APPENDIX 1

Darlington Joint Intermediate Care Plus Strategy

2011-2014

DARLINGTON BOROUGH COUNCIL

NHS County Durham and Darlington

Draft

Contents

PREFACE

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Preface

The Darlington Joint Commissioning Strategy outlines Darlington Borough Council (DBC), NHS County Durham and Darlington (NHSCDD) and Shadow Clinical Commissioners Group (CCG), intermediate care commissioning intentions based on an outcome based whole systems model of 24/7 integrated intermediate care services.

1. EXECUTIVE SUMMARY

Through the joint Strategic Commissioning arrangements the draft Intermediate Care strategy has been developed by DBC, NHSCDD and the emerging CCG. Based on the County Durham Joint Commissioning Strategy to enable consistency [1], it specifies how the partners intend to commission Intermediate Care and Re-ablement services over the next 3 years (2011-2014) reflecting the needs of the local population of Darlington.

Commissioners from Health and Adult Social Care have worked with the key partners involved in the patient/user journey to analyse the current picture of service provision and develop evidence based outcomes and strategic commissioning intentions.

This strategy has been guided by local and national policy and by the priorities set out in Darlington's Sustainable Community Strategy 2008 – 2021 [2], in planning for an ageing population and to work across health and social care to provide improved management of a broad range of long term conditions in the community, supporting good health and wellbeing.

The ambition is to improve the service user experience and quality of care whilst at the same time significantly reducing emergency admissions to hospital and the need for long term care.

The overarching vision for Durham and Darlington intermediate care services is:

To develop an equitable County Durham and Darlington approach to intermediate care using the principles of world class commissioning to drive cost effective use of resources and maximise independence and quality of life for service users.

1. County Durham and NHSCDD, Joint Commissioning Strategy for Intermediate Care (2009-2013)
2. One darlington: Perfectly Placed. A Vision for Darlington: (2008-2021) Darlington's Sustainable Community Strategy

2. STRATEGIC OUTCOMES

The outcome defined within Darlington's Sustainable Community Strategy (2008-2011), " People in Darlington are healthy and supported to live full and active lives" provides the overall context for developing intermediate care plus. What this outcome would look like for intermediate care is that;

1. People are empowered to make choices about their quality of life, health and care.
2. Effective early intervention and preventative services support vulnerable individuals, families and communities to secure good outcomes.

The development of Intermediate Care, and its integration with reablement and other rehabilitative community based services, is seen as essential to the transformation of health and social care and to maximising people's independence. In other words, developing a whole systems model of intermediate care – 'Intermediate Care Plus'.

NHSCDD, DBC and CCG are committed to investing in a unified Intermediate Care Plus framework model and have agreed to develop the joint commissioning strategy.
The next step is to commission an Intermediate Care Plus service 'Intermediate Care Plus would represent a whole systems model for a twenty-four seven outcome based Intermediate Care service which will intern provide a platform to support the better management of a broad range of long term conditions in the community.'[3]
It builds on the local approach to re-ablement.
Darlington GPs have been selected amongst 52 other GP Practices to be the first to take on commissioning responsibilities as part of the Government's plans set out in the NHS White Paper 'Liberating the NHS: Equity and Excellence' [4].

The Shadow CCG, will work together to manage their local budgets and commission services for patients direct with other NHS colleagues and local authorities.

These pathfinders will test the new commissioning arrangements to ensure they are working well before more formal arrangements come into place.
The targets related to the Shadow CCG are:

- Reduction in Zero and one day stays of over 65's (Consideration to better management of the intermediate care beds and spot purchasing ability will be required – undertaking a scoping exercise on the current usage of the beds).
- Reduction in zero and one day admissions of residents from nursing and care homes

3. County Durham and Darlington confirmed commissioning Intentions for the 2011/2012 financial year (NHSCDD)
4. White Paper: Equity and excellance: Liberatng th NHS (July 2010)

The strategic outcomes and evidence based commissioning intentions have been designed through consultation to reflect local needs, demographics and health profiles.

- **People are prevented from reaching a crisis situation through earlier intervention and joint working; including timely and appropriate access to specialist services, avoiding admissions to hospital**
- **People receiving timely and co-ordinated short term care at home or closer to home, enabled to live independently reducing unnecessarily admission to long term care, particularly following a period in hospital.**
- **People having control over their lives; involvement in their care and choice over their treatment**

High level actions have been developed to meet the outcomes and have been integral to the consultation on the development of a Joint Action Plan that will guide the implementation of the Joint Intermediate Care Plus Strategy.

