ANNEX 1

NHS
Bracknell and Ascot
Clinical Commissioning Group

Bracknell Forest Council



# Joint Commissioning Strategy for Intermediate Care 2015 - 2018

To help understand this document, there is a Glossary on page 25 to explain what some of the words mean. Words in the text that are explained in the glossary are underlined.

# Joint Commissioning Strategy for Intermediate Care 2015 - 2018

Since the publications of the Health and Local Authority Circular, Intermediate care[1] and the National Service Framework for Older People[2] in 2001, the concept of intermediate care, with the focus on reablement and independence, in order to prevent unnecessary hospital admission, promote timely discharge and reduce the need for long term residential care, has been put into practice. Updated guidance, Intermediate Care – Half Way Home (2009)[3], widened the focus to include all adults including young people approaching adulthood. With the advent of the Care Act 2014[4] and Better Care Fund[5] which promotes integration of working across health and social care, further emphasis on prevention and person centred approaches which impact on health and wellbeing, the timing is right to further develop the strategy for intermediate care within the Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group area. This strategy defines the future vision, principles and outcomes for intermediate care within the local area, an analysis of current service delivery and future demand, models for future development and priorities for future development.

## *What is a Commissioning Strategy?*

A commissioning strategy is a document which sets out how support and services for individuals will be developed. In order to identify the vision and priorities for the development of intermediate care within the next three years, the following has been taken into account:

- Feedback from people who have used intermediate care services both nationally and locally
- Views of people from commissioners and providers of intermediate care services
- Relevant legislation, national guidance and research
- An analysis of the needs of the local population, current service delivery and what is likely to change or needs to change in the future.

## *What is Intermediate Care?*

The legal definition of Intermediate Care contained in regulation 2 Community Care (Delayed Discharges) Act (Qualifying Services) (England) Regulations 2003[6] states that it is a "structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his home."

Intermediate Care – Half Way Home[3] defines intermediate care as follows:-

"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."

The initial Department of Health Guidance (2001)[1] defined intermediate care by the following criteria, which are still relevant to intermediate care services.

- They are 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.

- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.

- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.

- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.

- They involve practitioners and organisations working, with a single assessment framework, single records and shared protocols.

Half Way Home[3] also highlights the following:-

- Intermediate care is a function not a service.

- Prevention of admission to long term care in a care home is equally important to preventing unnecessary hospital admission and supporting timely discharge.

- Intermediate care should be considered not only at point of admission/discharge from hospital but also in earlier preventative stages

## *The Approach in Bracknell Forest*

Bracknell Forest has taken an approach to Intermediate Care that embraces the integrated approach, both in commissioning and provision. This ensures that both the social care and healthcare needs of individuals are assessed and met within a holistic approach. Details of this approach to date can be found in Appendix 2.

The CCG and the Council are not coterminous, and this adds complexity to taking a jointly funded approach. Bracknell Forest council recognises that patients of member GP practices in the Ascot area have needs that might sometimes be best met by an admission to Bridgewell. Whilst the priority of the service will always be to meet the needs of Bracknell Forest residents, consideration is given to requests from any BACCG GP who feels their patient's needs would be best met by an admission to Bridgewell.

# National Contexts

## *Statutory contexts*

The following legislation in how informs how intermediate care is developed within the wider health and social care systems:

### Health and Social Care Act 2012[7]

This legislation changed the way the National Health Service (NHS) works to deliver person-centred healthcare by:

- Giving patients greater choice, control and involvement – "no decisions about me without me"
- To improve the health of people.
- Removing unnecessary bureaucracy, cutting waste and making the NHS more efficient
- Creating Clinical Commissioning Groups (CCG) where local General Practitioners (GPs) commission (the delivery of) health services based on their community's needs.

Health and Wellbeing Boards have also been created in each local authority area with the specific role to improve health and wellbeing for all, and reduce health inequalities between different people.
The Act promotes the integration of health and social care to avoid unnecessary hospital admission, reduce delayed discharges from hospital and also to coordinate care so that people spend less time in hospital and are able to get the care they need at home.

### The Care Act 2014[4]

The Care Act requires local authorities to focus on the health and wellbeing of the individual (this includes carers) rather than just their need for practical support. It highlights the importance of early intervention and prevention to reduce acute needs, and putting people in control of their care and support. There is a requirement for co-operation and the promotion of integration of care and support with local authorities, health and housing services and other service providers to ensure best outcomes are achieved.
The Act states that where local authorities provide intermediate care or reablement to those who require it, this must be provided free of charge for a period of up to six weeks. This is for all adults, irrespective of whether they have eligible needs for ongoing care and support. The Care Act guidance states that although such types of support will usually be provided as a preventative measure under section 2 of the Act, they may also be provided as part of a package of care and support to meet eligible needs. In these cases, regulations also provide that intermediate care or reablement cannot be charged for in the first six weeks, to ensure consistency.

Whilst there is provision in the Act for compensation for NHS providers if local authorities delay hospital discharge, this is to encourage joint working and both the NHS and local authorities have responsibilities to reduce risks related to discharge. Local authorities do have a duty under the Act, not only to assess the person being discharged, but also their informal carers who require support as part of the discharge planning process.

Intermediate Care is a preventative process and Care Act Statutory Guidance defines three levels of prevention:

PREVENTATIVE: Primary Prevention
These are interventions aimed at individuals who have no current particular health or care and support needs, maintaining independence and good health and promoting wellbeing

REDUCE: Secondary Prevention
Targeted interventions aimed at individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down or reduce any further deterioration or prevent other needs from developing.

DELAY: Tertiary Prevention
These are interventions aimed at minimising the effect of disability or deterioration for people with established or complex health conditions, (including progressive conditions, such as dementia), supporting people to regain skills and manage or reduce need where possible.

This strategy is mainly concerned with secondary and tertiary prevention. Bracknell and Ascot CCG and the Council are currently have a project for Prevention and Self Care and primary prevention will be part of the this work.

## *Policy Contexts*

The following government guidelines inform how health and social care provides intermediate care:

### Intermediate Care – Half Way Home 2009[3]

The guidance provided renewed clarification on what intermediate care is and how it should be delivered. It identifies which groups intermediate care should be targeted at, why it is important, which services may contribute to it and that intermediate care is a function, not a discreet service. It states that the emphasis of intermediate care should be on active reablement, which is likely to require any one of a range of skills, including supporting people and their family carers to make the social and environmental adjustments (including the possibility of re-housing) that may be needed in response to loss of independence. It also states that Commissioners should set goals for the service and gives guidance on developing performance reporting and monitoring.

The 2009 guidance notes that those at risk of being placed in residential care inappropriately should be a priority for preventative support stating that:-

> All older people at risk of entering care homes, either residential or nursing, should be given the opportunity to benefit from rehabilitation and recuperation and for their needs to be assessed in a setting other than an acute hospital ward. They should not be transferred directly to long-term residential care from an acute hospital ward unless there are exceptional circumstances. Such circumstances might include:
>
> - those who have already completed a period of specialist rehabilitation, such as in a stroke unit
>
> - those judged to have had sufficient previous attempts at being supported at home (with or without intermediate care support)
>
> - those for whom a period in residential intermediate care followed by another move is judged likely to be distressing.

## Better Care Fund 2013[5]

The Better Care Fund combines existing NHS and Local Authority funding, which will now be jointly invested to:

- Ensure health and care and support work together, for example by sharing data and improving continuity of care
- Ensure services act earlier so that people can stay healthy and independent at home, and avoid going to hospital or A&E
- Deliver care that is centred on individual needs – such as NHS and social care staff completing joint assessments
- Move towards whole system provision of 7 day working.

It is important that the population is happy, healthy and active for longer, and the Better Care Fund programme will support in doing this, through having better information, access to health and care services when required and support to make the right choices. Areas will be assessed on how well healthcare and social care organisations work together to improve outcomes against measures for:

- Admissions to residential and nursing care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admission
- The experience of people using the services.

## Quality, Innovation, Productivity and Prevention (QIPP) 2014[8]

QIPP is a large scale programme of change in the health services (NHS), involving all NHS staff, clinicians, patients and the voluntary sector to improve the quality of care the NHS delivers. It also makes up to £20 billion of efficiency savings by 2014-15 which will be reinvested in frontline care. There are a number of national work streams designed to support the NHS to achieve the quality and productivity challenge it has been set. The work streams which may impact on Intermediate Care include Long Term Conditions, Urgent Care, Medicines Use and Procurement and Productive Care.

## *National Audit of Intermediate care 2013*[9]

This annual audit reviews a range of Intermediate Care Services within the NHS and local government. The audit found:

- The average investment in health based Intermediate Care was 1.9 million per weighted 100,000 population and in reablement £100,000.

