DERBYSHIRE COUNTY COUNCIL

SOCIAL CARE & HEALTH IMPROVEMENT AND SCRUTINY COMMITTEE

INTERMEDIATE CARE SERVICES IN DERBYSHIRE

A health overview and scrutiny review

Review Report

January 2005

DERBYSHIRE County Council
Improving life for local people

FOREWORD

We have found undertaking the Intermediate Care Services review to be an interesting and enjoyable experience.

We have welcomed the spirit of co-operation amongst the health and social care communities in undertaking this review. We are also grateful for the support of the Derbyshire Patient and Public Involvement Forums during the review process.

The Committee wishes to sincerely thank all those many people who gave their time and effort to assist this scrutiny review.

The Committee is very impressed with the enthusiasm and dedication of those we met and who have made the intermediate care service develop so rapidly. We were very impressed with the progress that has been made in a short time and think that the people of Derbyshire are well served by these developments. The evidence from users' feedback is that they are appreciated and valued by patients/clients and carers.

We are pleased to deliver a report comprising a series of recommendations which we hope will be implemented across NHS bodies and local government, and we have been impressed at the quality and range of services currently available.

Councillor John Bull
Chair – Intermediate Care Services Project Board

Vice-Chair, Social Care & Health Improvement and Scrutiny Committee
Derbyshire County Council
Matlock
Derbyshire

Further information is available from:

Shaun Gordon
Improvement and Scrutiny Team
Chief Executive's Office
Derbyshire County Council
01629 585263
shaun.gordon@derbyshire.gov.uk

DERBYSHIRE HEALTH SCRUTINY

INTERMEDIATE CARE SERVICES IN DERBYSHIRE

FINAL REVIEW REPORT

Content

		Page
1.	**Executive summary and recommendations**	**2**
2.	**What is Intermediate Care?**	**7**
3.	**The Range of Intermediate Care Services in Derbyshire**	**11**
4.	**Analysis**	**13**

APPENDICES	
1	Intermediate Care in Amber Valley, Chesterfield, Derbyshire Dales and South Derbyshire, High Peak and Dales, North Eastern Derbyshire (including Bolsover) and Tameside and Glossop
2	Statistics on Intermediate Care Places in Derbyshire
3	Intermediate Care - Hospital admissions that could have been avoided – A survey in Amber Valley PCT, October 2004
4	Literature Search by the Knowledge Services team at Amber Valley Primary Care Trust
5	Survey of Intermediate Care users and their carers - Chesterfield, North-Eastern Derbyshire and Erewash
6	Review methodology – Gathering evidence
7	List of Project Board members

1. Executive summary and recommendations

1.1 This review has shown that all parts of the County have developed intermediate care services and have plans to develop them further. The recommendations of this scrutiny review are intended to help Derbyshire's health and social care communities to move towards the next 'step change' in intermediate care, so that it becomes a fully recognised, important and validated part of a network of care for older people and available to everyone in the County.

The evidence is starting to show that the service users will benefit if this is achieved.

RECOMMENDATION 1 – driven by Key Element 1 ['Key Elements' set out on pages 6 and 7 of this Report]

Derbyshire's Health and Social Care communities should consider carrying out a Balance of Care, or similar exercise, to determine clear planning assumptions on the current need and future potential for Intermediate Care services.

In view of the significant use of acute hospitals outside Derbyshire by Derbyshire residents, Derbyshire' Primary Care Trusts and Derbyshire County Council Social Services Department should seek to include these other hospitals too.

The intended capacity of intermediate care schemes should be defined by all organisations.

RECOMMENDATION 2 - driven by Key Element 1

Derbyshire's Health and Social Care communities should jointly develop care pathways defining the agreed Intermediate Care process.

RECOMMENDATION 3 - driven by Key Element 2

Derbyshire's Health and Social Care communities should develop:

a) Integrated intermediate care teams with health and social care staff.
b) Single management of whole Integrated Care Service.
c) Integrated or joint budgets.

RECOMMENDATION 4 - driven by Key Element 2

Derbyshire's Health and Social Care communities should agree:

a) The level of integration intended for intermediate care services.
b) How this can be achieved.
c) A target date

RECOMMENDATION 5 – driven by Key Element 3

All Intermediate Care teams should be fully multi-disciplinary, including therapy, nursing and social services staff, working to a rehabilitation-led mode.

RECOMMENDATION 6 – driven by Key Element 4

Derbyshire's Health and Social Care Communities together identify the minimum key elements of an Intermediate Care service that they would wish to be available to all local residents and those registered with Derbyshire GPs.

The Committee considers that the key elements are likely to include:

a) A Community Rapid Response service able to respond at any time.
b) An Integrated Re-ablement team:
    i. Therapy-led (or nurse-led with strong therapy input).
    ii. Operating 7 days and extended hours.
c) Step up / step down residential services.
d) Day Services.
e) Good links to 'mainstream' services.

RECOMMENDATION 7 – driven by Key Element 4

All Intermediate Care services should define and publicise the response time that they aim to achieve

- Suggestion: Work towards a 1 hour response where hospital admission is being considered – 4 hours otherwise.

Intermediate Care services should also define what response can be expected within that time.

RECOMMENDATION 8 – driven by Key Element 5

Derbyshire's Health and Social Care Communities should complete the implementation of the Single Assessment Process, including the person-held record and rationalise the scales and tools for specialist assessment.

Integrated IT support would be very helpful to this process.
It is important to ensure that for users of intermediate care there is a single care co-ordinator, and the user is clear as to who they are and how to contact them.

RECOMMENDATION 9 – driven by Key Element 6

Derbyshire's Health and Social Care Communities should ensure that generic workers should be used for all teams.

Subject to evaluation and adequate funding, the scheme to enable home helps to work with intermediate care schemes using enhanced roles should be rolled out across the County.

RECOMMENDATION 10 – driven by Key Element 7

Derbyshire's Health and Social Care communities should check whether the current single point of contact arrangements or proposals are in all cases the simplest and best solution for referrers, staff and patients. It is recommended that it should be an objective to minimise the different numbers being used or developed.

RECOMMENDATION 11 – driven by Key Element 8

Derbyshire's Health and Social Care communities should allow for flexibility and choice to allow clients options where possible.
Health and Social Care communities should continue to develop an integrated approach to services for older people.
A focus on good communication with users and carers is an essential part of this work.

RECOMMENDATION 12 – driven by Key Element 9

Derbyshire's Health and Social Care communities should give priority to ensuring that there is an adequate infrastructure locally that can provide multi agency home based multi disciplinary rapid response services and subsequent re-ablement to the whole population who have the capacity to benefit from such services.

RECOMMENDATION 13 – driven by Key Element 10

Derbyshire's Health and Social Care communities should consider whether developing a more active partnership between the acute hospitals and community services, as in the examples given in the report, would increase the numbers of people appropriately accessing Intermediate Care.

