the project and to support the development and delivery of the future model of care;

(b) **Service review and needs assessment** – to show current provision of services and patient flows and future need;

(c) **Future model of care** – to inform needs assessment and informed by service review.
(d) **Commissioning plans, with outline business case** (if required) – for future model of care.

3 Engagement

3.1 The project has been communicated with the key stakeholders involved in commissioning and providing care across the health and social care, including the voluntary sector and patient representatives. The project group itself includes representatives from the following organisations, including district council housing representatives as it is recognised that home environment can impact on a person's care requirements and care outcomes:

- NHS South Kent Coast Clinical Commissioning Group;
- Kent County Council;
- Kent Community Health NHS Trust;
- East Kent Hospitals NHS Trust;
- Dover District Council;
- Shepway District Council;
- Carers Support;
- Age Concern;
- Patient representatives from Shepway Patient Participation Group plus eleven virtual patient representatives from across SKC

3.2 The project has been presented to local GPs and GP practices staff, through CCG committees and locality meetings, to provide information about the project and to seek input into the service review and development of the model.

3.3 Further engagement with local GPs will take place once the future model has been defined further following patient involvement and following the completion of the needs assessment.

3.4 The project group recognise the importance of engaging with patients to ensure they have opportunities to help shape the future model of care and to listen to patients about what is important to them when accessing the types of services along the intermediate care pathway across health and social care. A focus group is planned for early July to test the future model of care and explain how different it will be to the current model of care.

3.5 The project has been presented to the Deal Hospital Patient Experience Group. Participants felt very strongly that poor communication between services and with patients can impact on whether patients receive their care in the right setting and whether they achieve the best outcomes. They recommended that services should be more accessible as often patients don't know who to contact when they need help and advice. These points will be further explored at the focus group in July.

3.6 Other opportunities to engage with other patient representative groups will be utilised to test the agreed future model of care, including the Shepway, Dover and Deal Patient Participation Groups as well as the SKC Health Reference Group.

4 Agreed definition of Intermediate Care

4.1 The project group agreed at the outset that they should work to an agreed definition of intermediate care. This was felt necessary to ensure the project remained focused on the same patient outcomes when delivering each of the other project outcomes. At the first project meeting it was agreed that the national definition for intermediate care as set out in the 2009 Department of Health Guidance, *Halfway Home*. The group added to the definition by recognising the role of the voluntary sector in delivering intermediate care and that there are occasional exceptions to the six week time limited delivery of intermediate care. **See appendix II**, for an extract of the guidance as well as the project group's agreed additional points.

4.2 The national definition states that:

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

4.3 The project group have referred back to the national definition when defining the scope of the service review and while developing the future model of care.

4.4 Based on the national definition of intermediate care the project group agreed at its first meeting what current services would be included in the service review. The following services were identified as within the service review scope:

- **Kent Enablement at Home (KEAH)** – commissioned by KCC is aimed at providing time limited support to people in their own homes. Carers help patients cope with their disabilities, focus on confidence building and help people live as safely and independently as possible;
- **Short term beds** – commissioned by KCC and used to support hospital discharge, emergency and planned carer respite;
- **Community Hospital beds** - commissioned by NHS CCGs and used to support hospital discharges (step down) and admissions from the community (step up). Providing 24/7 nursing care for a short period of time;
- **Intermediate Care Teams** – commissioned by NHS CCGs and includes a multi-disciplinary team of nurses and therapists providing rapid response if needed. The teams assess and support patients in their own homes or within care homes and hospitals and provide care for a short period of time.

4.5 The national guidance document and its definition for intermediate care will be used to inform the more detailed commissioning plans which will be developed to implement future improvements to intermediate care.

5 Service review and needs assessment

5.1 The service review information requirements were agreed by the project group at the first project meeting. Work commenced in April to start sourcing and analysing data from each service within the scope of the project.

5.2 The project group originally agreed that the service review data would include service capacity and demand data to highlight service efficiencies and any gaps in provision and that the data be mapped to show patient flows. At the outset the project group agreed that there was a risk that the lack of accurate comparable data could limit the completion of the service review against the original criteria.