3. NATIONAL POLICY AND LOCAL GUIDANCE

Nationally the emphasis is to make care available, where safe to do so, outside hospital, closer to people's homes and tailored to the needs of the individual. This is supported in policy through "Putting People First – Transforming Adult Social Care" [4] and the national refresh of the intermediate care guidance "DH Halfway Home" (DH 2009) [5].

Definition of Intermediate Care

The original guidance (DH 2001) [6] described Intermediate Care as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, prevent premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

The key additions to the 2001 Intermediate Care Guidance (DH) includes services that meet the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are developing care plans that are person-centred and reflect the individual's outcomes. The timescales for reviews are incorporated into these.

4. Putting People First (DH 2007): A shared vision and committment to the transformation of Adult Social Care
5. Intermediate Care "Halfway Home" (DH 2009) updated guidance for the NHS and Local Authority
6. ASC/LAC Intermediate Care Guidance (DH 2001)

- They involve cross-professional working, with a single assessment.
- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood.
- Renewed emphasis on those at risk of admission to residential care.
- Inclusion of people with dementia or other mental health needs.
- Flexibility over the length of the time-limited period.
- Integration with mainstream health and social care services.
- Timely access to specialist support as needed.
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement.
- Governance of the quality and performance of services.
- Clarity on where decision-making falls.

With the advent of the new Coalition government in May 2010, the Secretary of State indicated that Health and Social Care economies must be influenced by the emerging priorities that:

- Patients must be at the heart of everything, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about them, without them.
- The focus for Health and Social Care should be to seek to achieve continuously improving outcomes. Not simply measuring inputs or constant changes to structures, but a consistent, rigorous focus on outcomes which achieve results for patients.
- Professionals are empowered to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes.
- As a society, focus should concentrate on improving the health and wellbeing and of preventing ill-health more effectively, of families and communities. This will result more in the overall health outcomes being sought, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society.
- Health and social care should be more integrated. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. There is a need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

The government's emphasis on the importance of partnership working as the main vehicle by which the delivery of intermediate care may be achieved is supported by much research. Fragmentation and lack of integration across health and social care remain features of current provision in Darlington and continue to have an impact upon the ability of intermediate care to deliver patient-centred care and contribute towards health and social care systems as a whole.

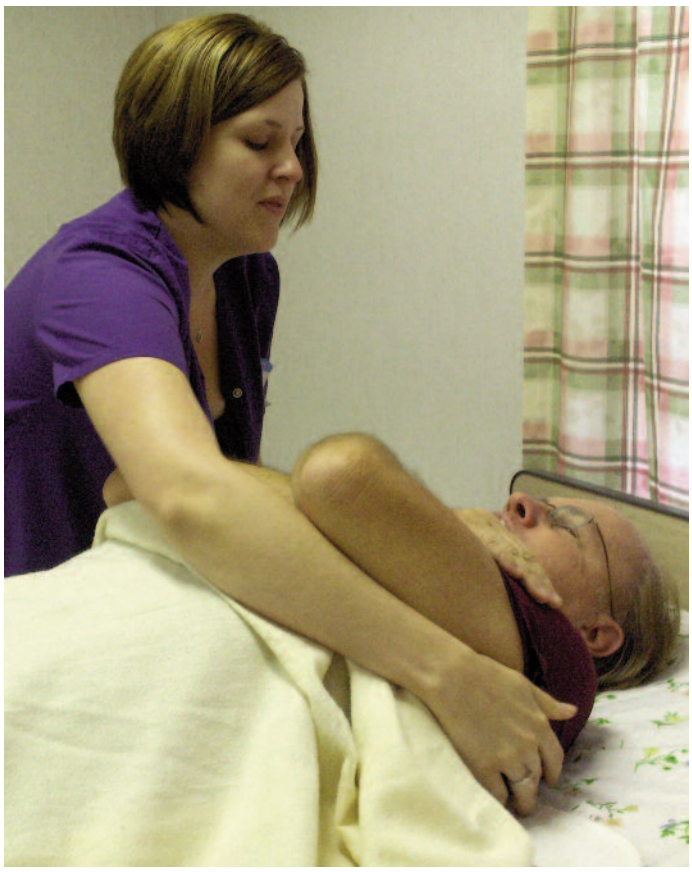
NHSCDD, DBC and CCG have jointly developed and produced this Intermediate Care Plus Strategy taking a common approach which will signal the need for provider integration. This supports the drive for efficiencies in the Council and the achievement of quality, innovation, productivity and prevention (QIPP) for NHSCDD and GP Clinical Commissioners. It will also support achievement of the pathfinder objectives.