RECOMMENDATION 14 – driven by Key Element 11

Derbyshire's Health and Social Care communities should develop plans to develop the capacity of Intermediate Care schemes to be able to provide a service for people with mental health problems or dementia. The Health and Social Care communities should also consider the provision of specialist support to teams.

RECOMMENDATION 15 – driven by Key Element 12

Derbyshire's Health and Social Care communities should move over time to a position where no one is admitted to permanent residential or nursing home care without having had an assessment to see whether they could benefit from Intermediate Care.

RECOMMENDATION 16 – driven by Key Element 13

Derbyshire's Health and Social Care communities should discuss with other sectors ways of working together to ease the transition from Intermediate Care to subsequent services.

RECOMMENDATION 17 – driven by Key Element 14

All Intermediate Care schemes should have arrangements for getting user and carer feedback on their services and the Health and Social Care communities should consider some standardisation of measures to aid comparability and validity.
Health and Social Care communities are asked to consider using the Discovery Interview technique as a way of enabling teams to learn directly from patients and carers.

RECOMMENDATION 18 – driven by Key Element 15

Derbyshire's Health and Social Care communities should regularly review the performance of intermediate care against targets, using an agreed common format.

RECOMMENDATION 19 – driven by "Other Issues – Information"

Derbyshire's Health and Social Care Communities should consider the implementation of the proposed Derwent system for collecting management information, or something similar as an interim measure.

RECOMMENDATION 20 – driven by "Other Issues – Carers"

Intermediate Care schemes should have explicit policies on their approach to involving and working with carers.
Carers should be involved with the personalised care plan.
Carer's assessment should be offered within the existing policies.

RECOMMENDATION 21 – driven by "Other Issues – Costs of Intermediate Care"

Derbyshire's Health and Social Care communities should ensure that all schemes record information on the costs and effectiveness of intermediate care, including estimates of any cost savings, so that informed decisions about investment and development can be made.

RECOMMENDATION 22 – driven by "Other Issues – Co-ordination and Learning"

Derbyshire's Health and Social Care communities should promote more interchange of ideas and experience across the county as a whole, so ideas that work in one area can be quickly transferred elsewhere.

The Key Elements of Intermediate Care Services[1]	
1	**Strategic leadership and vision at executive level. A jointly agreed whole system strategy for services which defines intermediate care and interim care and which aims for flexible services tailored to an individual's assessed need.**
2	**Integrated health and social care intermediate care services which are jointly managed.**
3	**Services which are therapy-led (or nurse-led with strong therapy input) and promote independence.**

[1] **'Changing Places' The Health and Social Care Change Agent Team. DH 2003 and 'Changing Times' The Health and Social Care Change Agent Team. DH 2004**

4	**Access by older people to fast, responsive services that are flexible and adaptable, provided in the home, in day hospitals, in community hospitals or care homes and which are able to provide care at night and the weekends.**
5	**Using the Single Assessment Process across health and social care to reinforce an integrated service.**
6	**Services delivered by highly skilled professionals empowered to develop new ways of working, supported by generic, well-trained support workers.**
7	**A single access point to all services offering a range of provision including an alternative to hospital, thereby avoiding the GP requesting an urgent avoidable hospital admission.**
8	**Services not constrained by rigid admission criteria, which exclude some people and allow others to fall between different schemes.**
9	**Provision of service in an older person's home is considered the best environment and reduces transfers between care settings.**
10	**Continuous review to ensure length of stay in bed-based services is kept to a minimum.**
11	**Links to mental health services to support people with dementia**
12	**Increased focus on prevention of admission and increased focus on providing assessment after acute admission in a non-acute environment.**
13	**Professionals recognising the need for a period of recuperation and longer-term rehabilitation, and services which make room for this.**
14	**Services which are continuously marketed, regularly evaluated to inform commissioning and delivery, with ongoing development of staff and services.**
15	**Clarity of outcomes expected from intermediate care. Monitoring and evaluation of those outcomes.**

2. BACKGROUND

2.1 What is Intermediate Care?

2.1.1 "*Older people will have access to a new range of Intermediate Care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.*"[2]

2.2 National Policy and Guidance

2.2.1 While the idea of providing structured rehabilitation, often at home or in local hospitals, is not new, the concept of intermediate care in its present form stemmed originally from concerns in the latter part of the 1990s that there were too many unplanned admissions of older people to hospital. These led in turn to too many premature admissions to long term residential care. There was an influential Audit Commission report in 1997 which concluded that there was too little investment in preventative and rehabilitative services.

2.2.2 This was followed in 2000 by a major piece of work, the NHS National Beds Inquiry. This Inquiry investigated the use of hospital beds. It noted that:
"*Year on year there has been a continuous growth in the proportion of older people requiring overnight stays in hospital. (In contrast the proportion of children and adults under 65 requiring overnight hospital stays has been falling for 30 years.) These trends, together with the growing numbers of older people and their generally poorer health, help explain why people aged 65 and over occupy two-thirds of general and acute hospital beds and account for over half the recent growth in emergency admissions.*"

2.3 NHS Plan

2.3.1 In response to these concerns, the NHS Plan in 2000 provided for a significant expansion of what was called 'Intermediate Care'; that is care that is 'intermediate' between an acute hospital and living independently. The Plan provided for an extra £900 million by 2003/04 for investment in intermediate care and related services to promote independence and improved quality of care for older people. It was intended to promote Independence through active recovery and rehabilitation services, with an extra 5,000 intermediate care beds and a further 1,700 supported intermediate care places, together benefiting

[2] National Service Framework for Older People, Standard 3 – Intermediate Care

around 150,000 more older people each year.

2.4 Intermediate Care Circular

2.4.1 Detailed Guidance on Intermediate Care came out in 2001 under HSC 2001/01, LAC 2001/01. It placed responsibility on NHS organisations and local authorities to plan and develop new intermediate care services. The circular said that to be 'Intermediate Care' a service should meet all of the following criteria:

- Targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care.
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- Have a planned outcome of maximising independence and typically enabling patient/users to resume living at home.
- Time-limited, normally no longer than six weeks and frequently as little as one or two weeks or even less.
- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

2.4.2 In essence, intermediate care is a time-limited service, targeted on those in hospital or at risk of admission, involving therapeutic input and aimed at maximising independence.

2.4.3 The circular is not prescriptive about how these services should be delivered, and suggests a range of possible models. These include:
Rapid response: a service designed to prevent avoidable acute admissions by providing rapid assessment/diagnosis for patients.

Hospital at home: intensive support in the patient's own home, including investigations and treatment which are above the level that would normally be provided in primary care.

Residential rehabilitation: a short-term programme of therapy and enablement in a residential setting for people who are medically stable but need a short period of rehabilitation.

Supported discharge: a short-term period of nursing and/or therapeutic support in a patient's home.

