NHS
South Kent Coast
Clinical Commissioning Group

Intermediate Care Project

Report to South Kent Coast Health and Well Being Board

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1. Introduction

Overview

1.1 This report sets out the recommendations from the South Kent Coast Intermediate Care Review Project which were put forward by the project team and approved on 14 August 2013 by NHS South Kent Coast Clinical Commissioning Group.

1.2 The recommendations have been informed by the work of the project team which has included a service review looking at current provision and a public health needs assessment looking at future demand on services. Building on these recommendations the project team has agreed a model of care based on an integrated intermediate care pathway, this model and the principles underpinning it have been co designed with patient representatives through several public engagement events.

1.3 The purpose of the report is to share these recommendations with the South Kent Coast Health and Well Being Board as Intermediate Care is a workstream within the South Kent Coast Integrated Commissioning Plan. The recommendation will be used by commissioners to inform a joint programme of work between health and social care to implement and deliver improvements across the intermediate care pathway.

1.4 The Intermediate Care project has been undertaken jointly between NHS South Kent Coast Clinical Commissioning Group, Kent County Council and the district councils focusing on achieving the right model of care for SKC residents. Other stakeholders involved include the public, voluntary sector, East Kent Hospitals Trust, and the Kent Community Health Trust. This particular project commenced in March 2013 when a project team was established and has been led by NHS South Kent Coast Clinical Commissioning Group on behalf of the wider team.

South Kent Coast Community Model for Integration

1.5 The outputs of this project and the work that commissioners take forward for intermediate care as a result of the agreed recommendations outlined in this report should be seen in the wider context of the overall work commissioners are taking forward across health and social care to improve models of care in the community and improve integration of services across various care pathways. The overall strategy of improving integration of services is to ensure patients receive the right level of care and support in the right setting, including in the comfort of their own homes wherever possible, and achieving the best possible outcomes.

1.6 NHS South Kent Coast Clinical Commissioning Group has been working with partners to develop integrated health and social care teams to deliver more coordinated care and support to patients in the community. Building on this integrated approach NHS South Kent Coast Clinical Commissioning Group has been redefining models or care for community nursing. The future community nursing model will be based on teams from health and social care, known as Neighbourhood Care Teams, working in a more integrated joined up way to pro-actively manage patient's conditions and needs in the community rather than being admitted and re-admitted to hospital. This proactive management of patient care will be coordinated by the

community nursing teams working closely with local GPs supported by a clinically led single point of contact to eliminate the numerous, and not always well known, entry points into community based health and social care services. The Neighbourhood Care Teams will integrate with a range of other services including those delivered along the intermediate care pathway to ensure as many people as possible receive the coordinated care they need. This development of the wider community teams, combined with the improvements to intermediate care as well as service improvements being made by social care commissioners are expected to make a significant improvements and benefits to services and their users in South Kent Coast.

2. Project Approach

Objectives

2.1 The project team agreed a set of objectives at the start of the project as follows:

- **Consider and agree a definition of intermediate care with all stakeholders** - 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;
- **Complete a service review** - to collectively better understand current provision and local patient flows;
- **Develop a future model of care** – to inform needs assessment; developed through public engagement;
- **Undertake a needs assessment** – to better understand future demand on service
- **Agree a set of recommendations** - to inform future commissioning plans.

Engagement

2.2 The project has been communicated with the key stakeholders involved in commissioning and providing care across the health and social care, including local GPs, the voluntary sector and patient representatives. The project team recognised the importance of engaging with the public to ensure they had opportunities to help shape and co-design 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.

2.3 The future model of care has been presented and discussed at a number of public events in recent weeks, including a focus group set up specifically for the project. The discussions at these events have helped shape the principles of the future model of care as well as the overall project recommendations set out in this report.

3. Future Model of Care

Service Review

2.4 The main aim of the project was to agree across agencies the future model of care for Intermediate care for South Kent Coast. The project team agreed to undertake a service review of existing local services to better understand current provision and where improvements were needed. The service review has been aligned to the national definition of intermediate care and includes a number of services identified within the scope of the project. **See Appendix I for the national definition of intermediate care and a list of services within the project scope**.