Intermediate Care Refresh – The National Direction

The future service provision in Darlington needs to take account of National developments. The Department of Health has consulted regionally with key personnel involved in planning and delivering intermediate care and those who have experienced intermediate care services. This consultation looked at whether the original guidance detailed in Circular LAC (March 2001), which includes the current definition of intermediate care was still relevant or whether it needed updating. A refresh of the guidance entitled 'Intermediate Care – Halfway House' was published in July 2009 by the Department of Health.

"Halfway Home" states that the services that might contribute to the Intermediate Care function include:

1. Rapid response teams to prevent avoidable admission to hospital for patients referred from Primary Care, Accident and Emergency or other resources, with short-term care and support in their own home;
2. Acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics;
3. Residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks;
4. Supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing;
5. Day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

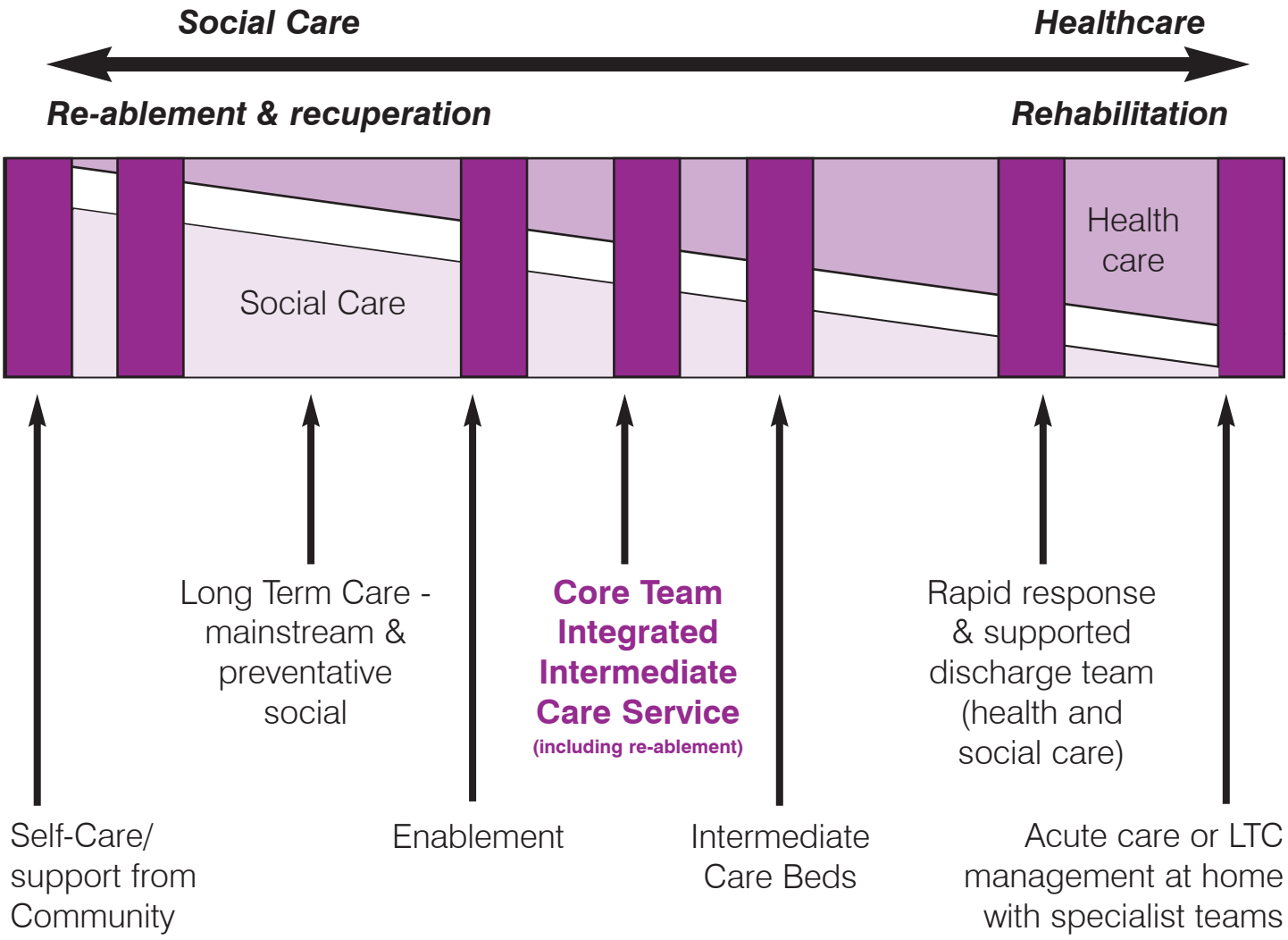


4. INTERMEDIATE CARE PLUS - The whole system model

Locally an approach 'Intermediate Care Plus' has been developed. A key aspect of this approach is to view the care delivery as a function which can be provided by a wide variety of community services and not stand alone team(s). Intermediate care supports anyone with a health and/or social related need through periods of transition. Operating across services, health and social care providers have a responsibility to assess or identify people where intermediate care will be of benefit. The role for a dedicated team(s) is in providing an intensive support function. In Darlington this could be provided through one integrated team forming a core intermediate care service.

Health and Social care provide different but complimentary intermediate care services an integrated model with strong links to the wider services should form a continuum of care. The diagram below has been adapted from Halfway Home to illustrate what could be delivered in Darlington spanning acute and long-term care, linking with social care re-ablement and through to on-going support and/or self care.

Figure 1: The continuum of Intermediate Care



A whole system model would include;

- Specification of service design
- Pathway
- Functions

Service Design Key Features

The whole system model is predicated on the key features identified below:

The Network of services

The majority of the intermediate tier function (i.e. care delivery) will be provided within an integrated or network of community health and social care services. Community Health and Social Care teams would need timely access to a core Intermediate care service and specialist support for intensive care and support. Ideally, integrated, but could be aligned services forming an interdependent network which draws on skills and expertise to benefit the individual. Partnership agreements will need to be in place to ensure effective flow through the intermediate tier, preventing delays in transfer of care from one element of service to another.

Available to all adults

Equity of access, all adults requiring health or social care should be assessed for their potential to improve and optimise their independence with input from community health and social care support, integrated assessment and care planning processes. Those who can be cared for safely in the community should not be excluded by age or diagnosis, particularly those with a mental health need.

Early intervention to prevent crisis

Proactively preventing unnecessary admissions through accessible medical and diagnostics, 24/7 response and risk management to increase earlier identification for interventions. The ability to be flexible in providing support services.

Time-limited

Care in the intermediate tier is short-term and goal-focused. It provides time for assessment, and/or interventions focused on specific, agreed outcomes to be achieved within days and weeks. People should be supported to return to self care or into support/longer term care provision. Care and support planning for longer term care should include an ongoing focus on maximising independence and continued enablement and rehabilitation.

Delivered at Home or in a Community setting

Wherever possible, assessment and provision of intermediate care will take place at home. Assistive technology will support managing risks and independence. For those assessed as at risk if 24 hour care is not provided or their home is unsuitable, a community Intermediate Care bed may be the only viable option.

Focused on Good Health and Well-Being

Access to services will be widely available, a person or their family or carers could identify their risks to professionals through self assessment. Professional integrated assessments must be holistic, taking responsibility for signposting or co-ordinating referrals to other services, for example, for benefits advice or dietetics. Where possible, this is with the aim of returning to an optimal level of independence.