Day rehabilitation: a short-term programme of therapeutic support, provided at a day hospital or day centre.

2.5 National Service Framework for Older People

The NSF for older people was published in March 2001. It set new national standards and service models of care across health and social services for all older people, whether they live at home, in residential care or are being looked after in hospital.

2.5.1 The NSF policies aim to:

- Tackle age discrimination.
- Ensure older people are supported by newly integrated services with a well co-ordinated, coherent and cohesive approach to assessing individual's needs and circumstances and for commission and providing services for them.
- Specifically address those conditions which are particularly significant for older people - stroke, falls and mental health problems associated with older age.
- Promote the health and well-being of older people through co-ordinated actions of the NHS and councils.

2.5.2 Standard 3 of the National Service Framework for Older People, developed the concept of Intermediate Care. Standard 3 states: *"Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care."*

2.5.3 It emphasised that intermediate care services should be integrated within a whole system of care including primary and secondary health care, health and social care, the statutory and independent sectors. This creates challenges for the commissioning, management and provision of care, entailing complex multi-sectoral work.

2.5.4 The NHS and councils were asked to develop implementation plans for intermediate care, as part of Local Action Plans and Joint Investment Plans.

2.6 Delayed Discharges

2.6.1 Another relevant policy initiative that has come into force recently is the provisions of the Community Care (Delayed Discharges) Act 2003. This has introduced a system by which local authorities that cannot cater for elderly patients ready to leave hospital reimburse the NHS for the use of the hospital bed. The sections of this Act on liability to pay charges were implemented in January 2004. This is clearly intended to give local authorities a financial incentive to work to get older people out of

hospital, and Intermediate Care is one part of a set of policy responses to achieve this.

3. THE RANGE OF INTERMEDIATE CARE SERVICES IN DERBYSHIRE

3.1 A wide range of Intermediate Care services are developing in Derbyshire. All areas have developed intermediate care rapidly in recent years, and there has been a step-change since 2001/2. (Details of services in each area are given in appendix 1a-g). Prior to that, there were rehabilitation and hospital at home schemes which had been developed earlier, but they were patchy and not part of an overall system. The publication of the National Service Framework for older people, allied with new investment and the realignment and modernisation of existing services has led locally to a step change in the amount and quality of services.

3.2 Since then the Derbyshire PCTs, with Derbyshire Social Services, have developed a range of services, which include rapid response, community rehabilitation teams, day centres, residential units and use of the local hospitals. The North and Southern Health Communities have developed an overall approach to development.

3.3 Almost all areas have some form of community rehabilitation or re-ablement team, or are developing them from existing resources or new investment.

3.4 The majority of areas have a rapid response service, or are planning to provide one.

3.5 The majority of areas have some form of day service, which provides intermediate care.

3.6 An Information Portfolio on the older person's NSF prepared in June 2004 identified 223 "places" in non-residential intermediate care. (See Appendix 2).
Most areas have step up and / or step down care.

3.7 Local hospitals provide a substantial service to older people in Derbyshire. It can sometimes be unclear as to whether all or part of that can be regarded as part of an intermediate care service. The Information Portfolio referred to in paragraph 3.6 above also shows 299 Intermediate Care beds in Derbyshire (excluding Derby). However, this is probably an exaggeration.

3.8 The use of County Homes for Older People for Intermediate Care is starting to be developed in some areas.

3.9 Little use is currently made of private or voluntary homes for providing intermediate care.

Overall, progress in developing and delivering Intermediate Care Services is to be commended.

The future challenge is to make the next step change, and create a comprehensive, reliable and effective intermediate care service that is as 'normal' a part of health and social care provision for older people as are the hospital services now.

4. ANALYSIS

The Key Elements of Intermediate Care Services[3]	
1	Strategic leadership and vision at executive level. A jointly agreed whole system strategy for services which defines intermediate care and interim care and which aims for flexible services tailored to an individual's assessed need.
2	Integrated health and social care intermediate care services which are jointly managed.
3	Services which are therapy-led (or nurse-led with strong therapy input) and promote independence.
4	Access by older people to fast, responsive services that are flexible and adaptable, provided in the home, in day hospitals, in community hospitals or care homes and which are able to provide care at night and the weekends.
5	Using the Single Assessment Process across health and social care to reinforce an integrated service.
6	Services delivered by highly skilled professionals empowered to develop new ways of working, supported by generic, well-trained support workers.
7	A single access point to all services offering a range of provision including an alternative to hospital, thereby avoiding the GP requesting an urgent avoidable hospital admission.
8	Services not constrained by rigid admission criteria, which exclude some people and allow others to fall between different schemes.
9	Provision of service in an older person's home is considered the best environment and reduces transfers between care settings.
10	Continuous review to ensure length of stay in bed-based services is kept to a minimum.
11	Links to mental health services to support people with dementia
12	Increased focus on prevention of admission and increased focus on providing assessment after acute admission in a non-acute environment.

[3] 'Changing Places' The Health and Social Care Change Agent Team. DH 2003 and 'Changing Times' The Health and Social Care Change Agent Team. DH 2004

13	**Professionals recognising the need for a period of recuperation and longer-term rehabilitation, and services which make room for this.**
14	**Services which are continuously marketed, regularly evaluated to inform commissioning and delivery, with ongoing development of staff and services.**
15	**Clarity of outcomes expected from intermediate care. Monitoring and evaluation of those outcomes.**

4.1 **<u>Key Element 1:</u>**

Strategic leadership and vision at executive level. A jointly agreed whole system strategy for services which defines intermediate care and interim care and which aims for flexible services tailored to an individual's assessed need.

4.1.1 <u>Need and capacity in Intermediate Care</u>

4.1.2 There is evidence that all areas in Derbyshire have or are developing strategies for intermediate care. But there is little information nationally or locally about how much intermediate care could be provided, or is needed. The original central guidance is concerned with establishing the service as a new element in the care spectrum. As such it defined expansion rather than tried to estimate an absolute level of need.

4.1.2 It is thus difficult to be absolutely certain about the extent to which current services in Derbyshire meet the need.

There are 125,000 people aged over 65 in the Derbyshire population, of whom 60,000 are aged 75 or more. The over-65 population is projected to increase by 9% by 2010.

4.1.3 There are around 26,000 hospital discharges of Derbyshire residents aged over 65 per year (in addition to around 8,000 residents of Derby), and on average they stay in hospital (duration of spell) around 12.5 days. There are around 1,150 supported admissions to permanent nursing/residential care per year. As the policy intent of Intermediate Care is to prevent unnecessary admissions, speed up discharges and prevent unnecessary admissions to institutional care, then these numbers would expect to be stabilised and reduced over time if the policy is successful.