5.3 There have been challenges obtaining the data required by the project which has meant the service review will not include all the details as originally stated in the project brief. These challenges included: information governance issues for sharing data between organisations; data not available in the required format or not recorded; delays obtaining data; and the time needed to understand and interpret data from multiple organisations.

5.4 However, based on the interim high level analysis of the data the project group have been able to understand the following:

- Number of SKC patients referred to and admitted into intermediate care services;
- Length of time SKC patients remain in intermediate care services;
- Re-referrals and re-admissions into intermediate care for SKC patients;
- Outcomes (for some services) for SKC patients following intermediate care;
- Locations of patients receiving intermediate care when admitted into a community based bed.

5.5 The final report will include the full analysis of the service review, including patient flows, and will be split by service and by the Shepway and Dover/Deal localities.

5.6 The needs assessment will be informed by the completed service review and the finalised future model of care. Using the demographic data from the service review the needs assessment will confirm which population will use intermediate care in the future and their profiles.

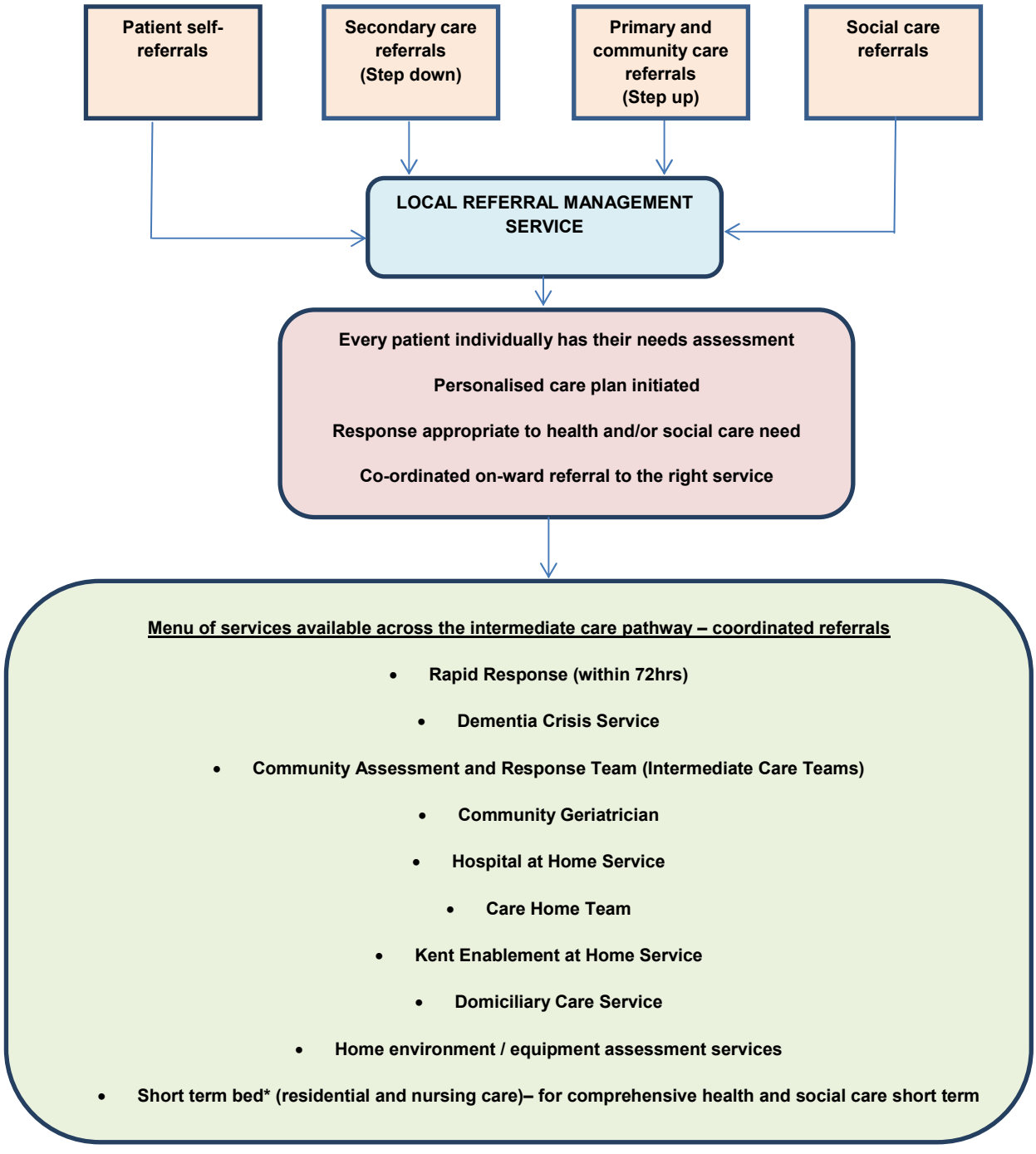
6 Future model of care

6.1 Intermediate care is a process and includes a range of service across health and social care all aimed at short term care to maximise independent living. Yet no formal pathway has been commissioned to ensure these services are integrated in ways that achieve the best outcomes for patients. Anecdotal feedback from local secondary and primary care clinicians are that these services work well most of the time individually. However, initial feedback is that by formally integrating these services across a pathway significant improvements could be made, such as reduced admissions to hospital, reduced length of stay and improved communication.

6.2 The project group agree that the patient's own bed is the best bed as long as they receive a comprehensive assessment to ensure they receive the care and support required to meet their needs and that services should be centralised and provided as locally as possible. The high level needs based pathway agreed by the project group is summarised below in figure 1.

6.3 This pathway will be presented in more detail in the final report following further engagement with stakeholders and patient representatives and the completion of the project needs assessment.

Figure 1. High level needs based intermediate care pathway summary