2.5 The service review analysis has been used to shape the future model and to inform the project recommendations. However, the project team agree that further work needs to be done by health and social care commissioners to look at additional information to ensure the right outcomes are being achieved for all patients across the intermediate care pathway.

2.6 Key messages from the service review is as follows:

- Intermediate Care service providers are using different systems and definitions for recording activity data or not recording data at all. This has limited the ability of the service review to fully understand the extent of how the current services are achieving the full benefits set out in the national definition of intermediate care, including reduced delayed discharges from hospital and prevention of unnecessary hospital admissions and whether patient outcomes are improving as a result of the intermediate care they receive, retrospectively analysing these elements as part of the project has not been possible;
- There is a difference between available 'step up' beds in Dover/Deal compared with Shepway, as such the location of current services largely influences where patients are admitted for intermediate care. Patients are more likely to go to a short term bed rather than a community hospital bed if they reside in Shepway and more likely to go to a community hospital bed than a short term bed if they reside in Dover/Deal however almost 100% of the community hospital admissions are 'step down' from hospital;
- Delayed discharges and unnecessary acute admissions as a result of limited local step down and step up intermediate care provision is a key indicator to fully understand how well services are meeting the aims of intermediate care. However data is not currently recorded in this clearly defined way, although it is reported by the acute trust that a significant number of patients remain in a hospital bed far longer than required. Retrospectively analysing this as part of the project has not been possible;
- The majority of community hospital bed admissions for SKC patients are within Deal Hospital, although a small number of patients are admitted to community hospitals located elsewhere in East Kent and no evidence has been made available for this service review that SKC patients admitted to community hospital beds outside of the SKC are actively repatriated back to SKC when a bed at Deal becomes available. Community hospital beds are often taken up with patient's who don't necessarily

require 24/7 nursing care but need more therapist input and other facilities do not have capacity and have not been commissioned for these groups of patients. These patients are often non-weight bearing patients who are not ready to go home.

2.7 In summary, the service review has started to highlight some of the main issues with current intermediate care provision that needs improving. Commissioners agree that further work needs to take place during 2013/14 to fully understand the extent of these issues to further inform commissioning intentions for 2014/15 onwards.

Needs Assessment

2.8 Alongside the service review a needs assessment of intermediate care has been undertaken by Public Health colleagues, the key messages from the needs assessment are as follows:

- Best practice models and evaluations of intermediate care services over the last 10 years have consistently stressed the importance of better integrated care rather than relying on one type of services;
- All the following components are needed to have a well-functioning intermediate care system: integrated approach to local planning, commissioning, delivery and evaluation; early hospital discharge or admission prevention; actions based on rapid comprehensive unified assessment and response; maximised independence with focus on rehabilitation; and multi-agency working and integrated teams supported by sound governance;
- The increasing older population over the coming years will have implications for commissioners and those providing intermediate care services so future provision needs to be commissioned in a way that these demands can be met;
- Public Health modelling shows that if pro-active and integrated care is commissioned and implemented the reliance on community and hospital bed use will reduce and the need for these services will reduce. This will enable patients to be better cared for in a seamless and integrated way, and preferably in the comfort of their own home.

Future Model of Care

2.9 The service review and the needs assessment has informed the future model of care which has been agreed by the project team and informed through several public engagement events. **See appendix II for the future integrated intermediate care pathway.**

2.10 Intermediate care is a process and includes a range of health and social care services all aimed at short term care to maximise independent living yet no formal integrated pathway has been commissioned to ensure these services consistently achieve the best outcomes for patients. The project team agrees that an integrated pathway should be commissioned to ensure an appropriate, streamlined response for all patients. The key principles of the future model of care are as follows:

- The future model of care should be commissioned across an integrated health and social care pathway with the patient / client at the centre;
- The main aim of the integrated intermediate care pathway is to maximise independent living for patients / clients and to provide care in the right location, as locally as possible, including the patient's own home wherever possible;
- All referrals into intermediate care services should be coordinated through a local integrated referral management service (single point of contact) to ensure coordination of onward referrals and joined up communication between services;
- All patients / clients referred to intermediate care services should include a clinically led comprehensive needs assessment to ensure timely identification of urgent referrals requiring rapid response and appropriate onward transfer of referrals;
- All patients / clients referred to intermediate care services should have a personalised integrated care plan that follows the patient;
- All patients / clients should have a named lead professional that they can contact directly for additional support and advice, this should have an option for 24/7 contact for patients with urgent needs;
- The local referral management service uses a menu of short term services to refer patients / clients to which includes the voluntary sector and other advice services (i.e. housing and equipment advice);
- The local referral management service could be combined with a similar service supporting the coordination of referrals into and out of the SKC community nursing Neighbourhood Care Teams to ensure wider integration of teams;
- The Intermediate Care Multi-disciplinary teams need to in-reach into the acute sites to identify patients at the point of admission and plan their intermediate care needs and undertake assessments outside of the acute setting.

4. Recommendations

4.1 A number of recommendations have been developed jointly by the project team, all of which have been drawn from the outputs of the service review and the needs assessment as well as discussions with patient representatives and local clinicians in primary and secondary care. Collectively the recommendations will inform the future commissioning of intermediate care services across the health and social care pathway.

4.2 The following recommendations have been approved by NHS South Kent Coast Clinical Commissioning Group Clinical Cabinet:

- **Integrated care and pathways**: commissioners of health and social care will work jointly to ensure that services are formally integrated across a pathway to achieve significant improvements for patient / client care as well as the wider health and social care system. Commissioners to ensure that the integrated intermediate care pathway includes proactive management of patient care across the whole pathway and also linked with other integrated teams, including the Community Nursing Neighbourhood Care Teams. The local referral management system supporting the intermediate care pathway should also be aligned to other single points of contact to ensure coordination between services. Commissioners also recognise the importance of providing carer respite, as often carer breakdown leads to hospital admissions, support should be in place for carers who need both emergency and planned respite;
- **Integrated service reviews and audit**: commissioners of intermediate care services recognise there are gaps in the information currently available to fully assess how services are performing, therefore there is a need to jointly re-specify the data required by providers to monitor patient / client outcomes and overall service performance across this pathway, this should include a number of key performance indicators to assure commissioners of delivery and support continuous improvements. Health and Social Care commissioners to undertake joint integrated care performance reviews and audits to better understand the impact of the integrated intermediate care pathway ensuring that the right patient outcomes and system improvements are consistently met and lessons learnt with regard to continuous improvement;
- **Flexible levels of provision**: based on the evidence made available to commissioners at this current time a need for permanent additional nursing beds has not been identified. However, commissioners are commissioning some interim additional beds to support the predicted winter pressures during 2013/14. Commissioners will evaluate the use of these beds and specify the requirements beyond March 2014 when the funding for these beds ends. If additional capacity is commissioned beyond March 2014 this should be monitored on an on-going basis and be flexed to reflect the wider improvements following the implementation of a patient outcome focused integrated intermediate care pathway. Through more proactive integrated care over time the level and type of beds may change, but currently commissioners recognise that there needs to be better use of existing beds to ensure patients are not admitted to hospital unnecessary. To achieve this requires: availability of sufficient ‘step up’ beds not just ‘step down’; commissioned pathways for patients who are admitted in to the wrong type of bed / facility for their needs such as non-weight bearing patients who are unable to be discharged home but need therapist input rather than 24/7 nursing care and patients with Dementia who have physical health problems;