4.1.4 Some health communities, including Nottingham, Medway, Berkshire, Oxford and Sheffield have worked with clinicians and carried out censuses of older people in hospital, and / or entering residential care

and clinically assessed what proportion could benefit from intermediate care. They have employed some form of Balance of Care model and have utilised an Appropriateness Evaluation Protocol (AEP) to do this. Results of these censuses vary with local circumstances. For example one health community found in 2003 that:

- 103 out of 661 acute patients surveyed (16%) were not admitted within AEP criteria.
- 295 out of 661 acute patients (45%) were not receiving care on the day within AEP criteria.
- Alternative care options were identified for 493 out of 1054 patients across all locations.

4.1.5 This study did not only focus on intermediate care, but did conclude that: "*There is potential for significant reduction in the demand for acute hospital beds* (as many as 136 occupied beds across the county) *if all intermediate care developments are progressed.*"

4.1.6 The cost of such studies is not insignificant (up to £30,000), but other areas have found them very valuable in making the case for investing in Intermediate Care, and directing where such investment might be most useful. They have also been found to be valuable in engaging clinicians in considering the issue.

4.1.7 A local survey was carried out for this Review of patients aged 65 and over in Babington Hospital, Belper (Amber Valley PCT)[4]. The results showed that the biggest single group of patients were aged 81 to 90. Five (15%) out of thirty-three patients who were there on the census day need not have been admitted had alternatives been available. Most of those had been admitted because of loss of mobility.

4.1.8 <u>Capacity</u>

4.1.9 There has been a rapid development of Intermediate Care locally. However, in many cases the capacity of schemes is not clearly defined, leading to an inability to be clear about how much exists and what else might be needed. As discussed above in paragraphs 3.6 and 3.7 the routinely available statistics suggest that there are 299 intermediate care beds and 223 non-residential 'places' in the county. However this does not appear to give a reliable picture of the services that are available. Without knowing the intended capacity it can be difficult to define how well schemes are performing and to debate the level of service needed.

[4] **See Appendix 3 – Profile of Intermediate Care Services in Amber Valley PCT**

4.1.10 Care pathways

4.1.11 Social Services have developed a care pathway for older people's services, following pilots in Erewash and Bolsover, and an implementation plan has been developed. This is to be commended.

4.1.12 An integrated care pathway is a document that describes a process within health and social care. It sets out anticipated, evidence-based, best practice and outcomes that are locally agreed and that that reflect a patient-centred, multi-disciplinary, multi-agency approach.

4.1.13 Few areas currently have documented care pathways specifically relating to intermediate care, and agreed between PCTs, Social Services and the acute sector, although Tameside and Glossop PCT has made some progress. The development of care pathways is a good way of getting agreement and clarity between all parties on the way schemes should work and how they fit into the wider context of health and social care.

RECOMMENDATION 1 – driven by Key Element 1

Derbyshire's Health and Social Care communities should consider carrying out a Balance of Care, or similar exercise, to determine clear planning assumptions on the current need and future potential for Intermediate Care services.

In view of the significant use of acute hospitals outside Derbyshire by Derbyshire residents, Derbyshire' Primary Care Trusts and Derbyshire County Council Social Services Department should seek to include these other hospitals too.

The intended capacity of intermediate care schemes should be defined by all organisations.

RECOMMENDATION 2 - driven by Key Element 1

Derbyshire's Health and Social Care communities should jointly develop care pathways defining the agreed Intermediate Care process.

4.2 Key Element 2:

Integrated health and social care intermediate care services which are jointly managed.

4.2.1 The development of integrated health and social care intermediate care services

4.2.2 Most schemes in the County are jointly developed and run between health and social care, and working relationships are very good. This is to be commended and encouraged. However by no means all schemes are fully integrated with an integrated management structure, shared budget and commissioning arrangements, and there are a variety of models. An exception is the Clay Cross Integrated Care Team which does have a single manager and a joint budget to which both health and social care have contributed. The Clay Cross scheme achieved the single manager not by deciding in advance whether it should be a health or social care post but by defining the job, appointing the best person and deciding who it was best for them to be employed by. This approach appears to have worked well.

4.2.3 Fully integrated services have the potential to provide a better service, and avoid duplication of management effort. They can focus on providing a person centred service. Such teams reduce the number of handovers and have the potential to improve communication. Aligning management and information systems is helpful to workers in such teams. Integration and joint training also assist in reducing the differences in culture and approach which still characterise the health and social care professions.

4.2.4 There are barriers to achieving full integration. There are often existing services and resources that need to be redesigned. There may be a perceived reluctance to work across the divide. There may be resource issues between health and social services. However the benefits make it worthwhile to address the barriers.

RECOMMENDATION 3 - driven by Key Element 2

Derbyshire's Health and Social Care communities should develop:

a) Integrated intermediate care teams with health and social care staff.
b) Single management of whole Integrated Care Service.
c) Integrated or joint budgets.

RECOMMENDATION 4 - driven by Key Element 2

Derbyshire's Health and Social Care communities should agree:

a) The level of integration intended for intermediate care services.
b) How this can be achieved.
c) A target date.

4.3 Key Element 3:

Services which are therapy-led (or nurse-led with strong therapy input) and promote independence

4.3.1 Composition of intermediate care teams

4.3.2 The rehabilitation or re-enablement teams in the County vary in the range of professional staff that is available to them. Most contain a mix of nursing, rehabilitation and social care staff, although the proportions vary.

4.3.3 Until recently there has been little rigorous evidence about the effectiveness of intermediate care in reducing hospital stays or improving the functioning of older people. (See Appendix 4 for a literature search on need for and effectiveness of intermediate care, carried out by NHS Knowledge Services based at Amber Valley PCT.)

4.3.4 Some teams in Derbyshire do collect data on outcomes for patients - for example the Clay Cross scheme and Tameside and Glossop PCT among others, and this is to be commended.
But there has been a lack of rigorous research studies until recently, and a national evaluation that has been carried out will not report until 2005.

4.3.5 However research has shown that rehabilitation can be effective. See for example:
Turner-Stokes L ed. The effectiveness of rehabilitation: a critical review of the evidence. Clin Rehabil 1999; 13 (Supplement 1).

4.3.6 In addition, a recent study looked specifically at an early discharge rehabilitation service, using a randomized control trial methodology using random allocation and blinded follow-up. The experimental group was controlled by a group receiving 'normal' services. Measures included Barthel scores and Nottingham Extended Activities of Daily Living scores. The rehabilitation team comprised two occupational therapists, two physiotherapists, three nurses, a Community Care Officer (liaising with social services), seven rehabilitation assistants, and secretarial support.
Cunliffe AL, Gladman JRF, Husbands SL, Miller P, Dewey ME, Harwood RH. Sooner and healthier: a randomised controlled trial and interview study of an early discharge rehabilitation service for older people. Age Ageing 2004;33:246-252.