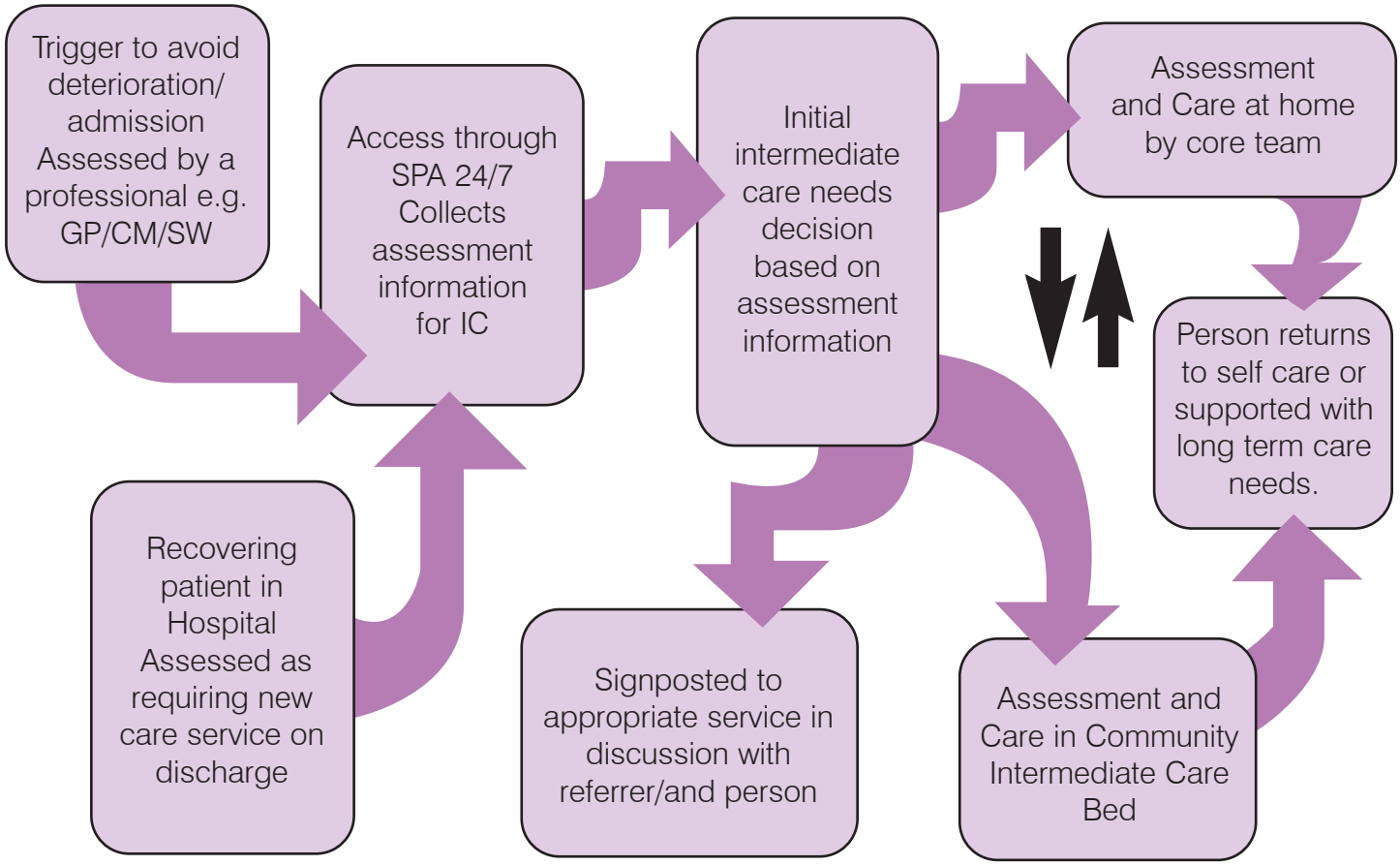
Intermediate Care Pathway

A streamlined pathway to ensure a flow through the intermediate care for the individual at a time and level their needs dictate. An effective pathway relies on interdependent community health and social care within the locality. Commissioning and service design will therefore need to be either joint or closely aligned to ensure there are no gaps and link to wider services which includes housing, independent sector and the ambulance service.

The general direction is clearly moving towards a broader view of intermediate care with specialist health care services falling under an 'umbrella' of bridging services between hospital to home and vice versa and from illness to recovery or wellness.

Access to the core intermediate care service needs to be simplified and through a Single Point of Access (SPA)

Figure 2: Draft Intermediate Care Pathway



Partnership agreements will be needed to ensure effective flows into and out of intermediate tier services to prevent delays in transfer of care, promoting ownership in the locality to identify problems early, preventing, where possible, crisis situations and facilitate timely discharge from acute care as soon as it is medically safe to do so.

The ambition to achieving a consistent pathway for intermediate care services across County Durham and Darlington will support effective links being made which are necessary so that potential users are referred into intermediate care from shared services such as Accident and Emergency, 111 or Ambulance. However this does not necessarily mean a uniform approach. Consistency needs to be delivered in a way that enables tailoring of local intermediate care services to the needs of the local population. In essence this means that the volume or capacity of services may vary according to local population needs, or that the method of service delivery or model may also reflect the local resources and preferences of that specific community.