- **Appropriate use of services**: clear criteria, with an element of flexibility, to be developed for the use of community hospital beds and short term beds to ensure the beds are used appropriately and therefore making better use of these resources and balancing the availability of step up and step down beds, particularly for the Dover/Deal locality where this is no access to 'step up' beds, to ensure avoidance of unnecessary acute admission's as well as supporting timely discharge from acute beds ensuring the use of care in the home interventions such as enablement and flexible domiciliary care where appropriate to ease pressures on bed based interventions;
- **Location of service provision**: commissioners to specify that patients should receive intermediate care in the right location depending on their needs, preferably in the comfort of their own home where appropriate. Where patients require admission to beds in the community providers should ensure patients stay as close to home as possible, and when they are admitted to facilities outside of South Kent Coast all patients should be actively repatriated to the next available local bed as a preference to using that bed for the next step down referral. Where patients are admitted outside of South Kent Coast the provider should make travel provisions for the patient's family and carers to visit them regularly;
- **Timely response to patient needs**: commissioners to work jointly with other authorities to ensure the integrated pathway meets the requirements of all patients in a timely way and to ensure no unnecessary delay, particularly where patients require housing adaptations and other aids/equipment to enable them to be cared for in their own homes. Commissioners recognise that if more care is to be delivered at home this will require more timely responses to ensure a patients home is a suitable environment for them to be cared in;
- **Patient engagement**: commissioners and providers to jointly undertake further engagement activities with service users and their representatives to ensure co-design of services on an on-going basis;
- **Integrated communication and training**: providers to undertake regular communication and training with staff, including GPs, particularly on falls prevention, dementia and end of life care (reflecting the growing number of older people) to ensure staff have the right knowledge to care for patients on the integrated intermediate care pathway. Providers also need to promote self-care with patients to help educate individuals about managing their long term conditions;
- **Joint implementation plan**: commissioners of intermediate care services to jointly take forward the recommendations from this project and agree a timetable and plan to deliver the improvements. This plan should include the commissioning of the integrated pathway across multiple providers and measures to monitor the impact of the changes. These plans will specify the delivery of some improvements during the remainder of 2013/14 and commissioning intentions to complete the full implementation of the integrated pathway with flexible capacity during 2014/15.

5. Next Steps

5.1 The recommendations from this project will now be used to develop an implementation plan. Elements of this plan will be delivered during the remainder of 2013/14 and other improvements will be realised through the implementation of specific commissioning intentions for 2014/15.

5.2 The initial priorities for 2013/14 are as follows:

- Undertake an audit of unnecessary admissions and discharges from the acute hospital to better understand reasons and numbers to inform future intermediate care capacity requirements;
- Undertake service audits to better understand patient outcomes at point of discharge and assess whether patients are returning to maximum levels of independence;
- Assess impact of interim beds commissioned during the winter months to understand impact on overall bed capacity and inform future commissioning requirements for patients using these interim beds (particularly non-weight bearing patients);
- Re-specify the service requirements for community bed use to ensure correct balance of 'step up' and 'step down' beds;
- Re-specify the intermediate care service requirements provided by the intermediate care teams;
- Develop joint performance indicators for health and social care intermediate care services to inform joint monitoring of continuous improvements to current service provision;
- Agree processes with appropriate authorities for ensuring rapid response for patients requiring housing adaptations.

5.3 Commissioners will ensure patient representatives are involved in this work at key stages to ensure changes to services are informed through patient feedback. As the work progresses jointly between health and social care commissioners over the coming months to realise the full range of recommendations from this project further updates can be made available to the South Kent Coast Health and Well Being Board.

6. Appendices

APPENDIX I

Intermediate Care Project – 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 and is a range of integrated services to promote faster recovery from illness 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.