- In the previous year, they had calculated that the capacity of intermediate care needs to be doubled to meet demands, however nationally there had been virtually no increase in investment and there had been disinvestment in intermediate care beds.

- There were in some areas a range of intermediate care services in an area, causing potential fragmentation of services, and unclear routes in and out of the service.

- The demand for intermediate care for those leaving hospital is limiting the capacity of services aimed at avoiding hospital admission.

- Referrals from accident and emergency departments are limited, although research studies suggest the most effective models for preventing hospital admissions is identifying people in these departments.

- There were delays in response to referrals from hospitals for people waiting discharge.

- In most services, nursing levels were at the Royal College of Nursing standards safe level[10] of care but below the standards for ideal, good quality care.

- Only 51% teams had training in mental health and dementia care and only 34% had rapid access to mental health services.

- The proportion of intermediate care services relying the persons GP for support appears high (71%) when reviewed against the level of support they are providing. The "Comprehensive Geriatric Assessment" (CGA) is known to reduce deaths, institutionalisation and hospital admission, and which requires a fully staffed multidisciplinary team is possibly not being fully utilised.

## *Performance Indicators*

The Department of Health sets a number of outcomes and indicators to hold local authorities and local National Health Services to account. These are called Outcome Frameworks. The key Adult Social Care[11], Public Health[12] and National Health Service[13] outcomes and indicators on which Intermediate Care will have an impact are detailed in **Appendix 1**. Bracknell Forest performs well against these outcomes, details of performance against the Adult Social Care framework, which measure Intermediate Care related outcomes, can be found here http://ascof.hscic.gov.uk/Outcome/614/

# Local Contexts

## *Health and social care service integration*

Bracknell Forest has existing, established joint funded, Intermediate Care Service, delivered via a pooled budget agreement between the Council (as lead commissioner) and Bracknell and Ascot Clinical Commissioning Group. It is made up of community based services and residential unit. Further development of Intermediate Care Services is a local priority for the Better Care Fund. Details can be found in Appendix 2.

## *Joint Health and Wellbeing Strategy[14]*

The local Health and Wellbeing Strategy was published in 2012. The objective of the strategy is to "make sure that every resident of Bracknell Forest lives in a healthy, safe and caring place, and gets good services and support when they need them." There are key underpinning principles in the strategy which should be considered when planning Intermediate care:

1. People should be supported to take responsibility for their own health and wellbeing as much as possible

2. Everybody should have equal access to treatment or services

3. Organisations should work together to make the best use of all the resources they have to prevent and treat ill-health

4. The support and services that people get should be of the best possible quality.

The priorities identified include:

- Mental Health, particularly Depression and Dementia

- Long Term Conditions, particularly respiratory illness, diabetes and cardiovascular disease

- Cancer

- Vulnerable groups – paying particular attention to people who are more likely to become ill, or who may need particular services.

## Underpinning Future Development

### *Principles of Intermediate Care in Bracknell Forest*

These principles have been developed in line with the views of people who have used the service, commissioners and providers of health and social care and in line with national policy, local policy and best practice.

1. Intermediate care is a time limited, integrated, multidisciplinary function across health and social care, within the context of the whole system.

2. All adults should have the opportunity to access intermediate care functions in a timely way, to prevent deterioration, improve, maintain or manage changes in levels of health and wellbeing.

3. People should be given the right information to make an informed decision about whether they want intermediate care.

4. There is a choice of location of care and decision made about location of care is made jointly with the person requiring it.

5. Intermediate care services should be flexible and designed around the person and their family. Planning of programmes should involve the person and their circle of support including both formal and informal cares.

6. People who require intermediate care have a structured programme and are involved in setting goals for what they want to achieve both in the short term and longer term.

7. People have reablement plans and their progress is monitored, ensuring that they move through the process in a timely way.

8. People should not move directly to long-term residential care from an acute hospital ward unless there are exceptional circumstances (see page 5 for exceptions).

### *Outcomes of Intermediate Care*

People will:

1. Improve their independence, health and wellbeing
2. Maintain their independence, health and wellbeing.
3. Have a managed decline in independence, health and wellbeing.
4. Have their ability to live independently maximised.
5. Avoid unnecessary hospital admission.
6. Be in hospital no longer than is necessary.
7. Avoid premature admission to long term residential care.

## *Understanding Needs*

Intermediate care is targeted at adults within the Bracknell area.

The total population, including children and adults, of Bracknell Forest was estimated to be 116,600 in 2013 (ONS 2013).[15] The population of people who are working age 18-64 are larger than the national average; the population of older people are lower than the national average. However By 2021, the population in Bracknell Forest is estimated to increase by almost 12,000 people. These figures are based on births, deaths and migration. As the birth rate was high in the 1950s and 60s and the people born in this era age, the older population is expected to increase at the greatest rate (JSNA 2014)[16].

The percentage of men to women in the adult population is comparatively equal until the age of 80, when there are more women than men (ONS 2013)[16].

It is difficult to predict the numbers of people who would benefit from intermediate care services. There are a number of indicators that point towards a demand for it.

- The number of people aged 18- 64, in Bracknell Forest who have a moderate physical disability is 5,700 and this is predicted to rise to 6,100 by 2020. The number of people aged 18 -64 with a serious physical disability is 1,700 and this is predicted to rise to 1,900 by 2020. (PANSI 2014)[17]

- The prevalence of long-term conditions rises with age, affecting about 50 per cent of people aged 50, and 80 per cent of those aged 65. Many older people have more than one long term condition, but in absolute terms there are more people with long-term conditions under the age of 65 than in older age groups (HSCIC, 2014)[18]

- The number of people aged 65 and over, in Bracknell Forest with a limiting long-term illness, whose day to day activities are limited is 6,901 and this is predicated to rise to 8,257 by 2020. (POPPI 2014)[19]

- The number of people 18- 64, in Bracknell Forest who identified themselves as having a limiting long-term illness, whose day to day activities are limited a little in the 2011 Census was 4,056 and those whose life is limited a lot was 2,420[20].

- Nationally 29% of the population has one or more long-term conditions. They use 50% of GP appointments, 64% of outpatient appointments and 70% of bed days. (DOH 2012)[21]

- An estimated 18 per cent of people with long-term conditions are in receipt of state-funded social care and a small proportion of those with the most disabling or complex conditions (less than 1 per cent of the total) receive NHS Continuing Care support and are currently eligible for personal health budgets (Angela Coulter et al 2013)[22].

- In 2012/13 There were 18.3 million accident and emergency attendances recorded at major A&E departments, single specialty A&E departments, walk-in centres and minor injury units in England; an increase of 4.0 per cent from 2011-12. 57.2% of all A+E attendances were for patients over 29 years old. (HSCIC, 2014)[18]

- When comparing 2011/12 to 2012/13 data, there has been an 8.28% increase in the number of people from Bracknell Forest being admitted to hospital in an emergency. Out of all 6 unitary authorities in Berkshire (Bracknell Forest, Windsor and

Maidenhead, Reading, Newbury, Slough, West Berkshire and Wokingham), Bracknell Forest had the 2nd largest increase between the two years (after Windsor and Maidenhead with an increase of 11%). (JSNA 2014)[16]

- 8.9% of the emergency admissions in the Bracknell and Ascot CCG area were for people with long term conditions. All of the patients included in this data had long term conditions that could have been treated via community care (JSNA).[16]

- Figure 1 shows the number emergency admissions in 2012/2013, of people within the Bracknell and Ascot CCG area, where the primary reason for admission was a specific long term conditions. Intermediate care may need to undertake some targeted work with people who have some of these conditions to reduce admission rates.

**NHS BRACKNELL AND ASCOT CCG, Number of Acute Hospital, Emergency Admissions for Specific Long Term Conditions2012/13**

| Condition | Number of Emergency Admissions: all ages |
|---|---|
| Diabetes Mellitus | 67 |
| Coronary Heart Disease | 260 |
| Stroke or Transient Ischaemic Attacks (TIA) | 181 |
| Chronic Obstructive Pulmonary Disease | 183 |
| Heart Failure Prevalence | 111 |
| Dementia Prevalence | 8 |
| Peripheral Arterial Disease | 18 |

**(Doctor Foster)[23]**

Figure 1.

- As well as the life limiting long term conditions, falls are a major cause of disability and mortality in people aged 75 and over in the UK. The Department of Health states that 35% of people aged 65 and over experiencing one or more falls on an annual basis and this percentage increases with age. (DOH, 2010)[24]

- Hip fractures are the most frequent fragility fractures caused by falls and are the most common cause of accident-related death. These are increasing against the national average with 96 people from Bracknell admitted with hip fractures in 2012/2013. (HES copyright 2013)[25].

