

SHEFFIELD PRIMARY CARE TRUST

Intermediate Care

Board Meeting

6 May 2008

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Purpose of Paper	
This paper sets out the vision and direction for the re-provision of intermediate care services for Sheffield.	
Key Messages (Maximum 5)	
<p>Outlines the current position, the case for change and the proposed model for the re-provision of intermediate care services.</p> <p>Sets out the case for the provision of care in the patient's own home and in a new build community facility to avoid inappropriate admission to hospital and early discharge for hospital.</p> <p>The work with our partners and stakeholders to deliver choice, quality of care, equity of access and cost effectiveness in the context of intermediate care for the people of Sheffield.</p>	
Strategic/Performance implications including links to Achieving Balanced Health	
This paper sets out the PCT's response to the requirements outlined in Achieving Balanced Health (pages 146-148), and the PCT Commissioning Intentions 2008/09 (page19).	
Resource Implications (including Revenue, Capital, Staffing etc.)	
<p>Work has been undertaken to understand specifically how much money is currently spent by the PCT on intermediate care services.</p> <p>Further detailed work is required to understand the financial implications of changing the model of care, the re-provision of services and the cost of a new build community facility.</p>	
Links to Targets e.g. ALE, SfBH, NHSLA, IG Toolkit, Business Plan and BAF	
<p>Progress will be monitored via the business plan:</p> <p>6.5 identify and deliver appropriate services as part of the PCT strategic approach to</p>	

intermediate care/older people's services.

Key referencing to the Board Assurance Framework -1,2,3: Standards for Better Health - 7,2,2: The Risk Register – 473,476,480

Associated Risks to the PCT

The principle risk to the PCT is not having the ability to respond swiftly and effectively to deliver a new model of intermediate care services.

The re-provision of services to enable more people with higher levels of need, to remain in their own home and the re-provision of the bed based service will present a range of risks and requires firm risk management /escalation plans to be in place.

Consultation Requirements

Older people, carers representatives, voluntary, faith and community sectors, staff groups from Sheffield Primary Care Trust (SPCT), Sheffield City Council (SCC), Sheffield Care Trust (SCT) and Sheffield Teaching Hospitals Foundation Trust (STHFT) have worked with the SPCT Strategy Directorate and the Sheffield City Council in the development of the Intermediate Care Pathway.

- Over 300 people have been engaged in this process
- Early discussions with the NHS Yorkshire and Humber (YHSHA) and engagement with its Services Assurance Process to ensure this work and it's proposals are "fit for purpose"
- There will be a need to undertake a formal three months consultation in due course

Equality/Diversity Impact

The baseline review of present intermediate care services will aim to address inequalities in accessing intermediate care particularly in relation to deprivation, ethnicity and disability.

An Equalities Impact Assessment will be completed.

Recommendations

The Board is asked to comment on and approve the progress made and recommendations of the re-provision of an integrated model of intermediate healthcare service for unwell older people to optimise recovery to independent living.

SHEFFIELD PRIMARY CARE TRUST**Intermediate Care****Board Meeting****6 May 2008****Executive Summary****A. What is the problem?**

The current Intermediate Care (IC) structure and processes have been developed in many small stages and have been affected by changes in the structure of the providing organisations. Since 2001, Sheffield's primary health service was divided into four PCTs and subsequently merged into the current Sheffield PCT. The division into four PCTs caused the split of community services devolved to the geographic areas of each PCT.

The problematic outcomes associated with the development of IC and frail older people services in Sheffield are¹:

- Above average length of stay in medical and surgical specialties compared to national benchmarks
- Large excess bed day payments from PCT to the Acute Trust due to delays in care
- Socially delayed transfers of care.
- Care Homes with nursing occupancy by frail older people in Sheffield is approaching double the National average rate.
- The majority of people entering permanent care, in Sheffield, do so by transferring from an acute hospital bed.