The results were that the rehabilitation team:
"*reduced their length of stay in hospital and improved their health in terms of activity limitation and psychological well-being in the short term. Furthermore, their carers had better psychological well-being. Benefits in terms of reduced activity limitation and better mood were found one year later. These health gains were achieved by home-based intensive rehabilitation and support, providing a mean of 22 visits over a maximum of 4 weeks*."

The authors concluded:
"…*some older people can be discharged from hospital sooner, with better health outcomes using a well-staffed and organised patient-centred early discharge service providing rehabilitation."*
The team delivering the care: "…worked within an explicit team ethos in which physical, psychological, social and environmental issues were all legitimate areas for intervention, for all members of staff irrespective of their professional background. [The team]….delivered skilled assessment, negotiated treatment goals that were meaningful to the patient, and met them with a co-ordinated team. Interventions included functional rehabilitation training, the teaching of skills, information giving and advice, overcoming emotional barriers to task performance, the provision of aids and appliances and the provision of personal and domestic care."

4.3.7 Feedback from patients in Derbyshire has shown that multi-disciplinary rehabilitation teams are popular and much appreciated by patients and carers. (See appendix 5). Users commented for example:

- "*From being incapable of looking after myself I am now on the way to an almost normal life*"

- "*Your carers were courteous efficient and friendly. The support given me was second to none. Thank you*.

RECOMMENDATION 5 – driven by Key Element 3

All Intermediate Care teams should be fully multi-disciplinary, including therapy, nursing and social services staff, working to a rehabilitation-led mode.

4.4 Key Element 4:

Access by older people to fast, responsive services that are flexible and adaptable, provided in the home, in day hospitals, in community hospitals or care homes and which are able to provide care at night and the weekends.

4.4.1 Key elements of the service

4.4.2 Given that there is a wide range of intermediate care services available locally, (see Appendix 1) there are no common local definitions of the key elements of an intermediate care service, or what they are called. Not all of the key service elements are present in all parts of Derbyshire. In addition, sometimes local teams with essentially similar functions are called different things, which in turn makes it difficult for example for staff in acute hospitals, particularly junior medical staff, to rapidly understand what they do, and therefore to refer to them.

4.4.2 Most areas are developing or have developed a community re-ablement service, and a rapid response service. (Most re-ablement services do not currently operate on a 7 day basis.)

4.4.3 The majority of areas have some day rehabilitation linked to local hospitals or elsewhere. (Members of the Project Board visited Babington Day Unit, and were impressed by the range of active rehabilitation that was being carried out. The local survey of users showed that day services were appreciated.)
Local hospitals are used by most areas to provide step up or step down care, as well as a range of other services, and care homes are also being developed to meet this need.

4.4.4 Recent research elsewhere has suggested that a care home intermediate scheme (i.e. bed-based) reduced hospital stay, but didn't improve outcomes or reduce long term care rates. In fact it delayed patients return home (they spent longer in the intermediate care facility than they would have spent at home). It is therefore a diversion service. The scheme studied however had little rehabilitation input.
Fleming S, Blake H, Gladman JRF, Hart E, Lymbery M, Dewey ME,McCloughry H, Walker M, Miller P. A randomised controlled trial of a care home rehabilitation service to reduce long term institutionalisation for elderly people. Age Ageing 2004;33:384-390.

4.4.5 **This research suggests that it is the availability of an active and managed programme of intervention with a strong element of active rehabilitation, which is the key to effective intermediate care.**

4.4.6 Thus, as Intermediate Care services have developed rapidly in the last few years, there is an uneven spread across the County, with patients/clients in some areas having access to a much wider range of services than elsewhere. This reflects in part the legacy of services with which areas started, as well as their different resource positions. Some areas, for example Dronfield, Eckington, and much of Derbyshire Dales do not currently have what could be described as a comprehensive intermediate care service. While this is understandable given the rapid development of services, it does mean that there is not currently equity of provision in different parts of the County.

RECOMMENDATION 6 – driven by Key Element 4

That Derbyshire's Health and Social Care Communities together identify the minimum key elements of an Intermediate Care service that they would wish to be available to all local residents and those registered with Derbyshire GPs.

The Committee considers that the key elements are likely to include:

a) A Community Rapid Response service able to respond at any time.
b) An Integrated Re-ablement team:
   i. Therapy-led (or nurse-led with strong therapy input).
   ii. Operating 7 days and extended hours.
c) Step up / step down residential services.
d) Day Services.
e) Good links to 'mainstream' services.

4.4.7 <u>Speed of response</u>

4.4.8 There are substantial variations around the County in how rapidly an assessment for intermediate care can be achieved once an urgent referral is received. Tameside and Glossop PCT aim to have their Rapid Response Team make contact within 1 hour. Not all other local services have declared specific targets, and some will aim to respond in days rather than hours. This would seem to indicate that areas are offering substantially different services.

4.4.9 One of the major reasons that GPs give for admitting people to hospital rather than referring to intermediate care is that they know that an admission can be achieved quickly, and that the situation can be held pending further investigation. Intermediate Care will become a more mainstream service if that level of certainty can be achieved for alternative services.

4.1.10 The Project Board recognised that achieving a very rapid response will be difficult where a fully developed service is not yet in place.

RECOMMENDATION 7 – driven by Key Element 4

All Intermediate Care services should define and publicise the response time that they aim to achieve

- Suggestion: Work towards a 1 hour response where hospital admission is being considered - 4 hours otherwise.

Intermediate Care services should also define what response can be expected within that time.

4.5 Key Element 5:

Using the Single Assessment Process across health and social care to reinforce an integrated service.

4.5.1 Single assessment and care co-ordination

4.5.2 The issue of professionals accepting each other's assessments has long been contentious. It appears that progress is being made locally, particularly within integrated teams, but some respondents commented that there was still some way to go.

4.5.3 The National Service Framework for Older People calls for a single assessment process (SAP), and this is being developed on a Countywide basis in Derbyshire and Derby. An electronic SAP being piloted in Chesterfield and Derbyshire Dales, and a person held record will be tested out with older people using the Derby PCTs Intermediate Care services. It is currently intended that the SAP (though not necessarily the electronic version) be implemented in the County and in Derby from April 2005. This will be facilitated through the implementation of the personally held records, starting in April 2005.

4.5.4 Single assessment leads to clear and consistent communication between professionals, and with service users, about needs and plans, and is an important part of a comprehensive service. It helps with a consistent approach to patients/clients, and avoids having to ask them the same questions repeatedly.

4.5.5 The need to utilise the Countywide Single Assessment Process has probably inhibited local intermediate care schemes from developing their own local solutions, and may have therefore have held back some progress in the short term. However the benefits of implementing a well thought through and comprehensive process should outweigh any short-term delays. In addition it will be of benefit to the development of intermediate care, and the people it serves, to be using a system which is common across all older people's services.