- Around 350 in every 100,000 people in Bracknell Forest will be diagnosed with cancer every year. Rates of diagnosis have remained relatively stable over the past seventeen years and are similar to the rates of diagnosis across the country. Mortality rates in the UK are higher than the European average (JSNA 2014).[16]

- People with diabetes have an increased risk of having other life limiting long term conditions; 41% more likely to have a myocardial infarct, 17.3% more likely to have a stroke, 68.9% are more likely to have a hospital admission related to heart failure. (Diabetes Community Health Profiles, 2013)[26].

- 9.6% of the population in Bracknell Forest are black and ethnic minority communities, the largest number being Asian or Asian-British according to the 2011 census[20]. People from Black African and Caribbean origin are 3 times more likely to develop type 2 diabetes and those of South Asian Origin are 6 times more likely to develop type 2 diabetes. These groups also tend to develop diabetes at an earlier age. (Diabetes UK)[27].

- In the 2011 census[20] 9,600 residents identified themselves as unpaid carers. The 2012/13 RAP statutory return showed 900 carers, almost 10% of the total number of unpaid carers in the area, received assessments and, following this, received information and/or support from Adult Social Care. The number of assessments are likely to increase under new requirements in the Care Act[4]. It is important for intermediate care to undertake carers assessments, as the assessments need to take place close to the time the person they care for is being assessed, to find out if the carer wishes to take on a caring role and if they do, provide timely support for them and the person they care for.



(Note Estimates have been rounded to the nearest 100 to fulfil the copyright of the data providers).

## *Feedback from People who have Used Intermediate Care Services*

Following an episode of intervention from the main intermediate care service in Bracknell Forest, the Community Response and Reablement Team, people are requested to complete a satisfaction questionnaire. From January – June 2014, 150 questionnaires were completed. Of those 138 (92%) rated the service as very good or excellent.

There were a number of key themes, drawn from peoples comments on what made the service effective and their experience a positive one as well as comments which expressed dissatisfied with the service.

- People need to have information about services and a choice where reablement is given.
- People and care givers, including informal carers need to be involved in planning.
- Hospital and community teams need to communicate effectively so people have the right support at the right time.
- Equipment (both health and social care) needs to be delivered in a timely way to support the reablement process.

These local findings reflect the finding in "Intermediate Care: a realist review and conceptual framework"[28]**.** The authors completed a systematic review of all the evidence into intermediate care services including evidence from people who use the services. They found that intermediate care can improve outcomes when:-

- People who use intermediate care are listened to, what they say is acted upon and decisions are made collaboratively.
- Agreed intermediate care is co-ordinated and delivered in a timely fashion.
- Practitioners have a detailed understanding of what intermediate care services are available and are able to combine this knowledge with the needs and preferences of people who use the service.
- There are a range of places where intermediate care can take place e.g. in the home, in the persons local community, in a clinic and health and social care staff explore with people who use the services, where the best place would be to enable independence, health and wellbeing.
- Goals are planned with the individual for achievement, extending beyond the timeframe of intermediate care.
- People who are in the person's primary social and care network (including informal networks) are involved in the planning and implementation of intermediate care programmes.

## *Feedback from Commissioners and Providers of Intermediate Care*

- There was strong agreement that locally based bed based intermediate care needs to have clearer criteria for admission and processes and focus on reablement.

- Intermediate Care provision needs to take account of developments and changes within the local health and social care systems e.g. development of Rapid Access Community Service (RACS) and Integrated Care Teams.

- There was strong agreement, particularly among medical practitioners, that the development of a consultant geriatrician service would provide leadership, specialist assessment, diagnostic and clinical management support intermediate care.

- The need for practitioners to develop intermediate care practice and processes within mental health services was identified.

- There is also a need for practitioners in intermediate care to have more of a focus on health and wellbeing including being able to provide psychological support and reducing social isolation.

- The development of specialist expertise and services in the rehabilitation of people with neurological conditions, especially those for people with brain injury, is required within the local area. It was acknowledge that these need to be developed as part of a neuro-rehabilitation pathway, although intermediate care has a role.

- There is currently a lack of space and resources to develop intermediate care focused clinics within the borough, including specialist clinics such as neuro-rehabilitation and chronic obstructive pulmonary disease. However, clinics have the potential to improve delivery and efficiency of services. Current services are out of borough and people find them difficult to travel to.

- That intermediate care needs to draw upon and support the wider health and social care system to effectively support people who need reablement.

- Carer assessments are usually completed towards the end of the intermediate care processes. Carers assessment and support should be an ongoing process throughout intermediate care.

- Information needs to flow through the system to avoid duplication of assessment and limit risks of harm by not having by lack of information or incorrect information.

- Rehabilitation and reablement should be goal focused and people should be supported to move through the system and achieve their goals in a timely way.

## *Current Service Provision*

There are a range of services within Bracknell Forest that can deliver or support intermediate care functions. The main service is Community Response and Reablement Team, which delivers intermediate care in people's homes and own communities as well as in the local bed based service in the Bridgewell Centre. Services such as Community hospitals, Rapid Access Community Services, Community Health Clinics, specialist nurses, GP services, district nursing, physiotherapists and social care teams also have a role in intermediate care. There is a programme of development within health and social care support the delivery of the Care Act[4] and to integrate services to improve delivery and efficiency of services. The

strategy for intermediate care will inform these local developments. Details of services that provide intermediate care and how they operate as part of the whole system are given in **appendix 2.**

## *Future Model of Intermediate Care in Bracknell Forest*

The model for Intermediate care in Bracknell Forest has been informed by analysis of policy, evidence, feedback from people who have used the service, feedback from commissioners and providers of services, current service delivery and gaps in service delivery. It also draws on a conceptual framework developed by the NHS Institute for Innovation and Improvement[28]".

The NHS Institute for Innovation and Improvement developed a Conceptual Framework based an extensive review of evidence[28]. This framework is designed for services that support people at point of "health crisis" and does not look at the wider strategy for improving independence, reducing dependence on long term care, reducing avoidable hospital admissions and reducing the time spent in hospital. This model recognises that intermediate care is a part of continuum of services and focuses on the person and their wider circle of support being active participants in decision making and the programme of support. It also recognises that the outcomes for the person are wider than functional improvement and include:

- Improvement in independence, health and wellbeing
- Maintaining independence, health and wellbeing.
- Managing decline in independence, health and wellbeing

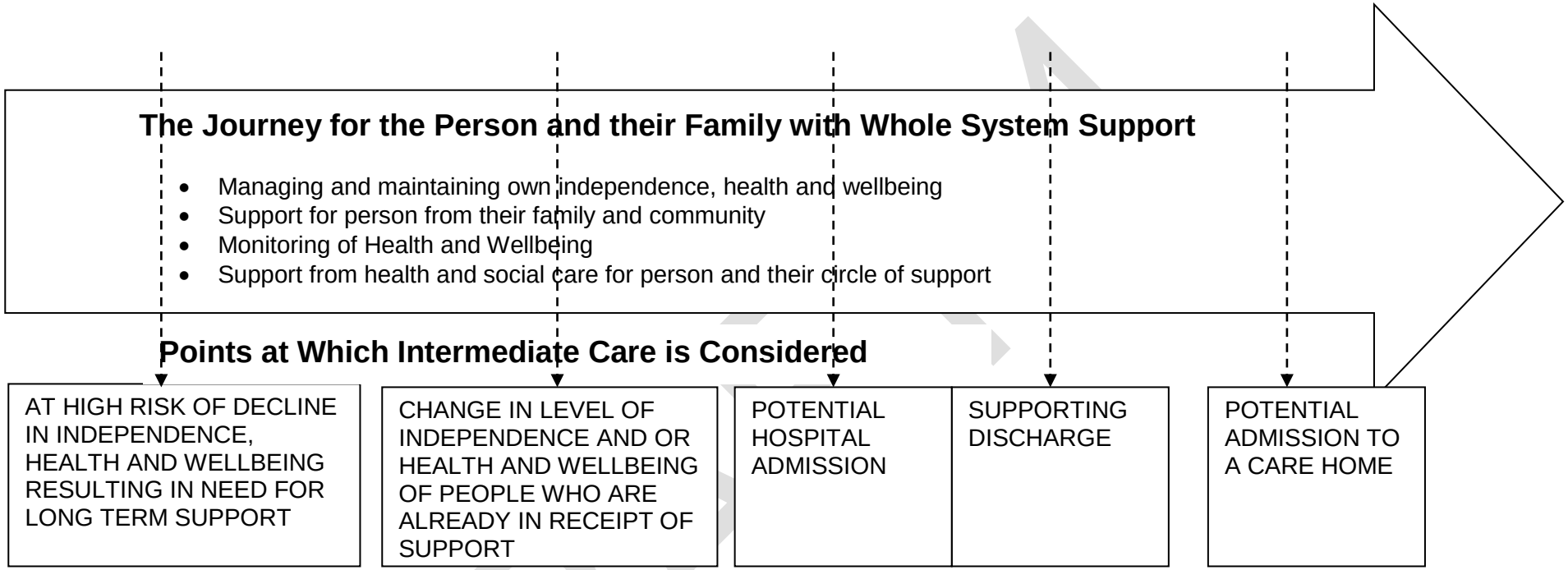
### The Model

The model of intermediate care (figure 2) in Bracknell Forest recognises that people with long term conditions and disability are primarily taking responsibility for managing and maintaining their own independence, health and wellbeing with support from their family and wider community. Health and Social care, as part of the whole system, have roles in monitoring and supporting people and their circle of support. There are five key points within a person's journey where they could benefit from intermediate care;

- when there is a high risk of decline in independence, health and wellbeing resulting in need for long term support
- when they are already receiving support and there is a change in their level of independence
- when there is potential that they may be admitted to hospital
- to support timely discharge and
- when there is a potential admission to a care home

Current provision of Intermediate Care in Bracknell Forest reflects this model, and this strategy identifies options to enhance and extend approaches to facilitate improved outcomes for people.