The problems defined by staff are:

- Fragmentation / Complexity of Intermediate Care Services
- Communication issues
- Delay / impaired flow
- Clinical Governance issues
- Workforce Problems
- 'Gaps' in service

Professionals agree, having undertaken an options appraisal process, that the current service could be more effective.

¹ Pathways for Intermediate Care in Sheffield, Report recommendations, Dr Tom Downes, 2008

B. What is the solution?

In September 2007, it was recognised that Sheffield could do better in the delivery of IC services. The Sheffield Chief Officers Group asked for a future model of Intermediate Care to be produced within 6 months that all parties would sign up to deliver. Our ambition and the outcomes of the work commissioned, recommends the re-provision of an intermediate care service that is:

- Patient centred and offers choice
- Promotes faster recovery from illness
- Prevents unnecessary acute hospital admissions
- Supports timely discharge
- Maximise independent living

The report commissioned by the PCT, author Dr Tom Downes (Consultant Geriatrician, from Sheffield Teaching Hospitals Foundation Trust)² describes an integrated model of Intermediate Health Care for unwell older people to optimise recovery and independent living with no age discrimination, addressing service areas of:

- Care at home
- Care in a community facility
- Care in hospital

References are made in the report that:

- The Local Authority need to achieve timely social assessment and improved access to support services and technology to facilitated independent living
- There is a need for a new build community facility to provide specialist older people's care

C. Challenges

Organisational

- Sequencing next steps related to present services and future model (transition)

Beds

- Redefining intermediate care (IC) health beds as not chargeable, with a clear distinction between health beds and social care beds that are chargeable

Impacts

- Impact on current health and social care services and the workforce across the city

Clinical/Current Provision

- Further development of the Single point of access
- Dual role of health worker providing social care within IC
- Mental Health care integration within mainstream IC

Financial

- Further detailed work is required to understand the financial implications of changing the model of care, the re-provision of services and the cost of a new build community facility

² Pathways for Intermediate Care in Sheffield, Report recommendations, Dr Tom Downes, 2008

D. Mechanism to put things right

It is neither appropriate nor feasible to implement all the priorities in a short timescale and therefore the proposed action plan will be over a phased period of three years. The key priorities are proposed for 2008/09.

- The adoption of a Programme Management approach to achieve transformational change
- The appointment of a Programme Lead with clear governance arrangements
- The appropriate level of clinical advice and support to implement the new model
- The development of the service specification June 2008 and implementation from September 2008 for 2008/09
- Work with PCT provider service in 2008/09 to begin the transformation of the community workforce in line with the recommendations
- A three month public consultation period following board approval
- The development of a detailed three year programme plan April 2009/12 that will include a procurement plan for the new model of service

Intermediate Care in Sheffield

1 Introduction

This paper sets out the vision and direction for the re-provision of intermediate care services for Sheffield, outlining the current position, the case for change and the proposed model of re-provision. It sets out a model for a quality service to support people at home to receive their care in the first instance in their own home and secondly in a new build community facility, supporting people to get home from hospital (step down care) and step up care to avoid inappropriate admission to hospital.

This work has been undertaken jointly by the Sheffield PCT and the Sheffield City Council, with the full engagement of the following groups; older people; carer's representatives; voluntary, faith and community sectors; and staff groups from Sheffield Primary Care Trust (SPCT), Sheffield City Council (SCC), Sheffield Care Trust (SCT) and Sheffield Teaching Hospital Foundation Trust (STHFT).

Importantly, working with our partners and all stakeholders to deliver choice, quality of care, equity of access and a cost effective intermediate care service.

It also sets out the key definitions and principles of the service before describing the important components of the services.