4.5.6 In implementing the Single Assessment Process, Intermediate Care teams will need to:

- Streamline their documentation, and rationalise scales and tools for specialist assessment.
- Decide how reviews are to be done, and whether one person can do on behalf of the team.
- Clarify roles and responsibilities in co-ordinating the comprehensive assessment.

4.5.7 Evidence from Discovery Interviews and from the survey carried out by the review has shown that it is not always clear to service users and carers locally as to who is co-ordinating their care, and who they need to contact about it.

One carer said:
"There doesn't seem to be a person taking total control of everything, there seemed to be various little bits of the organisation providing what is their area of expertise…"

Clarifying roles and responsibilities will help both in implementing the Single Assessment Process and will also make things clearer for users and carers.

RECOMMENDATION 8 – driven by Key Element 5

Derbyshire's Health and Social Care Communities should complete the implementation of the Single Assessment Process, including the person-held record and rationalise the scales and tools for specialist assessment.

Integrated IT support would be very helpful to this process.

It is important to ensure that for users of intermediate care there is a single care co-ordinator, and the user is clear as to who they are and how to contact them.

4.6 Key Element 6:

Services delivered by highly skilled professionals empowered to develop new ways of working, supported by generic, well-trained support workers

4.6.1 Generic workers

4.6.2 There are not enough qualified therapists, and they need to be used effectively, in conjunction with other staff.

4.6.3 In Derbyshire many areas employ varieties of generic workers and some but not all areas are developing enhanced roles for home helps. A project in New Mills, supported by the NHS Modernisation Agency under the 'Changing Workforce' Programme is evaluating home helps carrying out enhanced roles, working closely with qualified nurses. While the final evaluation report is not yet available, the area reports that it is proving very valuable, and that the staff appreciate the extension of their role.

4.6.4 Research supports the use of generic workers. One of the authors of the research quoted above has said:
"In the early discharge service we reported on, generic workers were very much a part of the service. Therefore we can say that they can be part of an effective solution. Our study showed that these people need to have skills (and so be trained) and should work in teams (and so not left unsupervised). But given the issue of availability of fully trained staff, I think it there is enough evidence and reason to include such people within the service."

I think every service has to look very carefully indeed on EXACTLY what transformations they intend to makes and EXACTLY how they are going to be achieved. This then defines the working practice and skill mix needed. It is likely that skilled physiotherapy, occupational therapy, nursing and medical expertise will be needed as core disciplines to manage the health problems of older people, and social workers will be needed to control the social services responses. Loads of others will be needed by liaison. But workers who can support physiotherapy, occupational therapy and bits of nursing, while providing day to day care make every bit of sense." [Personal communication]

RECOMMENDATION 9 – driven by Key Element 6

Derbyshire's Health and Social Care Communities should ensure that generic workers should be used for all teams.
Subject to evaluation and adequate funding, the scheme to enable home helps to work with intermediate care schemes using enhanced roles should be rolled out across the County.

4.7 Key Element 7:

A single point of contact for access to all services offering an alternative to hospital, thereby avoiding the GP requesting an urgent hospital admission.

4.7.1 Single Point of Access

4.7.2 Providing a Single Point of Access is an important part of making intermediate care an accessible mainstream activity. Medical staff in hospitals as well as GPs regard it as a key element in ensuring that intermediate care is considered in all appropriate cases. It has not yet been fully implemented in Derbyshire, although most areas have plans or have partial implementation. There is however the potential for there to be a number of Single Points of Access phone numbers in the County, and even within areas.

RECOMMENDATION 10 – driven by Key Element 7

Derbyshire's Health and Social Care communities should check whether the current single point of contact arrangements or proposals are in all cases the simplest and best solution for referrers, staff and patients. It is recommended that it should be an objective to minimise the different numbers being used or developed.

4.8 Key Element 8:

Services not constrained by rigid admission criteria, which exclude some people and allow others to fall between different schemes

4.8.1 Flexibility of service

4.8.2 Intermediate care is one part of a spectrum of services, predominantly for older people, which are themselves subject to change and development. The Department of Health is making patient choice a major priority. At the same time it has recently given greater policy emphasis to the need to develop better and better co-ordinated services for people with chronic diseases. Many (but not all) of the people who receive intermediate care will have one or more chronic illnesses. Primary Care Trusts are developing their services in this area, and a number of specialist nurses in for example diabetes or chronic respiratory problems have been appointed. At the same time, and associated with this, health communities in the Trent Strategic Health Authority area are working towards implementing a comprehensive scheme of chronic disease management. This model involves, among other things, case management of the small proportion of the most vulnerable older people who are most at risk of repeated hospital admission.

4.8.3 All these arrangements need to work in a flexible and integrated way, so as to meet individual needs. While it is important to have plans and care pathways, it is also important that they can accommodate changes in circumstances. For example, while intermediate care schemes are short term and have policies aiming at a 6 week maximum length of stay, it can be appropriate on occasions to be flexible if for example a review clearly demonstrates that the service user has capacity to benefit further from the rehabilitation services available.

4.8.4 Flexibility is only real to patients and carers if they know what choices are available. Responses to the survey carried out for this review showed that while two thirds of respondents understood from the start what the intermediate care programme was trying to achieve, one-third did not fully understand or felt that it had not been discussed. Similarly one third of respondents felt that their views on assessment were only partially sought or not sought.

RECOMMENDATION 11 – driven by Key Element 8

Derbyshire's Health and Social Care communities should allow for flexibility and choice to allow clients options where possible.
Health and Social Care communities should continue to develop an integrated approach to services for older people.
A focus on good communication with users and carers is an essential part of this work.

4.9 Key Element 9:

Provision of service in an older person's home is considered the best environment and reduces transfers between care settings

4.9.1 Home based services

4.9.2 There is a substantial legacy of infrastructure within Derbyshire, in the form of local hospitals and County Homes for Older People (HOPs). While they have not been the focus of this review, local hospitals are a substantial part of the health service for older people, and they do provide some intermediate care. In some areas major improvements are being made to local hospitals to provide excellent step-up/step down services. Members of the Project Board visited Babington Hospital in Amber Valley and were very impressed with the new Derwent Suite which has been specifically designed for intermediate care. Parts of HOPs are also being developed to provide intermediate care, for example in Erewash.

4.9.3 There is definitely a need for such residential based step up or step down care as part of a comprehensive service. However the assertion made by the Department of Health Change Agent Team, and backed up by research is that a good community based infrastructure providing intensive service to a persons own home wherever possible is the core of an effective intermediate care service. The teams need to be able to provide a rapid assessment and holding service, followed if appropriate by intensive re-ablement focused services. Teams need to be therapy led or have a significant therapy presence, and have a range of health and social care skills available. As shown above, not all parts of the County yet have this available, although all have plans to move in this direction.

RECOMMENDATION 12 – driven by Key Element 9

Derbyshire's Health and Social Care communities should give priority to ensuring that there is an adequate infrastructure locally that can provide multi agency home based multi disciplinary rapid response services and subsequent re-ablement to the whole population who have the capacity to benefit from such services.