## Future Model for Intermediate Care within Bracknell Forest




**OUTCOMES**

1. Improvement in independence, health and wellbeing.
2. Maintaining independence, health and wellbeing.
3. Managing decline in independence, health and wellbeing.
4. Ability to live independently is maximised
5. Avoidance of unnecessary hospital admission.
6. Be in hospital no longer than is necessary.
7. Avoid premature admission to long term residential care.

**OUTCOME MEASURES**

1. Level of independence/dependence pre and post intervention linked to the aims of their support.
2. Measure of peoples health and wellbeing pre and post intervention
3. Measure of carers health and wellbeing pre and post intervention.
4. Percentage of people who had reablement prior to social care package or placement.
5. Number of referrals to prevent admission to hospital
6. Location of people 91 days following hospital discharge
7. Outcome of intervention based on service following discharge.
8. People and their circle of support's satisfaction with the service.

Figure 2

**Operation as part of a whole system**
Intermediate care needs to operate as part of and draw on the support of the whole system and therefore be accessible and respond to demands seven days a week. This means that some parts of the service may need to operate 24 hours a day. Intermediate care functions and pathways, whether they are part of another service or part of a core service must be clearly defined and communicated to people who refer to the service and those that use the service. In order to have an informed and co-ordinated approach to care, information needs to be passed through the whole system. Anyone should be able to refer to the service, including people who need support, family and friends. A single point of access helps people navigate the system and should be one of the times that practitioners start to explore with the person where the best place would be for intervention.

**Person and family centred approached**
People and their circle of support need to be actively involved in decision making and participate in the programme**.** In order for people to be fully involved in decisions about their care, the purpose and the journey through intermediate care are clearly communicated to referrers and people who use the service. Intervention must be timely and focused on long term as well as short term goals and negotiated with the person to optimise reablement. People should be enabled to be as independent as possible, reducing dependence on their circle of support and the system. However, support from the person's family and local community is essential, when the person wants it, to help the person achieve their goals; therefore a whole family approach needs to be adopted and they too should be involved in decision making. It is important that carers are supported in their own right and in a timely way find out if they wish to continue in their caring role and if so, enable them to maintain their health and wellbeing. As well as this, it is vital that the physical environment is taken into account so that it shaped and adapted to support the person's independence.

**Intermediate care staff roles and facilities**
The development of intermediate care functions, in a complex system needs clear leadership at both a strategic and operational level to ensure that

- services are well co-ordinated, flexible and responsive to demand
- there are clear lines of responsibility and accountability
- governance structures are in place and there is continuous improvement in the quality of the service and high standards of care
- any gaps in service delivery are reduced and potential for duplication is avoided
- the service is performing to agreed levels, outcomes are achieved and it is value for money.

The development of named co-ordinator roles within front line practice who act as navigators and who retain responsibility for intervention and experience throughout the persons journey is recommended in Care Co-Ordination through Integrated Health and Social Care Teams[29].
Levels of staffing and skill mix in the team are required to be appropriate for at a minimum, safe practice in line with Royal College of Nursing[10], to fulfil the role of intermediate care and be cost effective. Supervisory structures must support staff as part of a team and in their professional roles.

Finally the infrastructure (built environment) needs to be developed in order to give people choice of location for their care, enhance accessibility to service, allow intermediate care to provide for people whose condition is at varying levels of complexity.

**Outcomes and Measures**
The following outcomes of service delivery are not only positive for the person but the whole system.

1. Improvement in independence, health and wellbeing

2. Maintaining independence, health and wellbeing

3. Managing decline in independence, health and wellbeing

4. Avoidance of unnecessary hospital admission

5. Be in hospital no longer than is necessary

6. Avoid premature admission to long term residential care.

Enabling people to manage their own health and wellbeing and to be independent as possible reduces dependence and costs on the whole system. Hospitals and care homes are high cost forms of care which intermediate care is trying to avoid. Intermediate care itself is resource intensive but by taking a goal directed approach and motivating people through the system it can be cost effective. It is important to develop clear measures in order to show the effectiveness of all parts of the service and the outcome measures could include the following. Work is underway to determine how success on some of these outcomes can be evidenced.

1. Level of independence/dependence pre and post intervention linked to the aims of their support

2. Measure of people's health and wellbeing pre and post intervention

3. Measure of carers' health and wellbeing pre and post intervention

4. Percentage of people who had reablement prior to social care package or placement

5. Number of referrals to prevent admission to hospital against number of people who then required admission

6. Location of people 91 days following hospital discharge

7. Outcome of intermediate care based on services following discharge, e.g. no further service, support package, placement.

8. People and their circle of support's satisfaction with the service.

## Priorities for future development

The following priorities have been identified based on the comments from people who have used the services, commissioners and providers, as well as national and local policy and best practice:

1. Review and appraise the options for bed based intermediate care services in response to changes in bed based capacity and future demand.

2. Review and develop community based intermediate care in line with increasing demand and developments of other community based services such as the Integrated Care Teams and Rapid Access Community Service, so that it is a sustainable model and continues to be accessible, offer timely support, maintain the quality of the service and achieve its outcomes of care.

3. Investigate the development of community consultant geriatrician roles to support the development of all the integrated care teams, providing medical leadership, enabling the provision of community based services to those with complex medical needs, to enable Comprehensive Geriatric Assessments to take place and develop local clinics targeted at specific groups of people, similar to those developed for people who have fallen, for example people with COPD, Heart Disease and Parkinson's Disease as part of the RACS and intermediate care.

4. The development of intermediate care functions in Community Mental Health Teams for Older Adults and develop mental health expertise within intermediate care are currently being addressed as part a workforce development programme within the Local Authority which will be implemented in 2015.

5. Explore the feasibility of developing facilities for community based clinics within borough to support intermediate care, RACS and integrated care teams.

6. Strengthen the links and communication with specialist service areas (e.g. specialist nursing services such as for people with Parkinson's Disease) so that the all parts of the system are working together in a timely way to support outcomes for people.

7. Review and develop intermediate care processes for carers assessment and support so that their needs are met in a timely way and so that they are partners in support.

8. Develop the outcome tools for intermediate care to include health and wellbeing e.g. use of outcome stars

9. Develop tools and processes to support communication between services. Issues and risks associated with transferring of information electronically are being addressed through the Interoperability Project within East Berkshire.

10. Ensure that approaches respond appropriately to the complexity arising from the lack of co-terminosity between the CCG and the Council.

## Next Steps

A health and social care working group is to be established to develop an action plan for the implementation of the strategy. Ongoing implementation will be monitored through the Intermediate Care Partnership Board.