Intermediate Care Functions

A comprehensive core intermediate care service will provide three strands of care – making up the 3 "R"'s. These may be delivered intensively by a core team or by other providers who have a responsibility to deliver some aspect of the intermediate care function to meet individual outcomes.

The "3R's"

- Recovery
- Rehabilitation
- Re-ablement.

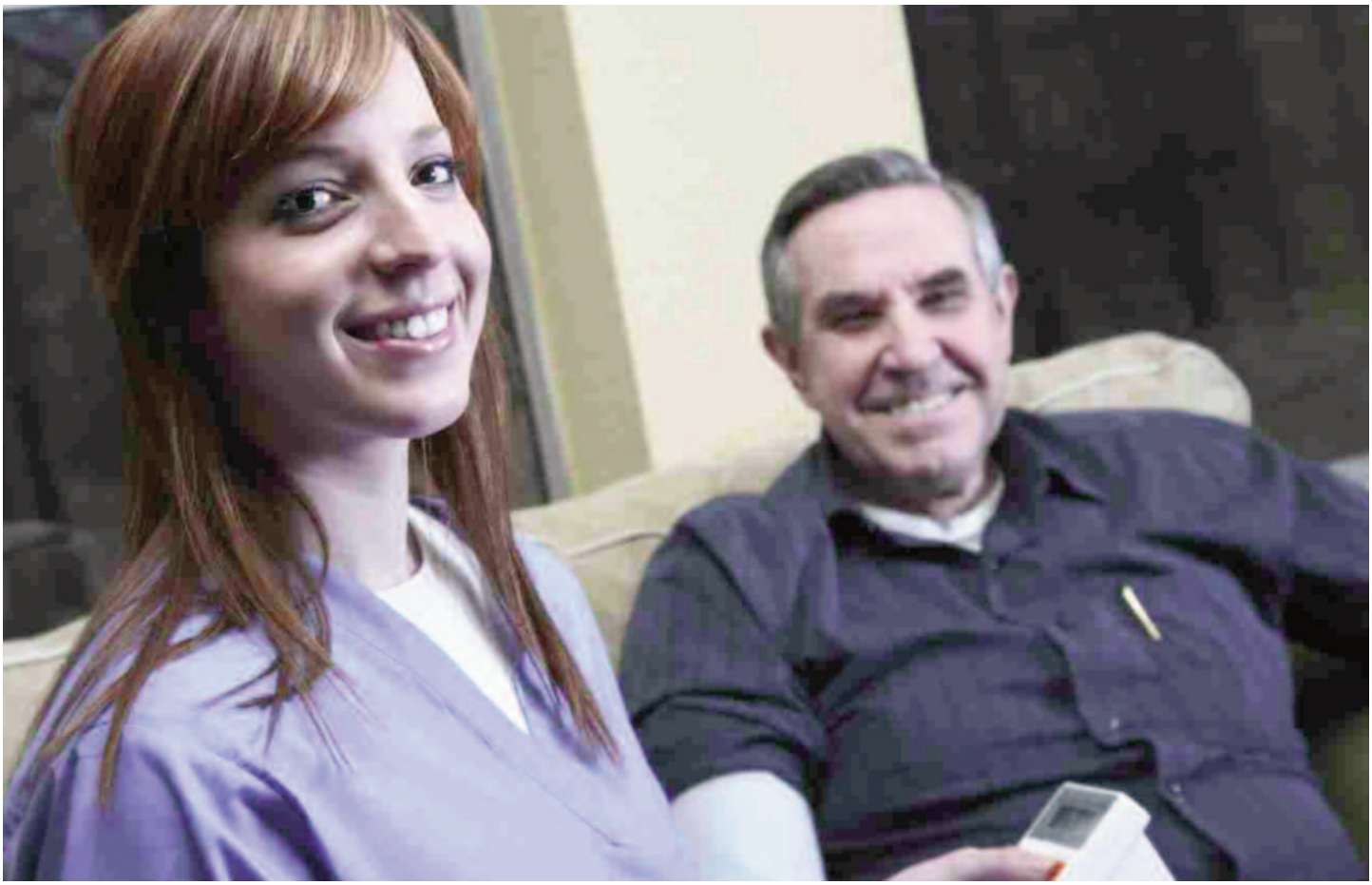


Table 1. The Intermediate Care Functions.