4.10 Key Element 10:

Continuous review to ensure length of stay in bed-based services is kept to a minimum

4.10.1 Intermediate Care and Hospitals
Two of the major objectives of intermediate care are to avoid unnecessary hospital admissions, and to facilitate discharges. A number of different arrangements are being developed round the country to help acute and community services to work closer together to achieve this end.

4.10.2 For example, in Nottingham there is a well developed and evaluated A&E ‘front door assessment and care team' (FACT), employed by the acute trust. This multi-professional rapid response team provides full functional and social assessment for older people attending the emergency department. Their aim is to prevent unnecessary hospital admission by providing safe discharge and link closely with intermediate care services to promote follow-on rehabilitation.

4.10.3 In Liverpool a 'tracker team' has been developed, made up of community trained nurses who are employed by the PCT but work in the Royal Liverpool United Hospital, working with wards to identify patients ready to be transferred to intermediate care. The scheme claims that there has been a dramatic improvement in throughput of patients from acute to intermediate care, and when the hospital is on red alert, an up-to-date list of patients suitable for transfer to intermediate care is immediately available.

4.10.4 Locally, Burton Hospital is opening a Clinical Decisions Unit - a GP run service based in Accident and Emergency and including nursing and Staffordshire Social Services support, to divert people from admission. The East Staffs PCT Community Intervention Team will follow up.

4.10.5 Relationships between the acute sector and intermediate care locally are generally good, and there is an acknowledgement of the rapid development that has taken place in this field. Some collaborative work between the sectors is developing – for example in High Peak and Dales, the PCT is employing a nurse to work in Stepping Hill hospital (in Stockport) to review patient's admissions with a view to appropriately preventing admissions or facilitating discharge.

RECOMMENDATION 13 – driven by Key Element 10

Derbyshire's Health and Social Care communities should consider whether developing a more active partnership between the acute hospitals and community services, as in the examples above, would increase the numbers of people appropriately accessing intermediate care.

4.11 Key Element 11: Links to mental health services to support people with dementia

4.11.1 Support for people with dementia

4.11.2 The single biggest gap identified in the current range of Intermediate Care services, and one which was raised by staff in all of the areas, was the very limited range of services for older people with mental health problems or dementia as well as physical problems.

4.11.3 This is not just a local issue. Prof. Ian Philp, the Clinical Director of the Older People NSF has noted that:
"People with dementia are a particular group of people who are best staying in their own familiar environment with familiar faces. One of the things we are finding as we are developing intermediate care services, which includes services which help prevent hospital admission for appropriate people and help support early discharge, is that the people who might benefit most from these services, that is people with dementia and a physical problem, an acute problem, are often people who get excluded from these services because they are the most challenging to look after…. The challenge for our whole health and social care system… is to manage the people with the greatest needs in the most homely environment that we can."
[Prof. Ian Philp. Evidence to Select Committee on Health 2002]

4.11.4 This is an issue which will increase in the future. The University of Leicester has made estimates of the future numbers of older people with dementia, and with depression in Derbyshire. They estimate that the number of cases of dementia among older people aged 65 and over will increase from 7,900 in 2000 to 8,700 by 2010 and 9,300 by 2015: an increase of 17% in total. Cases of depression among older people are estimated to increase from 13,900 in 2000 to 16,400 in 2015, an increase of 18%.

4.11.5 Areas within Derbyshire are starting to address this issue, and the Southern Derbyshire Health Community is starting to develop an overall approach, which is to be commended. It could not be said currently that there is a comprehensive approach across the County. Such an approach would involve developing the competencies of all staff in NHS and social care to recognise and manage people with dementia properly. It would also involve having professional expert advice, support and education from a range of mental health professionals within, or at least available to intermediate care teams. Members of the Project Board visited Nottingham Intermediate Care services and noted that such support was available to Intermediate Care teams there, and appeared to be much appreciated.

4.11.6 'Dementia Voice' have developed a template, recommended by the Department of Health, as a statement of principles for developing Intermediate Care for people with dementia:
http://www.dementia-voice.org.uk/Consultancy/Intermediate_care2.htm
This states that the aim of Intermediate Care for people with dementia should be to enable people with dementia to retain or regain abilities, where the loss of these abilities would significantly change the quality of their life experience and/or living arrangements, and such change would not be consistent with their understood wishes.

RECOMMENDATION 14 – driven by Key Element 11

Derbyshire's Health and Social Care communities should develop plans to develop the capacity of Intermediate Care schemes to be able to provide a service for people with mental health problems or dementia. The Health and Social Care communities should also consider the provision of specialist support to teams.

4.12 Key Element 12:

Increased focus on prevention of admission and increased focus on providing assessment after acute admission in a non-acute environment

4.12.1 Intermediate Care Assessment and admission to residential care

4.12.2 One of the objectives of Intermediate Care is to prevent unnecessary admissions to care, in residential or nursing homes. Some older people do want the security of entering such an establishment, but the majority wish to retain maximal independence and to return to their own homes after a hospital stay. The Discovery Interviews have revealed a number of patients expressing a strong motivation to return home.

4.12.3 In addition one of the carers surveyed for the Review commented, *"Without this mother would have needed to go to hospital and would have become institutionalised, which was beginning to happen after four weeks in hospital."*

4.12.4 An Intermediate Care assessment should be an interdisciplinary endeavour, using the single assessment process, designed to establish whether the patient has the capacity to benefit from a re-ablement process. Currently not every person who enters such a home will have such an assessment.

RECOMMENDATION 15 – driven by Key Element 12

Derbyshire Health and Social Care communities should move over time to a position where no one is admitted to permanent residential or nursing home care without having had an assessment to see whether they could benefit from Intermediate Care.

4.13 Key Element 13:

Professionals recognising the need for a period of recuperation and longer-term rehabilitation, and services which make room for this

4.13.1 Transition from intermediate care to other services

There is evidence from the surveys accessed by this review that service users do not always understand how long they will be in intermediate care, and sometimes find the transition to mainstream services difficult. This may be a reflection of the fact that they found the experience so positive that they miss it when it is no longer available!

For example one user noted: *"Intermediate care was very good but has ceased to carry on. No one has been near me since to assess me."*

A carer remarked: *"In discharge, not always clear who doing what though a lot of talk beforehand."*

4.13.2 Other organisations including the private and voluntary sector can play a valuable role in easing the transition to home based care. In Derbyshire, Age Concern offers befriending and other help, although capacity is limited. In Nottingham an Age Concern organiser is in the same office as the intermediate care team, and there are other examples with different organisations.

4.13.3 Day care can also help to ease the transition to mainstream services if they are needed, as can a period of overlap with intermediate care.

RECOMMENDATION 16 – driven by Key Element 13

Derbyshire's Health and Social Care communities should discuss with other sectors ways of working together to ease the transition from intermediate care to subsequent services.