## Glossary

| | |
|---|---|
| Accident and Emergency | Accident and Emergency departments treat people who have had a serious injury or sudden illness |
| Acute needs | Illness or medical problems that begin and progress rapidly, sometimes causing a serious problem, that needs medical intervention. |
| Better Care Fund | A budget underpinning approaches to improve the ways health services and social care services work together, with an emphasis on preventing avoidable admissions to hospital. |
| Block Contract | An arrangement with a health service provider where a defined range of services are provided for a fixed period and are paid for by an annual fee given in instalments. |
| Brain Injury | Damage to the brain. |
| Cardiovascular Disease | Conditions that affect the heart and blood vessels. |
| Cancer | Diseases in which abnormal cells divide without control and are able to invade other tissues. |
| Care Act | A new law on how local authorities should provide information advice care and support to people and their family carers. |
| Care Home | A home where people can be cared for 24 hour a day, with or without nursing. |
| Carers | A person who provides unpaid support to a partner, family member, friend or neighbour who is ill, struggling or disabled and could not manage without this help. This is distinct from a care worker, who is paid to support people. |
| Chronic Obstructive Pulmonary Disease (COPD) | Diseases that cause the airways to become obstructed, usually permanently, so that people have difficulty breathing. |
| Circle of support | A group of people who give support to an individual, and who can contribute to identifying what is important for that person, and how they can be supported to reach their goals and outcomes. This circle may involve family, friends, paid support workers, medical practitioner etc. |
| Clinical Commissioning Group (CCG) | A Clinical Commissioning Group is group of GP practices that are working in partnership to arrange health services for the local population.<br>The Clinical Commissioning Group for Bracknell Forest is called the Bracknell Forest and Ascot Clinical Commissioning Group. |
| Clinical management | Management of medical problems. |

| | |
|---|---|
| Commissioners | A person or organisation that plans the services that are needed by the people who live in the area the organisation covers, and ensures that services are available. Your local council is the commissioner for adult social care. NHS care is commissioned separately by local clinical commissioning groups. Health and social care commissioners' often work together to make sure that the right services are in place for the local population. |
| Commissioning Strategy | A plan for developing health and social care services within the local area. |
| Community Response and Reablement Team | An intermediate care team in Bracknell Forest, targeted at adults and old people with physical illness or disability. Intermediate care is provided in the persons own home, in their local community and in bed based services. People referred into the service are assessed and wherever possible offered time limited, reablement interventions which aim to maximise independence. |
| Comprehensive Geriatric Assessment | A process that is used by a multidisciplinary team to diagnose medical problems and assess the capabilities of an older person in order to develop and implement a coordinated plan to maximise overall health and wellbeing. |
| Coterminous (coterminosity) | Having the same geographical boundaries. |
| Delayed Transfers of Care | When people are ready to return home or transfer to another form of care but are still in a hospital. |
| Dementia | A set of symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with:<br>• memory loss<br>• thinking speed<br>• mental agility<br>• language<br>• understanding<br>• judgement<br>How fast dementia progresses will depend on the individual person and what type of dementia they have. Each person is unique and will experience dementia in their own way. |
| Department of Health | The Department of Health is a part of Government that is responsible for policy and some funding for health and social care services and for improving the country's health and well-being. |
| Depression | Low mood which is so bad that it affects a person's life to the extent that they are unable to take part in the things they usually do, like work or social activities. |
| Diabetes/<br>Diabetes Mellitus | A lifelong condition that causes a person's blood sugar level to become too high**.** |
| Diagnosis | The identification of illness or other problems by examination of symptoms. |

| | |
|---|---|
| Emergency Admission | When admission to hospital is unpredictable and at short notice because the person needs health treatment immediately. |
| Fragility fractures | Bones should be able to withstand a fall from standing height, so a broken bone caused when someone falls from standing are called fragility fractures. They are often caused by a disease called osteoporosis which weakens bones. |
| General Practitioner (GP) | Doctors who provide medical care for people in the community. They diagnose and treat illness, disease and infection. |
| Geriatrician | A doctor at consultant level that specialises in the medical, social and psychological issues that concern older adults. |
| Goals | What a person wants or needs to achieve |
| Health and Wellbeing | Being in a position where you have good physical and mental health, control over your day-to-day life, good relationships, enough money, and the opportunity to take part in the activities that interest you. |
| Health and Wellbeing Boards | A forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. |
| Health and Wellbeing Strategy | A plan that sets out the priorities that commissioning organisations need to think about when developing health and social care services. |
| Health crisis | A sudden change in health. |
| Heart failure | A condition caused by the heart failing to pump enough blood around the body at the right pressure. It usually occurs because the heart muscle has become too weak or stiff to work properly. |
| Health inequalities | Preventable and unfair differences in the health of groups, populations or individuals. They are caused when social, environmental and economic circumstances are unequal which effect the risk of people getting ill, their ability to prevent sickness or their opportunities to have access to the right treatment. |
| Independence | Being able to make decisions and carry out every day activities for oneself. |
| Integrated Care Teams | A team to identify those with long term conditions or who are frail elderly, at risk of deterioration and hospital admission, and to support them to effectively manage their condition. |
| Intermediate Care | A structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in their home. |
| Integrated | Combined, co-ordinated team, system or services |
| Interoperability Project | A project to identify technology to enable systems and organisations work together. |
| Limiting long-term condition | A long term illness or disability that affects a person's ability to carry out every day activities. |
| Local Authority | An administrative body in local government. Also referred to as a council. For this strategy, the local authority is Bracknell Forest Council. |

| | |
|---|---|
| Long Term Conditions | These are health conditions for which a person needs on-going treatment, management and/or support. They include things like Diabetes, COPD. |
| Mental Health | A persons condition relating to their psychological and emotional health and wellbeing. |
| Mortality/<br>Mortality rates | A number of deaths in a particular area, with a specific cause or over a period of time. |
| Multidisciplinary | Practitioners from a different professional backgrounds e.g doctors, nurses, social workers, occupational therapists and physiotherapists working together. |
| Myocardial Infarct | A heart attack. |
| National Health Service | The system in the UK that provides healthcare to people free at the point of need and is paid for by taxes. |
| Neurological | Disorders of brain, spinal cord or nerves. |
| Neuro-rehabilitation | A process to restore lost skills as a result of disorders of the brain, spinal cord or nerves to enable people to be as independent as possible. |
| NHS Continuing Care | Ongoing care outside hospital for someone who is ill or disabled, arranged and funded by the NHS. This type of care can be provided anywhere, and can include the full cost of a place in a nursing home. It is provided when your need for day to day support is mostly due to your need for health care, rather than social care. The Government has issued guidance to the NHS on how people should be assessed for continuing health care, and who is entitled to receive it. |
| Occupational Therapist | A professional with specialist training in working with people with different types of disability or mental health needs. An OT can help you learn new skills or regain lost skills, and can arrange for aids and adaptations you need in your home. Occupational therapists are employed both by the NHS and by local councils. |
| Outcome Frameworks | The set of outcomes that all relevant organisations in the country are expected to use to set standards for their work. |
| Outcome Star | This is a tool used to work with a person to help them identify the particular goals that are important to them to achieve. This will take account of their individual lifestyles and preferences. |
| Parkinson's Disease | A condition in which part of the brain becomes progressively damaged over time mainly affecting movement but also can cause other physical and psychological symptoms. |
| Peripheral Arterial Disease | A condition in which a build-up of fatty deposits in the arteries restricts blood supply to the leg muscles. |
| Physiotherapist | Physiotherapists help ill, injured or disabled people recover movement and function as far as possible. |

| | |
|---|---|
| Pooled Budget | Pooled budgets combine funds from different organisations to purchase integrated support to achieve shared outcomes. |
| Procurement | The activities and processes required to acquire goods and services. |
| Productive | Providing services to a wide range of people with positive outcomes for the people receiving the services. |
| Providers | People and organisations that deliver health and social care. |
| Rapid Access Community Service (RACS) or Rapid Access Community Clinic (RACC) | A service to support the clinical management of the frail and elderly and to avert inappropriate hospital admissions for patients through an integrated care model. |
| Reablement | A way of helping you remain independent, by giving you the opportunity to relearn or regain some of the skills for daily living that may have been lost as a result of illness, accident or disability. It is similar to rehabilitation, which helps people recover from physical or mental illness. Your council may offer a reablement service for a limited period in your own home that includes personal care, help with activities of daily living, and practical tasks around the home. |
| Recuperation | Recovery from illness |
| Rehabilitation | A process to restore lost skills as a result of illness or injury to enable people to be as independent as possible. |
| Respiratory Illness | Diseases that affect breathing and lungs. |
| Single Assessment Framework | The means by which health and social care organisations work together to ensure that assessment and care planning are centred around the person, effective and coordinated. |
| Social Care | Care and support for people who need extra help to manage their lives and be independent - including older people, people with a disability or long-term illness, people with mental health problems, and carers. Social care includes assessment of people's needs, provision of services or allocation of funds to enable people to purchase their own care and support. It includes residential care, home care, personal assistants, day services, the provision of aids and adaptations and personal budgets. |
| Specialist Nurse | A nurse with advanced experience and expertise in a particular area of practice. |
| Stroke | A stroke happens when the blood supply to part of a brain is cut off, damaging or destroying brain cells. It can be caused by a blockage in one of the blood vessels leading to the brain or a bleed in the brain. |
| Transient Ischaemic Attack (TIA) | A temporary disruption of the blood supply to a part of the brain. It usually does not cause any lasting damage but is a warning sign that a person may go onto have a stroke. |
| Type 2 Diabetes | Diabetes where the body does not produce enough insulin to ensure it functions properly. This type of diabetes can often be controlled by medication. |

| | |
|---|---|
| Urgent Care | Treatment, management and support for health conditions that need immediate attention. |
| Whole System | All organisations involved in providing health and social care including the statutory, voluntary and private sectors. |