2 Current Service Provision

“Intermediate care is defined as, a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living – is a vital component of the programme to improve the health and well being of older people and raise the quality of services they receive. Properly developed and implemented it will enhance appropriateness and quality care for individuals but will also have a significant impact on the health and social care systems as a whole by making more effective use of capacity and establishing new ways of working”³

Intermediate Care describes a range of services with the following aims:

- To provide care in or near people's own homes such that admission to hospital can be avoided
- To provide short term rehabilitation, including nursing and therapy, to enable people to fully recover following hospital treatment, so that they can regain their independence and prevent premature need for ongoing social and health care, including placement in care homes. No-one should be placed in long term residential care without having the opportunity for rehabilitation
- To facilitate early discharge from hospital or residential care settings, as part of the pathway home

³ Intermediate Care: Moving Forward , DH, 2002

2.1 Current Services

There are a wide range of services within Sheffield that are described as intermediate care.

These include:

Community Based Services	Commissioner
Rapid Response Team	PCT, Partnerships for Older People Project (POPPS)
Community Stroke Team	PCT
Community Therapy Team	PCT
N&CC Offsite Intermediate Care Teams (HOSICT)	SCC
Assessment and Integrated Care Teams (AICS)	Pooled Budget
Extended AICS	PCT (in STHT contract)
Early Discharge Team	PCT
Hospital Discharge Liaison Team	PCT (in STHT contract)
Short Term Intensive Team support (STIT)	SCC
Bed-based Services	Commissioner
Beech Hill – 24 Nursed beds	PCT
Jasmin Court - 20 nursed beds	PCT
Heeley Bank - 14 Nursed Beds	PCT
Ravenscroft from February 2008 14 beds (Relocated beds from Tannery Lodge Resource Centre)	SCC, with contribution from PCT
Sevenfields Resource Centre – 17 IC beds - 3 flexi /interim beds	SCC, with contribution from PCT
Hazlehurst Resource Centre – 13 IC beds - 8 flex/ interim care	SCC, with contribution from PCT
Pexton Grange (formally Gleneagles) -19 IC beds -12 EMI IC beds from April	PCT
Grenoside Hospital 13 IC Dementia beds	PCT

Resource centres also include respite care beds and longer term residential care beds.

There are a total of 157 beds that cover Intermediate Care and Interim Care which provide care for frail elderly and older people with a mental illness within Sheffield.

2.2 Need

Over 65y Age group:

This age group is entering the phase of life with rapidly increasing morbidity and mortality. The Balance of Care study⁴ demonstrated that over 75% of acute adult hospital beds were occupied by patients over 65 years of age in Sheffield. Despite the decrease in absolute number of people aged over 65y the demand for acute medical admission increased by 3-5% per year between 2000 and 2005. Over the next 20 years there is a predicted growth of this age group by over 25%. With this predicted increase in population, demand for service is likely to continue to increase unless other change occurs such as effective preventative care and effective management of long term conditions.

Over 85y Age group:

This age group has a very high demand for both health and social care. Currently there are approximately 11,600 people aged over 85 in Sheffield. This is predicted to increase by over 40% in the next 20 years to 16,300. The demand for health and social care is therefore expected to rise rapidly over the next few years. Services will need to be able to respond to these changes which for organisations as large as the NHS and Local Authorities are relatively short timescales.

There are several indicators of a greater need for intermediate care currently, including:

- The “Balance of Care”⁵ audit of people in hospital beds that demonstrated a large number who could be cared for outside of hospital
- The number of discharges from hospital that are currently delayed and the number of Excess Bed days
- The number of admissions to hospital considered to be avoidable.

2.3 Performance of Current Services

Some intermediate care services, perhaps particularly those delivered in patient’s own homes such as the SCC funded short-term intervention service and the PCT/POPPS funded rapid response service, are well received and considered to be effective. However, services across Sheffield are not currently consistent, as services developed differently in the four predecessor PCTs. The wide range of services, some with different access criteria, creates a fragmented service. The distinctions between nursed intermediate care beds, resource centre beds and interim care are not always well understood. Professionals agree, having undertaken an options appraisal process, that the current service could be more effective.

There is evidence that people with mental health needs in addition to physical health problems could have their needs better met.