4.14 Key Element 14:

Services which are continuously marketed, regularly evaluated to inform commissioning and delivery, with ongoing development of staff and services

4.14.1 Research and user feedback

4.14.2 A survey was carried out for this review covering 62 service users of Intermediate Care schemes in parts of the County. The survey showed that:

- Three quarters of respondents had found the experience of Intermediate Care very helpful, and another 20% found it fairly helpful. Three people reported it as not helpful.
- 89% of users thought that their views on progress were sought in full or partially, and 11% thought that they were not sought.
- Most respondents understood fully or partially what the intermediate care programme was trying to achieve and how long it would last, but around 10% felt that it had not been discussed.

4.14.3 A number of areas do get service user feedback on a regular or occasional basis, and some survey all those who have received a service. In addition a number of schemes in southern Derbyshire are undertaking 'Discovery Interviews'. Discovery Interviews are an initiative sponsored by the NHS Modernisation Agency, which are intended to identify realistic and manageable ways for teams to learn directly from patients and carers about their needs so they can be met better. The interviews create a 'narrative' about the user/carers journey through their experience which led them to need intermediate care. These narratives are then shared directly with the teams. Amber Valley PCT intends to use this technique as part of its evaluation of a new residential Intermediate Care facility that it is opening.

RECOMMENDATION 17 – driven by Key Element 14

All Intermediate Care schemes should have arrangements for getting user and carer feedback on their services and the Health and Social Care communities should consider some standardisation of measures to aid comparability and validity.

Health and Social Care communities are asked to consider using the Discovery Interview technique as a way of enabling teams to learn directly from patients and carers.

4.15 Key Element 15: Clarity of outcomes expected from intermediate care. Monitoring and evaluation of those outcomes

4.15.1 Targets and objectives

4.15.2 Few schemes appear to have specific targets or objectives in terms of reductions in numbers of hospital or nursing home admissions, or facilitating discharge, and few therefore monitor performance in this area. A few schemes, such as Clay Cross and High Peak and Dales have made some moves to looking at outcomes, and this is to be welcomed. Nottingham management teams regularly receive reports on the performance of Intermediate Care, and this is used to manage performance, and to justify investment.

Overall however, while they are undoubtedly doing good work, it can be difficult to be clear about what the outcomes of the Derbyshire Intermediate Care services are. As Intermediate Care is a joint venture, it would be helpful if a jointly agreed set of performance monitoring information could be devised.

RECOMMENDATION 18 – driven by Key Element 15

Derbyshire's Health and Social Care organisations should regularly review the performance of intermediate care against targets, using an agreed common format.

4.16 Other Issues – Information

4.16.1 Few areas have well-developed arrangements to provide overall management information on the working of the Intermediate Care system as a whole, and there is little in the way of common management information that is available to Health and Social Care partners. Some areas, such as High Peak and Dales have developed their own spreadsheet based systems.

4.16.2 The Southern Derbyshire Intermediate Care Group has been working with Derwent Shared Services to produce an Intermediate Care database which will be able to produce better information on the usage and profile of the schemes. While this might be superseded in the future by developments in information systems, particularly in the NHS, it could provide a useful short-term method of addressing this gap, particularly if rolled out across the County.

In the longer-term fully integrated electronic information systems would save practitioner's time and provide more coherent care.

RECOMMENDATION 19 – driven by "Other Issues – Information"

Derbyshire's Health and Social Care Communities should consider the implementation of the proposed Derwent system for collecting management information, or something similar as an interim measure.

4.17 Other Issues – Carers

4.17.1 A survey of 26 carers carried out for this Review showed that a majority of carers, three quarters of those responding, had found Intermediate Care helpful, and felt that their views had been sought. A typical quote is: *"Help and advice was always there when required".*

Another respondent said that the team: *"Answered all my questions throughout this programme."*

4.17.2 The Discovery Interviews with carers confirm this view. Not everyone at the beginning however understood what the programme was trying to achieve or how long the programme would last. A small number felt that their views on assessment or on progress were not sought.

One respondent noted that: *"There was never any discussion with myself. I have to work full-time."*

Another commented that what was needed was: *"More consultation with main carer and consideration of carers needs and other responsibilities."*

In some cases carers have suddenly been thrust into a new role. One carer said*: "...becoming a carer its like a bit of a shock because you are not used to it…We were both a little bit stressed at first because we didn't know exactly what to do."*

4.17.3 It is worth noting that less than half of carers in the survey described their health as 'very good' or 'good'. More than half said it was 'fair' or 'poor'

4.17.4 This review has found that all Intermediate Care schemes in Derbyshire intend to involve carers in their assessment and programme of intervention, and the interview results would seem to show that in most cases they do so. Few however had any explicit policies on how and under what circumstances to involve carers, and few mentioned carer's assessments.

RECOMMENDATION 20 – driven by "Other Issues – Carers"

That Intermediate Care schemes should have explicit policies on their approach to involving and working with carers.
Carers should be involved with the personalised care plan.
Carer's assessment should be offered within the existing policies.

4.18 Other issues – Costs of Intermediate Care

4.18.1 There has been little rigorous evaluation of the effectiveness of intermediate care, although there are an increasing number of studies becoming available. Economic evaluations of intermediate care are also thin on the ground.

4.18.2 Locally, the Clay Cross Integrated Assessment and Intermediate Care Team are evaluating costs and outcomes. Over the first three months of operation the team estimated that it prevented 11 hospital admissions and facilitated early discharge for 12 people, as well as reducing the support input required to maintain 22 people in their own homes. They estimated that the opportunity cost savings of these changes is £185,000 in a full year. They also estimate further savings from reduced future admissions due to improved physical ability and functioning.

4.18.3 Members of the Project Board visited Nottingham, and were given a copy of their Intermediate Care Strategy. Nottingham estimated in 2003 that the average annual cost of an Intermediate Care 'place' was £26,000, and that a 'place' will provide 12 episodes per year. Their planning assumption is that admission to intermediate care will reduce length of stay by an average of 10 occupied bed days.

RECOMMENDATION 21 – driven by "Other Issues – Costs of Intermediate Care"

Derbyshire's Health and Social Care communities should ensure that all schemes record information on the costs and effectiveness of intermediate care, including estimates of any cost savings, so that informed decisions about investment and development can be made.

4.19 Other Issues – Co-ordination and Learning

4.19.1 Good work is being done within the north and south of the County in co-ordinating developments, which is to be commended. However those working in the area are not always aware of what is happening elsewhere in Derbyshire. This is particularly true between the north and south of the County.

RECOMMENDATION 22 – driven by "Other Issues – Co-ordination and Learning"

Derbyshire's Health and Social Care communities should promote more interchange of ideas and experience across the county as a whole, so ideas that work in one area can be quickly transferred elsewhere.