# REFERENCES


[1] Department of Health, Health Service Circular: Intermediate Care
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/lettersandcirculars/Healthservicecirculars/DH_4003694

[2] National Service Framework for Older People, March 2001
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

[3] Intermediate Care, Half Way Home, Department of Health
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

[4] UK Government Legislation: The Care Act 2014,
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[5] Department of Health, Better Care Fund Guidance 25th July 2014
http://www.england.nhs.uk/wp-content/uploads/2014/07/bcf-rev-plan-guid.pdf

[6] UK Government Legislation: Community Care (Delayed Discharges) Act (Qualifying Services) (England) Regulations 2003
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/DH_4067409

[7] UK Government Legislation: Health and Social Care Act 2012
http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

[8] NHS Networks: QIPP, 2014
http://www.networks.nhs.uk/nhs-networks/qipp-network/ltc

[9] NHS Benchmarking Network: National Audit of Intermediate Care 2013
http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/icsurvey/NAIC%202013/NAICNationalReport2013.pdf?bcsi_scan_78DE3714605F185F=0&bcsi_scan_filename=NAICNationalReport2013.pdf

[10] Royal College of Nursing; Guidance on safe nurse staffing levels in the UK
http://www.rcn.org.uk/__data/assets/pdf_file/0005/353237/003860.pdf

[11] Department of Health: Adult Social Care Outcomes Framework 2014/15 (2013)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/263783/adult_social_care_framework.pdf

[12] Department of Health: Public Health Outcomes Framework 2013/16 (2012)
https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

[13] Department of Health: National Health Service Outcomes Framework 2014/15 (2013) https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

[14] Bracknell Forest Council and Bracknell and Ascot Clinical Commisioning Group: Joint Health and Wellbeing Strategy 2014 http://www.bracknell-forest.gov.uk/BF-JHWS-v10-1.pdf
[15] ONS - Office for National Statistics 2014
http://www.ons.gov.uk/ons/regional-statistics/index.html

[16] Bracknell Forest Council and Bracknell and Ascot Clinical Commissioning Group: JSNA – Joint Strategic Needs Assessment http://jsna.bracknell-forest.gov.uk/

[17] Oxford Brookes University and Institute of Public Care: PANSI – Projecting Adult Needs and Service Information 2014 http://www.pansi.org.uk/

[18] Health and Social Care Information Centre: 2014 http://www.hscic.gov.uk/

[19] Oxford Brookes University, Institute of Public Care and Extra Care Charitable Trust: POPPI – Projecting Older People Population Information 2014 http://www.poppi.org.uk/

[20] Office for National Statistics: 2011 Census Data
http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html

[21] Department of Health: Long Term Conditions Compendium of Information: Third Edition 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

[22] Angela Coulter, Sue Roberts, Anna Dixion: Delivering Better Services For People with Long Term Conditions; The Kingsfund 2013
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/delivering-better-services-for-people-with-long-term-conditions.pdf

[23] Doctor Foster – Intelligence In Healthcare
https://my.drfoster.co.uk/Users/Account/Logon?ReturnUrl=%2f

[24] Department of Health: Our Health and Wellbeing Today, 2010
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215911/dh_122238.pdf

[25] Health and Social Care Information Centre: Hospital Episodes of Care 2013
http://www.hscic.gov.uk/hes

[26] Public Health England: Yorkshire and Humber Health Intelligence; Diabetes Community Health Profiles 2013 http://www.yhpho.org.uk/default.aspx?RID=8470

[27] Diabetes UK: Diabetes in the UK: Key Statistics on Diabetes 2010
http://www.diabetes.org.uk/documents/reports/diabetes_in_the_uk_2010.pdf

[28] National Institute for Health Research: Intermediate Care: A realistic Review and Conceptual Framework, Mark Pearson, Harriet Hunt, Chris Cooper, Sasha Shepperd, Ray Pawson and Rob Anderson 2013
http://www.nets.nihr.ac.uk/__data/assets/pdf_file/0016/85120/ES-10-1012-07.pdf

[29] The Kings Fund: http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/care-coordination

# Appendix 1

National Outcome Frameworks on which intermediate care will have an impact.

| Adult Social Care Outcome Framework 2014/15 | Public Health Outcome Framework 2013/16 | National Health Service Outcome Framework 2014/15 |
|---|---|---|
| OF 2 –Delaying and reducing the need for care and support.<br><br>2A Permanent admissions to residential or nursing care per 100,000 population 65 or over (Quarterly).<br><br>Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.<br><br>Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.<br><br>2B Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.<br><br>When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.<br><br>2C. Delayed transfers of care from hospital, and those which are attributable to adult social care<br><br>OF 3 - Ensuring that people have a positive experience of care and support.<br><br>People who use social care and their carers are satisfied with their experience of care and support services. | Domain 1 - Improving the wider determinants of health.<br><br>1.06ii – percentage of adults in contact with secondary mental health services who live in stable and appropriate accommodation.<br><br>1.18i – social isolation: percentage of adult social care users who have as much social contact as they would like.<br><br>Domain 2 h- Health Improvement.<br><br>2.23i – Self-reported well-being- with a low satisfaction score.<br><br>2.23ii – Self reported well-being – with a low worthwhile score.<br><br>2.23iii Self reported well-being with a low happiness score.<br><br>2.23ii Self reported well-being with a high anxiety score.<br><br>2.24 Injuries due to falls.<br><br>Domain 4 – Healthcare public health and preventing premature mortality.<br>4.11 Emergency readmissions within 30 days of discharge from hospital. | Domain 2 - Enhancing Quality of life for people with long term conditions.<br><br>2 Health related quality of life for people with long term conditions.<br><br>2.1 Ensuring people feel supported to manage their conditions.<br><br>2.3 Reducing time spent in hospital by people with long-term conditions.<br><br>2.5 Enhancing quality of life for people with dementia.<br><br>Domain 3 - Helping people to recover from episodes of ill health or following injury.<br><br>3.1a Emergency admissions for acute conditions that should not usually require hospital admissions.<br><br>3.1b Emergency readmissions within 30 days of discharge from hospital.<br><br>3.3 Improving recovery from injuries and trauma.<br><br>3.4 Improving recovery from stroke.<br><br>3.5 Improving recovery from fragility fractures.<br>3.6 Helping older people to recover their independence after illness or injury. |

| Adult Social Care Outcome Framework 2014/15 | Public Health Outcome Framework 2013/16 | National Health Service Outcome Framework 2014/15 |
|---|---|---|
| 3A. Overall satisfaction of people who use services with their care and support<br><br>3B. Overall satisfaction of carers with social services<br><br>Carers feel that they are respected as equal partners throughout the care process.<br><br>3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for<br><br>People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.<br><br>3D. The proportion of people who use services and carers who find it easy to find information about support<br><br>People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual. | 4.12 Hip fractures in older people. | Domain 4 – Ensuring people have a positive experience of care and support.<br><br>4.6 Improving the experience of care for people at the end of their lives.<br><br>4.9 Improving peoples experience of integrated care. |

# Appendix 2

## Current Intermediate Care Provision

There are a range of services within Bracknell Forest that can deliver or support intermediate care functions. These services are mapped below  with the core services being the Community Response and Reablement Team and the Bridgewelll Centre.