⁴ The “Balance of Care Project, Tom Bowen, Dr Chris Foote, Paul Forte, The Balance of Care Group, 2005

⁵ The “Balance of Care Project, Tom Bowen, Dr Chris Foote, Paul Forte, The Balance of Care Group, 2005

The recent intermediate care bed audit showed that both admission and discharge from intermediate care beds could be more timely and effective.

3 What do we want?

A service based on defined outcomes and objectives that:

- Patient centred and offers choice
- Promote faster recovery from illness
- Prevent unnecessary acute hospital admissions
- Support timely discharge
- Maximise independent living

Services should:

- Be targeted at people who would otherwise face unnecessarily long hospital stays or avoidable admission to acute in-patient care, long-term residential care or continuing NHS care
- Be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active treatment and rehabilitation
- Be designed to maximise independence and to enable patients/users to remain or resume living at home
- Involve short term interventions, typically lasting no more than six weeks and frequently as little as 1-2 weeks
- Involve cross-professional working, within the framework of the single assessment process, a single professional record and shared protocols⁶

4 The Case for Change:

4.1 National Policy Context

A number of government initiatives and policies have set out the direction for PCT commissioning of services within the NHS and also for the measurement of the quality of these services. These include among others: “Commissioning a patient led NHS”⁷, “Standards for Better Health”⁸, “Payment by Results”⁹, Our Health, Our Care, Our Say¹⁰, Our NHS, Our Future led by Lord Darzi¹¹ and the 2008/09 Operating Framework¹².

When viewed together these point to the PCT as commissioners of services being held accountable for quality service commissioned to meets the needs of their population and therefore for the need to develop robust service specifications and contracting mechanisms to provide the necessary assurance of the quality of all the services procured.

⁶ Pathways for Intermediate Care in Sheffield , Report of recommendations, Dr Tom Downes, March 2008

⁷ Commissioning a Patient Led NHS , DH 2005

⁸ Standards for Better Health, DH 2004

⁹ Payment by Results Guidance 20007/08, DH 2006

¹⁰ Our Health, Our Care, Our Say, DH 2006

¹¹ Our NHS, Our Future led by Lord Darzi 2008

¹² 2008/09 Operating Framework DH 2008

The Healthcare Commission has indicated that over the next few years it will be stepping up the level of responsibility it places upon PCT's as commissioning bodies with regard to the quality of all commissioned services. This is a responsibility and approach requiring a significant change in culture and capacity management whilst ensuring critical components of quality services are delivered.

The focus is on developing world-class commissioning as a key agent for change on behalf of patients and the public, using the full range of levers and incentives to transform services and improve outcomes.

4.2 Local Policy Context

The Sheffield context is provided in "Achieving Balanced Health –The Way Forward", as we seek within the commissioning of a quality Intermediate Care Service to address the key outcomes of "new forms of health services developed which are more responsive and flexible to people's needs and enable people to remain in their own home where every possible and with fewer admissions to hospital"¹³.

4.2.1 The PCT has made a further commitment within the PCT Commissioning Intentions 2008/09 (page19) to jointly work with partners to "develop a clear statement of requirements for intermediate care services, including specifications and performance measures, and will then work with provider organisations to plan service change to establish more effective services to enable more people to benefit from rehabilitation and avoid admission to hospital.

4.2.2 Previous Board Papers

A joint paper on behalf of the PCT and SCC "Commissioning Intermediate Care" was presented to the PCT Board meeting in November 2007¹⁴. The recommendations approved were to review current services and consider options for securing delivery of the specific service, including discussions with current service providers by the end of March. The outcomes of this work are outlined in the section 4.2.3 below and the full report to which this refers.

4.2.3 The report commissioned by the PCT from Dr Tom Downes (Consultant Geriatrician, Sheffield Teaching Hospitals Foundation Trust)¹⁵ describes an integrated model of Intermediate Health Care for unwell older people to optimise recovery to independent living, addressing service areas of;

- Care at home
- Care in a Community Facility
- Care in hospital

Further references are made to the need for the Local Authority to achieve timely social assessment and improved access to support services and technology to facilitate independent living.

