

# Pathways for Intermediate Care in Sheffield

Report of recommendations

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## **Executive Summary**

### **1.1 Summary**

The current Intermediate Care service in Sheffield is not providing the city with the outcomes that are required. This document records the results of a 3 month secondment by Dr Tom Downes, Consultant Geriatrician, to Sheffield PCT from January to March 2008. The purpose of the secondment was to evidence and recommend care pathways for a future model of Intermediate Care in Sheffield.

### **1.2 Methodology**

The process undertaken to define these recommendations consisted of:

- Literature review of research evidence, local policy and context of national policy
- External visits to the Intermediate Care services of four UK cities; Nottingham, Birmingham, Bristol and Leeds
- Engagement with staff in Sheffield involved with Intermediate Care to define problems with the current service from a citywide multi-disciplinary perspective
- Option appraisal sessions with staff groups to define preferred options on selected aspects of a future potential service structure
- Engagement with more than 300 staff, users and carers of the Intermediate Care service including representation from charity, voluntary and ethnic minority sectors.

### **1.3 Results**

The engagement with staff groups provided a large pool of information from which consistent themes emerged to define the problems with the current Intermediate Care service. The themes were;

- Fragmentation and over complexity
- Poor Communication
- Delays and impaired flow of pathways
- Safety issues Eg. Infection control, medicines management
- Workforce problems

- Gaps in the service

The external visits confirmed that Sheffield's Intermediate Care service is different from other areas. We observed consistent elements of Intermediate Care successfully delivering favourable outcomes during the visits to other UK cities. We observed that Intermediate Care needs to be developed and delivered locally. Therefore, the recommendations are evidenced by a combination of observations, that we consider applicable to Sheffield, selected from all four cities visited.

The options appraisal work with staff groups clarified that there is citywide agreement of the need for a new community bed based service delivering specialised rehabilitation. The preferred option to achieve this was a new single site community facility.

Engagement with users and carers evidenced the need to deliver care at home whenever possible. When not possible the preference was for specialised rather than generic care, acknowledging the potential need to travel further from home.

#### 1.4 **Recommendations**

All the following recommendations are evidenced by current practice we have observed in the UK.

The key recommendations are:

- To commission an inclusive integrated needs based model of Intermediate Care. This will care for unwell older people to optimise recovery and independent living.
- To achieve the principle aim to deliver care at home whenever possible.
- The team delivering care in patients' own homes should be a single citywide service split geographically in two (North and South), co-ordinated from two hubs.
- To commission and provide, within health, a pool of dual skilled workers to deliver home care and therapy assistant input to patients receiving Intermediate Care at home.
- For Local Authority to achieve timely social assessment and improved access to supporting services and technology which facilitate independent living
- To commission a new community facility to provide specialist older people's care. The facility should have at least 120 beds and a future proof design to allow expansion. The bed base should deliver

specialised care including stroke, orthogeriatric and geriatric rehabilitation.

- The facility should have a day hospital, community diagnostic services and provide the hub for co-ordinating care in patients' own homes in the south of the city.
- To decommission the current Intermediate Care bed based services and the Assessment and Rehabilitation Centre.
- To consider the co-location and development of other health and social care services with the community facility.