7 Commissioning plans

7.1 The project group will help inform the commissioning plans at its final meeting at the end of July. These plans will be informed by the completed service review, the finalised model of care and the needs assessment.

7.2 The commissioning recommendations will then be presented to the CCG Clinical Cabinet in August for consideration and agreement. They will also need approval from KCC commissioners. Once the agreed pathway based future model of care has been formally approved, commissioning plans will be developed to ensure implementation and delivery of the changes linking to the overall integrated commission strategy.

7.3 Implementation of the pathway based model of intermediate care will require on-going monitoring to assess the use of services to ensure good patient outcomes are achieved and that services become better integrated. A review of service capacity will also be required following implementation of the pathway to understand the impact of the changes, in particular that services remain locally provided closer to or in a patient's own home.

8 Next stages of project

8.1 As stated at the beginning of this report, the projects' planned completion was the end of June, however the complexities of the service review data collection has meant the completion will be a month later than planned. The challenge of completing this project was recognised at the project outset, particularly to ensure sufficient engagement has taken place to test the planned model of care with local clinicians and service users.

8.2 There are several key stages required to complete the project, which are as follows:

- Complete the service review data analysis – mid of June;
- Undertake the needs assessment – end of June;
- Test future model of care with focus group participants – 5 July;
- Undertake further engagement with clinicians and patients – mid July;
- Project group finalises model of care and finalises recommendations – end July

8.3 At the end of July the project will be complete and the final report will be available to the SKC HWBB in September. This final report will also be tabled at the SKC CCG Clinical Cabinet Committee in August for consideration and agreement. Commissioning plans will then be defined to implement the improvements needed to achieve the future model of care.

9 Conclusion

9.1 The SKC HWBB members are asked to consider the report and endorse the approach taken by the project group to develop a future model of care for intermediate care based on a needs

assessed pathway which includes a menu of short term based services aimed to deliver as much care as possible close to or within the patient's own home wherever possible.