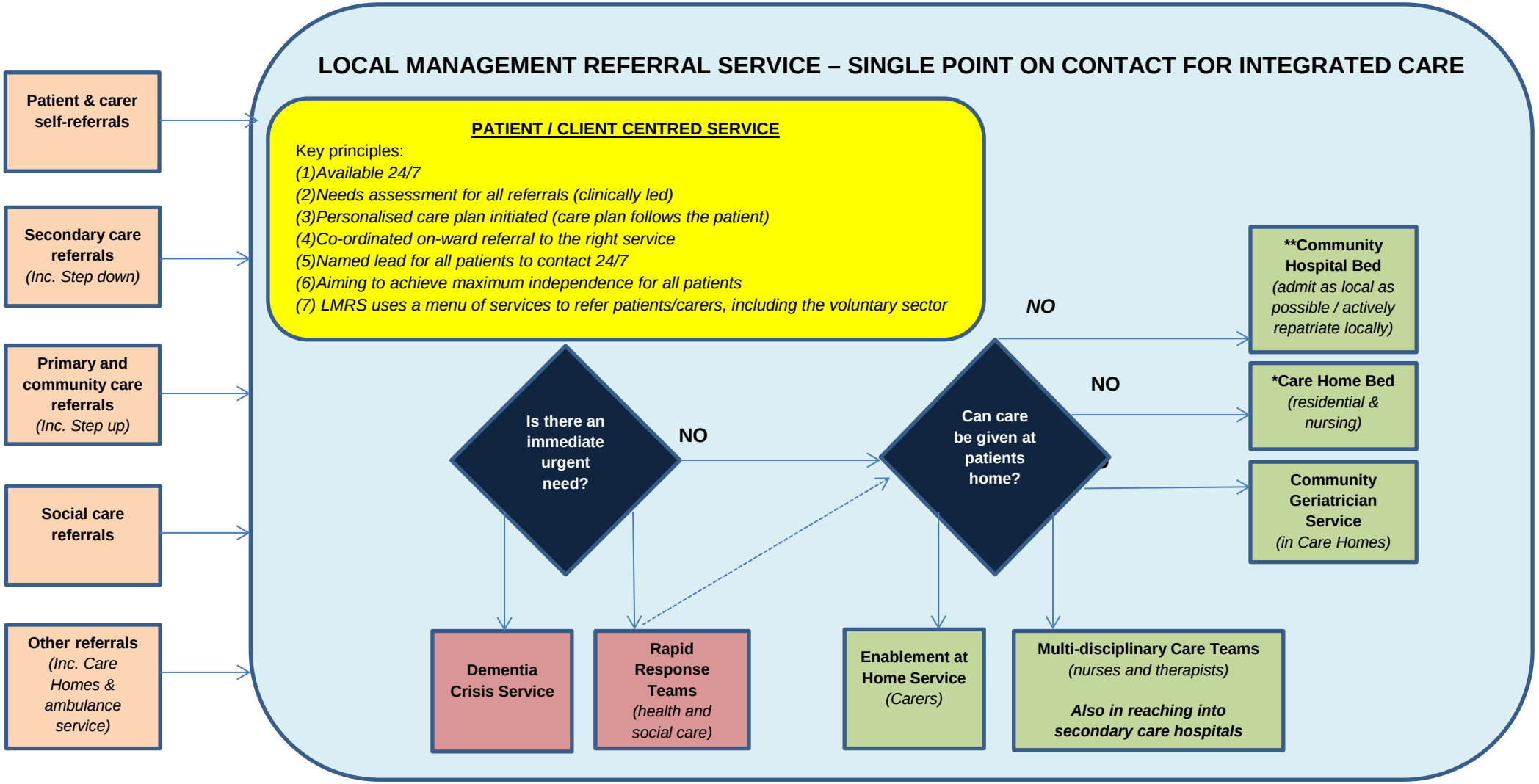
Services within project scope

- **Kent Enablement at Home (KEAH)** – commissioned by KCC aimed at providing time limited support to people in their home helping them cope with their disabilities, focus on confidence building and to 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.

South Kent Coast Clinical Commissioning Group

APPENDIX II South Kent Coast - integrated pathway for future intermediate care model

'Achieving more integrated care in the right location'



**Care Home Beds – used for comprehensive short term comprehensive health and social care assessments and for carer respite*
***Community Hospital Beds – used for comprehensive assessment, for patients needing 24/7 nursing care and for carer respite*