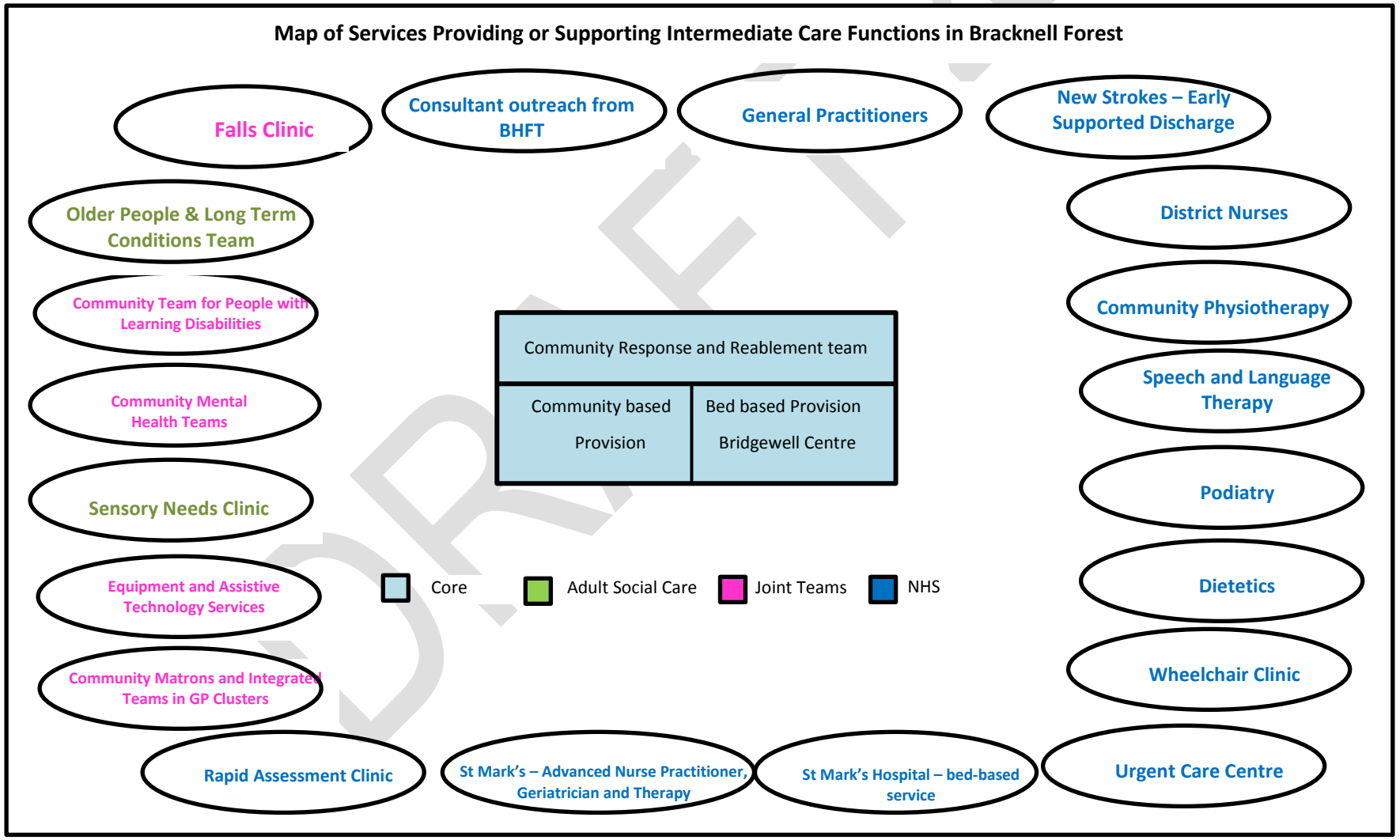



Figure 1

## *Community Response and Reablement Team*

The Community Response and Reablement Team, hosted by Bracknell Forest Council, is an integrated health and social care team funded by Ascot and Bracknell CCG and Bracknell Forest Council through a pooled budget agreement. The team is primarily targeted at adults and old people with physical illness or disability. Referrals are triaged at a single point of access into council based services for older people and people with long term conditions. People referred into the service are assessed and wherever possible offered time limited, reablement interventions which aim to maximise independence.

The team that assesses and provides services within the community, based around people's home environment is located in Time Square Bracknell and consists of health and social care practitioners. The community based service was enhanced to enable services to respond within two hours and to provide end of life care in October 2010. Bed based intermediate care is provided in The Bridgewell Centre, a registered care unit with a manager, domestic staff, support workers, occupational therapists, physiotherapists, nursing (nursing is provided through a contract with BHFT) and GP support. People with unstable or complex medical problems that need 24 hour nursing support or specialist medical support go to the community hospitals.. The Bridgewell Centre originally had 19 beds but this was expanded to 26 in 2012 to support the needs of people with dementia and care at the end of life.

The Community Response and Reablement Team operates 7 days a week with out of hours intermediate care managed by the Emergency Duty Service. The team provides an in-reach service to work proactively with the 3 acute trusts within the area, to support timely discharge. The service can respond to urgent crises within two hours to prevent unnecessary admission and this is operated through the duty therapy, social work and nursing teams.

The service aims to

- Provide a seamless, coordinated health and social care experience for the individual
- Promote faster recovery from illness, prevent unnecessary acute hospital admissions, support for timely discharge and maximises independent living
- Improve the health and wellbeing, confidence, quality of life and functional abilities of people so that they can stay at home or return home following hospitalisation or a health crisis at home
- Provided tailored individual support with on-going re assessment throughout the period of intermediate care.

Figure 2, below shows that the demand for Community Response and Reablement has increased over the past 3 years and during 2013/2014, 1,552 people were assessed by the service, of which there were 189 admissions to Bridgewell. However, the numbers of people accessing the Bridgewell Centre has reduced since March 2014 as a result of properly implementing the criteria for admission and processes to ensure that the unit operates at a safe level. Figure 3 shows that the majority of people were referred to the service to maximise independence and or to ensure safety within the community (57.44%), followed by facilitating timely hospital discharge (31.44%). Figure 4 shows where people were on discharge from the service. The majority were at home with 55.95% not requiring support

and 27.84% with support. The overall demand for intermediate care is set to continue increasing with the new duties in the Care Act and it is important that there is a sustainable model for intermediate care for the future.