APPENDIX I

PROJECT BRIEF

Project: South Kent Coast Intermediate Care Review

Project Aim: This South Kent Coast (SKC) Health and Wealth Being Board (HWBB) sponsored project is an opportunity for multiple partners to work together on assessing the future needs of intermediate care services in the Dover, Deal and Shepway areas to inform the commissioning of an intermediate care model of care which is both innovative and effective at delivering care closer to or within patients own homes whilst responding to changes in the local population needs.
Description: A detailed assessment will be undertaken of the needs for intermediate care services in SKC to assess whether the current model of care, including the number of and access to intermediate care beds and other community options is appropriate for future local needs. A small 'Task and Finish' group will be established to ensure engagement with key stakeholders and ownership across partners. **Task and Finish Project Group:** Zoe Mirza –Head of Integrated Commissioning, NHS SKC CCG (Project Lead); Dr Joe Chaudhuri – GP and LTC Clinical Lead, NHS SKC CCG (Project Clinical Lead); Paula Parker – Commissioning Manager Lead for Urgent and Intermediate Care, KCC; Jo Empson – Commissioning Manager Lead for Reablement and Homecare, KCC; Janice Duff – Head of Service Dover and Thanet, KCC; Debbie Pyart - Senior Operations Manager UCLTC, East Kent Hospital University Trust Karen Jefferies – Community Services Director South Kent Coast and Thanet, Kent Community Health Trust; Nicola Osbourne – Head of Intermediate Care Service, Kent Community Health Trust; Debbie Barry – Chief Officer Deal Age Concern and Chair DASP (Voluntary Sector representative); Tricia Cole – CEO Carers Support (Voluntary Sector representative); Sue Chitty – Chair of Patient Participation Group Shepway (Patient representative) **Additional Project Support:** Alison Scantlebury – Kent and Medway Commissioning Support Unit - information support;

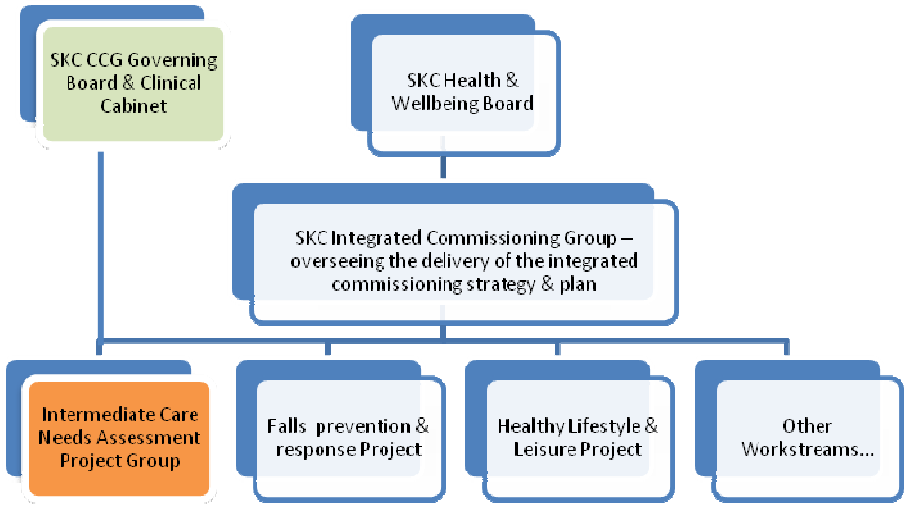
Kevin Tupper – Head of Finance, NHS SKC CCG;
Jessica Mookherjee – Public Health Support

A small virtual group of service users has been identified to support the project and will be communicated with by the project lead and the project's patient representative.

Each representative must be able to provide data and information from their organisation to support the needs assessment completion and contribute towards the development of the future options for an innovative intermediate care model of care.

Project Governance: This project is one of several that reports to the Integrated Commissioning Group which is a sub-committee of the SKC HWBB.

This project reports to the SKC CCG Governing Board (through the Clinical Cabinet) as well as the appropriate governance routes within KCC.



Scope:

(i) South Kent Coast geography and residents – outputs split by Dover, Deal and Shepway localities;
(ii) All current Intermediate Care Service functions (aligned to agreed definition). To include:

- Unplanned carers respite;
- Kent Enablement at Home (KEAH) – care workers in patient's own home;
- Short term residential beds – social care enablement and or/ ICT therapies;
- Broadmeadow Care Home – integrated care beds;
- Community Hospital Intermediate Care Beds – which should accept both 'step-up' and 'step-down' intermediate care patients;
- Dover /Deal/Shepway Community based Intermediate care teams

Project Outcomes:

(i) Agreed Definition - a common understanding of intermediate care to steer the project and to support the development and delivery of the future model of care;
(ii) Service Review – analysis of data to show current service provision, efficiencies, costs and

patient flows;

(iii) Needs Assessment – analysis of demographic data to map future needs of intermediate care taking into account population changes and the defined future pathway;

(iv) Commissioning options - informed by needs assessment to achieve the future vision and outcomes for intermediate care. These options will include flexible short and medium term options;

(v) Outline business case (if required) - for future model of care.