4.2.4 Sheffield (stakeholder's views)

¹³ Achieving Balanced Health – The Way Forward SPCT, 2007

¹⁴ SPCT and SCC Commissioning Intermediate Care Board, Tim Furness & Simon Kirk, Nov 2007

¹⁵ Pathways for Intermediate Care in Sheffield, Report recommendations, Dr Tom Downes, 2008

Involving the public in designing our services¹⁶

- Older people and carers in a number of settings

Staff groups from:

- Sheffield Primary Care Trust (SPCT),
- Sheffield City Council (SCC),
- Sheffield Care Trust (SCT)
- Sheffield Teaching Hospital Foundation Trust (STHFT)
- Representatives and voluntary, faith and community sectors,

The above groups have worked with the PCT Strategy Directorate and Sheffield City Council in the development of the Intermediate Care Pathway that has informed this report and will inform the specification.

The overall preferred option on the basis of nine staff options appraisal sessions was “deliver care at home” in the first instance and secondly decommissioning of current beds and commission a new build community facility.

We heard the clear message from users and carers that care should be delivered close to home whenever possible¹⁷.

5. What will it look like

5.1 Aims and Objectives

To provide care in or as near to people’s own home; maximising care at home and minimising the need for hospitalisation.

To provide short term rehabilitation, including nursing and therapy, to enable people to fully recover from an acute episode (step up care) or following hospital treatment (steps down care). To enable patient’s to regain their independence and prevent a premature need for ongoing social and health care, including placement in care homes.

No-one should be placed in long term residential care without having the opportunity for rehabilitation

To facilitate early discharge from hospital or a community facility, as part of the pathway home

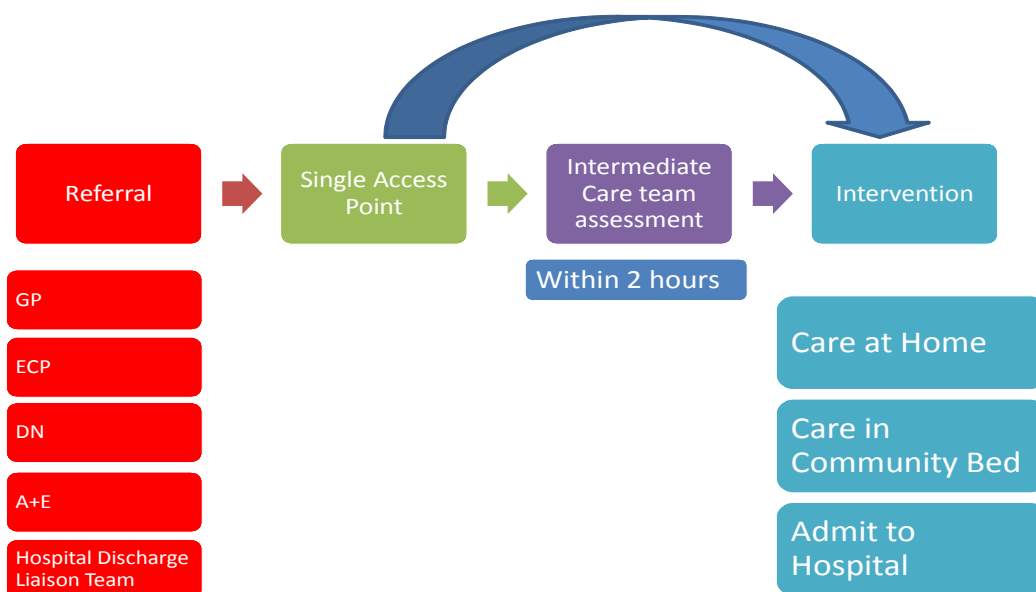
5.2 The principles of:

- Patient centred health and social care
- Improved choices and outcomes for older people
- Partnership working of IC multidisciplinary teams
- Meeting the needs of people with non complex mental health problems, short term neurological conditions and people with learning disabilities (where appropriate)
- Ensuring the patient’s stay in intermediate care is managed so that outcomes are achieved within the target of 21days for most patients, 28 days for stroke patients
- Ensuring the right staff skill mix are available, including medical cover
- Efficient and effective use of resources

¹⁶ Achieving Balanced Health –The Way Forward, Sheffield Primary Care Trust, 2007

¹⁷ Pathways for Intermediate Care in Sheffield, Report recommendations, Dr Tom Downes, 2008

The Recommended Care Pathway



Figure

1

The Principles and Components of the service model will provide:

- Care in the persons own home by a multi-disciplinary intermediate care team
- A single point of access
- Medical responsibility for patients cared for in their own home will remain with their own GP
- The principle will be the referral is accepted to ensure the most appropriate response for the individual needs of the patient (no handoff)
- Respond within two hours for an assessment in the patients own home¹⁸
- Access to additional community support services/IC day hospitals

Offering:

- A one-stop Comprehensive Geriatric Assessment
- Specialist falls prevention assessment and falls programme
- Day rehabilitation for patients who can be supported at home but have more complex / group rehabilitation needs

Getting home and the use of a temporary home-from-home (community facility) to optimise their return to independent living and minimise rate of admission to care homes

- A critical mass of community health beds (approximately 120)
- Access to a comprehensive geriatric assessment and diagnostics
- Short term rehabilitation
- Facilitated discharge from hospital

¹⁸ Please note in the patient's own home refers to; their property and those who may be in permanent care and it is considered to be their own home

6. Monitoring

A number of high level indicators have been identified below, to measure the impact of the new service model and to performance manage the resources to deliver this new service.

- Total number of non elective admissions 70+
Rationale: Improved performance as a result of reconfiguration of the IC teams providing intensive support to be cared for in their home (admissions avoidance)
- Total number of non elective admissions 70+
Rationale: Substantial reduction in beds days due to the proactive management of people within STHFT through improved intermediate care and discharge planning (reduction in delayed discharges)
- Number of excess beds days funded by the Sheffield PCT
Rationale: Improved pathways in key areas of Stroke and Orthogeriatric to ensure potentially timely discharge to IC care at home or a community facility
- Admissions to care homes
Rationale: Seek to reduce admissions to care homes through a strategy of no admission direct from an acute bed into a care home, further intensive home support, extra care housing, use of telecare and other equipment, including the provision of longer term social care assessment beds.

Further work will be required to ensure the service is responsive to patient; need and experience, accurate assessment and assurance of quality patient care.

6.1 High Quality of services

Commissioners will ensure that all these elements of quality are present in each part of the service procured.

Services should consistently:

- Meet all national requirements including access
- Use clinical evidenced based practice
- Deliver high levels of patient experience
- Meet the standards set out in the core standards of Standards for Better Health¹⁹
- Demonstrate continuous quality improvement engaging with the workforce in developing services further to meet future population needs
- Ensure all organisations whether in secondary care, primary care, the independent sector or voluntary sector providing a specific service, deliver the service to the same schedule as any other provider delivering that service.

6.2 Information Systems

Robust information systems that will enable the commissioners to manage the performance of the service against stated requirements.

Key primary information flows are needed to support the process, each with a different timescale.

- National target /performance monitoring or audit information, required by commissioners monthly

¹⁹ Standards for Better Health, DH, 2004

- Provider routine activity data collection: - required by commissioners quarterly
- Provider local or regional service audit data: - required annually by the commissioners
- Annual Service Declaration and spot check reviews

7. Recommendations

The Board is asked to comment on and approve the proposed re-provision of intermediate care services for Sheffield.

Paper prepared by Margaret Gibson
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On behalf of Simon Kirk
Director of Strategy

28 April 2008