## Total Number of Referrals to Intermediate Care Services Between April 2010 and March 2014 with Trend Line

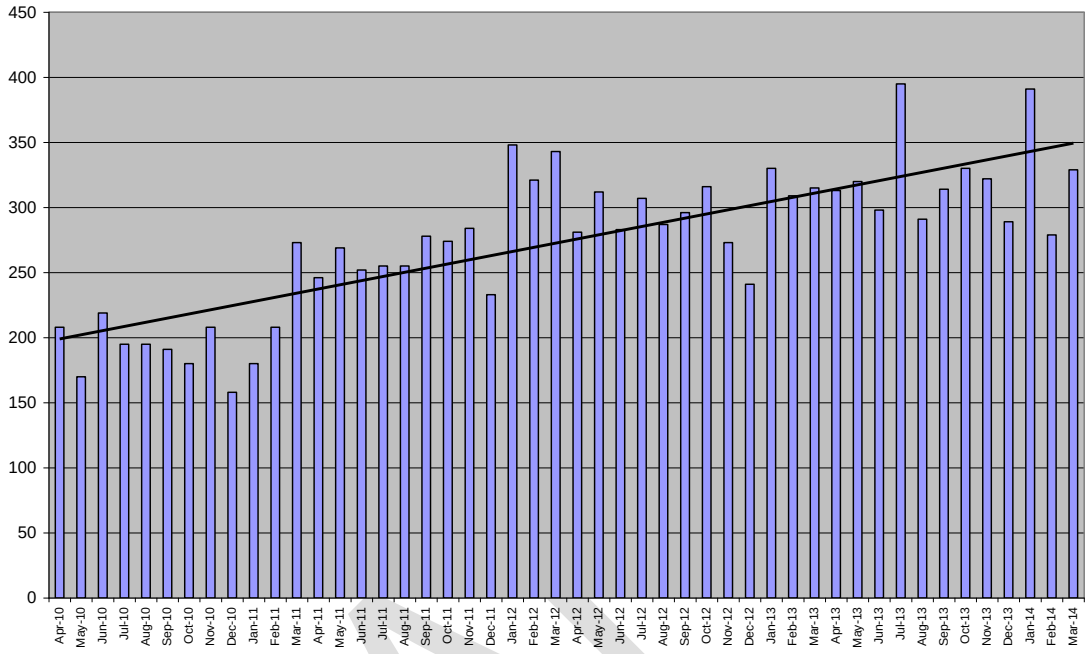



Figure 2

## Reason for Referral to Intermediate Care Services 2013/2014

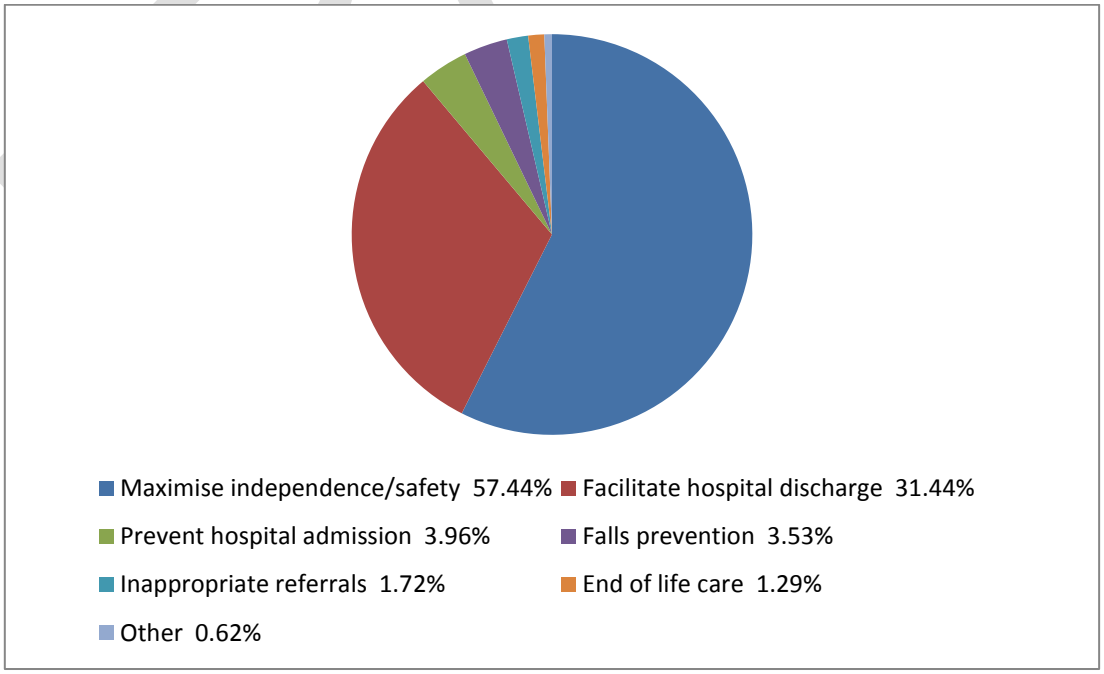



Figure 3

## Intermediate Care Service Discharge Destination 2013/2014

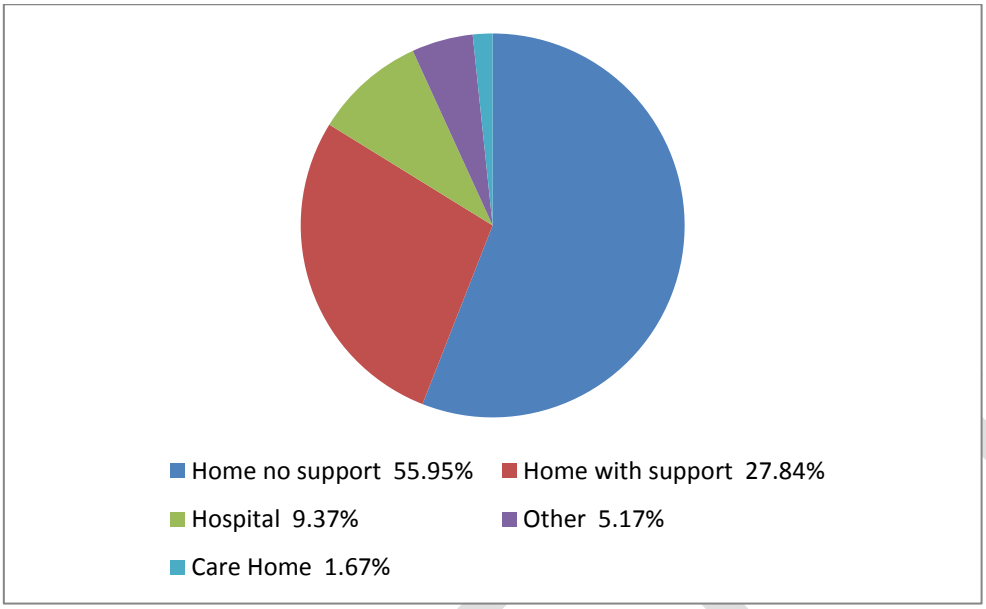



Figure 4

## *Intermediate Care Functions as Part of Whole System*

There is programme of development within council based services to review the structure and processes within the Older People and Long Term Conditions Services (including intermediate care) to enable it to fulfil all the duties within the Care Act[4]. These council services also need to align with Integrated Care Teams, which were set up in April 2013 to identify those with long term conditions or are frail elderly, at risk deterioration and hospital admission and supporting them to effectively manage their condition. The Integrated Care Teams are led by community matrons work in partnership with primary care, two councils and community health providers (Berkshire Health Foundation Trust) and delivered around the three GP clusters, Bracknell North, Bracknell South and Ascot. First year data shows that 129 people were seen between 1st April 2013 and 31st March 2014. It is anticipated that the referrals to the Integrated Care Teams and potentially, intermediate care will increase with GPs reviewing the top 2% patients at risk of avoidable admission.

Intermediate care and Integrated Care Teams are primarily supported medically by GPs, although there is some limited support from a community based consultant geriatrician but this is not formalised. Relying on GPs was raised as a concern in the National Intermediate Care Audit, 2013[9] as community based intermediate care services are often supporting people with unstable and complex medical needs who need geriatrician intervention. As well as this, the report identifies the need for geriatrician support to be developed widen the use of the comprehensive geriatric assessment which is known to reduce mortality, institutionalisation and hospital admission.

At present Bracknell Forest has access to a Rapid Assessment Community Service (RACS) and a Community Health Clinic at St Marks Hospital. The aim of the RACS is to support the clinical management of the frail and elderly and to avert inappropriate hospital admission for patients through an integrated care model. It delivers rapid assessment and treatment for

older people with complex health and social care needs in times of mild to moderate health deterioration in the community. The RACS supports intermediate care functions such as the falls prevention and intervention. The RACS is co-located with the Community Health Clinic, which offers routine/non urgent multi-disciplinary assessment and rehabilitation for older people including specialist comprehensive geriatric assessments and treatment programmes aimed at promoting and maintaining independence. Clinics include falls, stroke, leg ulcer and heart failure programmes. However there are fewer referrals for people in the Bracknell Forest area than those from Windsor and Maidenhead, suggesting that if services were delivered locally within Bracknell Forest, these services would be utilised further. Work is underway to implement a RACS within Bracknell Forest and whilst there is some space to run clinics with diagnostics within the Health Space, there are limited affordable facilities to fully implement it. Equally, currently there are insufficient, affordable facilities to consider the development of clinic based services which have an integrated, intermediate care focus – ways in which to develop these facilities are being explored.

There is currently a consultant led falls clinic, based at the Bridgewell Centre with support from occupational therapist and physiotherapist from the intermediate care service. The clinic is being moved to the health space but there is insufficient space within this area to provide rehabilitation and reablement. Work is currently being undertaken to look at the whole of the falls pathway from prevention through to those needing specialist care and the development of the RACS is a key part of this. Many of the aspects of the falls pathway work are around intermediate care functions and the model used can be reflected in intermediate care. As well as this, a major part of intermediate care work is supporting people who have mobility problems or have fallen.

Learning disability and Mental Health Teams already operate as integrated teams, with an enabling approach to their work. People with learning disabilities and or mental health problems are able to access Community Response and Reablement if they have a physical illness or long term condition. However there is scope for intermediate care to be developed within the Community Mental Health Teams to support people whose primary problem is a mental health condition, e.g. dementia, or other medical conditions which reduces their independence, health and wellbeing. This will enable the development services along a clear route, reducing the need for people to receive a range of services and simplify communication channels. Many people with long-term physical health conditions also have mental health problems and a Kings Fund report (2012)[1] states that these can lead to significantly poorer health outcomes, making physical illness worse and reduced quality of life. Therefore the development of expertise in identification of mental health issues and intervention in intermediate care would be of benefit to people who use the service. As well as this total health care costs can increase by at least 45 per cent for each person with a long-term condition and mental health problem.

There is a specialist early supported discharge service for people who have had a stroke and people can be referred to intermediate care for further rehabilitation if necessary. The intermediate care team does provide services to people with other neurological conditions and their role needs to be considered as part of the neurological pathways of care, to support people with brain injuries from stroke or accident and progressive neurological conditions such as multiple sclerosis and Parkinson's disease.

Bracknell and Ascot CCG commission beds from St Marks Community Hospital in Maidenhead and Upton Community Hospital in Slough under a block contract with Berkshire

[1] The Kings Fund, Chris Naylor, Amy Galea, Michael Parsonage, David McDaid, Martin Knapp, Matt Fossey: Long Term Conditions and Mental Health http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health

Healthcare NHS foundation Trust for people who have higher complexity of medical need than can be managed within the Bridgewell Centre as there is 24 hour nursing support. 12 people were admitted to community based beds between 1st June – 26th August 2014. Options for delivery of future bed based intermediate care services need to be reviewed to meet future demands, with an increasing older population.

Safeguarding, Mental Capacity Act 2007 and the Deprivation of Liberty Safeguard processes can be used to ensure that people's rights are protected, so that they are not detained unlawfully by the state and they have a right to a family and private life, especially if the person concerned does not have capacity to make the decision for themselves. These processes can be used to ensure that people do not go into residential care unnecessarily from acute hospitals and can evoke intermediate care processes.

Potential carers are identified during the intermediate care process, but they are often not assessed until the person they care for is near end of the intermediate care process or when the person they care for has a long term support package. In order to find out if carers wish to continue in their caring role and have support in a timely way, it is important that they are assessed at the beginning of the process.

Finally, there are a number of single profession service such as specialist nurses, district nurses and dietitians that support intermediate care. Commissioners and providers of services identified that intermediate care needs to draw upon and support the wider health and social care system to effectively support people who need reablement.