The outputs of the project will be reported to the SKC HWBB.

Project Information Requirements:

The needs assessment information requirements will be mapped against an agreed definition. And will be analysed to show current service efficiencies

INFORMATION	SPLIT BY	DATA SOURCE	PROVIDED BY
Current capacity (by location/service)	Number of patients that can be seen by service / number of beds	Carers Support KCC KCHT	Tricia Cole Jo Empson / Paula Parker Karen Jefferies
Actual demand (by location/service)	Total no's of admissions / placements; Source of referrals; Patients not accepted with reasons; Waiting Lists and waiting times; Occupancy rates / empty bed days; Average length of stay; DTOCs / reasons; Discharge destinations; Patient health outcomes; Re-admisison rates; Acute discharges / LOS / DTOCs	EKHUFT	Debbie Pyart
Patient Flows	Mapped to show where patients are currently receiving IC; Reasons if provided outside of SKC	As above – above data will inform mapping	N/A
Population Needs (to show impact on service and future need)	Current needs impact on health and social care services vs. future needs; Current population rates – mapped against age and medical condition of patients receiving IC; Projected population growth (next 5-10years) – mapped against increase in elderly population, and increase in long term condition prevalence	Public Health risk stratified analysis	Jess Mookherjee Other public health specialists

Additional data will be requested from the acute trust.

Measurement timescales agreed by Project Group – April 2012 to March 2013.

Key Milestones :

(a) 26 Feb – Draft Project Brief to be developed further by Integrated Commissioning Group;
(b) 11 March – Project Group members to be finalised and informed of Project Brief;
(c) 25 March – Project Group meets to sign off Project Brief and agree intermediate care definition and information requirements of needs assessment;
(d) 9 April – Project update to SKC HWBB;
(e) 10 April – Project update to SKC Clinical Cabinet;
(f) April to May - Commissioner to undertake wider engagement with SKC CCG members through locality meetings;
(g) 15 April– Project Group makes available information to complete needs assessment and meet to assess the outputs;
(h) April – Project Group jointly reviews information analysis and options for future vision;
(i) Early May – undertake discussion with patient participation group;
(j) Early May – Commissioner develops, with input from project group, recommendations and develops options for future vision;
(k) May – further engagement with SKC CCG members to share project outputs;
(l) End May – Project Outputs Final Report signed off by Project Group;
(m) 18 June - Report to the SKC CCG appropriate committee and SKC HWBB.

Risks:

(a) Lack of engagement with stakeholders – keep project group small with minimal meetings yet drive project forward with regular communication as project progresses. Undertake engagement with service users via the project patient representative and the project's virtual patient participation group.
(b) Lack of accurate and comparable data – agree with project member's data requirements with a clear definition for each set of data and use the same timeframe for measurement where possible and agree deadlines for providing data.
(c) Unable to deliver project within timeframes – review and agree milestones with project group and report any issues within the CCG in advance if project moves off track and highlighting the reasons.

South Kent Coast
Clinical Commissioning Group

APPENDIX II

Intermediate Care Project Group
Using an agreed definition of Intermediate Care

Intermediate Care – Halfway Home (2009 DH Guidance)

- Intermediate care has an important function in meeting the health and social care needs of individuals.
- Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living. Intermediate care services should:
    - be targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care;
    - be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
    - have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home;

- be time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less;
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

Additional elements added to the above definition by project group

- Intermediate care is broader than health and social care and includes the Voluntary and Community Sector (VCS). The role of the VCS cuts across the continuum of intermediate care, for example through the function of supporting carers of patients who require intermediate care.
- There will be exceptions to the time limited provision of intermediate care. When an exceptional circumstance arises when a patient needs intermediate care for longer than six weeks it should be because clinically this would significantly maximise the patients outcome.