Recovery	
Rapid response	To fast responsive intermediate tier function both in the community and in the acute setting to manage people back into the community from A&E. Diagnostics/advanced and emergency practitioner skills, for example, intravenous antibiotics, suturing, confusional episodes.
Skills in care planning and management	To pro-actively identify and care plan for the deterioration of long-term conditions and provide advance level care when required including mental health care. To prevent deterioration or recovery following an episode of acute or sub-acute care. General nursing and therapy for people with dementia and mental health needs with ability to identify as mental health specialist services are required.
Medical Care	General Practitioners work with the community teams with speedy access to specialist medical care including Psychiatrists
Provision of 24 hour care	• Access over 24 hours to Intermediate Tier services • Assistive technology used to minimise risk and manage short-term episodes at home. • Bed base designed to meet sub-acute, rapid diagnosis through to recuperation for those service users who cannot be cared for in their home
Rehabilitation	
Therapy-led	Community Rehabilitation, both physical and mental health, focused on short-term outcome focused rehabilitation. Allied Health Professionals assessing and providing care supported by technical assistants includes dietician, SALT and pharmacy technician support as required. Generic health and social care workers provide the ongoing needs during a period of rehabilitation. Access to assistive technology. The therapists will also need to provide professional assessment, care planning and supervision of re-enablement.
Re-ablement and enablement	
Therapy-led (Darlington) County Durham will not be Therapy-led	Optimising a person's independence within agreed short-term and goal focused care plans. All new service users and those with a change in circumstances who are referred to health and long-term social care to be considered for assessment of their potential to improve or learn new skills with support, aids and adaptations. Care provided by generic and specialist health and social care workers working with the enablement ethos.

The most fundamental drive for this strategy is for the Intermediate Care function to be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management.

The IC Plus model has been developed in line with the direction of travel outlined in this Strategy and is based on task group intelligence and collated workshop information.

5. THE CURRENT POSITION AND PROPOSED PROVISION OF INTERMEDIATE CARE IN DARLINGTON

The strategic direction to develop and modernise health and social care towards a whole systems model of intermediate care plus means that Adult Social Care, In-house Home Care teams, Community Health Teams independent sector providers will be required to change the way in which they work in order to provide services which meet intermediate care plus outcomes.

The direction of provider health and social care rehabilitative and re-ablement services in Darlington is to restructure the operational function. Adult Social Care restructuring and Transformation of Community Services will support the integration and development of Intermediate Care Plus and utilise the strategic commissioning function to better effect.

Intermediate Care Provision

The core service should generally be provided in the person's own home or community-based settings, but a range of services is likely to be needed, including beds in residential settings, some with nursing care. A dedicated intermediate care facility is proposed, developing and providing intermediate care functions as opposed to long term care.

DBC has set up reablement through bringing together the in-house Home Care team and 'Social Care' Intermediate care team and are now known as the Reablement Team. The Team now consists of 5 Care Managers, one Assessment Officer, 3 OT's and an in house support service. A 'Pathway' has been developed to include progress to an enablement team with close links to the lifeline mobile warden service.

The health Intermediate Care Team, may include a rapid response team to provide assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. It could also include more intensive support and treatment in the person's home to avoid admission or to facilitate discharge, sometimes described as 'hospital at home'. Part of the service should be available on a 24-hour, seven days a week basis, with access to assessment.

Sheltered or extra care housing can be part of Intermediate Care, providing a range of options with input from the core team. Within Darlington there are two reablement flats established within Extra care for those not able to receive reablement in their own home. In addition the core reablement team provides in reach into permanent care and 'short break stay' supporting people living in residential care to return home.

Rapid care and repair services/'handy man services have been identified as areas for development that enable people to move back home who might otherwise have remained in hospital or a residential setting.

Assistive Technology for instance such as Telecare has been identified as an area to be further developed in supporting the care pathway for intermediate care, supporting people to remain at home safely and independently who might otherwise have needed either residential care or more intensive home care. (Darlington Telecare Strategy 2011 -2014). Telehealth is also being piloted as a tool for early detection of deterioration within peoples own homes and in the care home environment.

Whilst much progress has been made there is a recognition that the current model for intermediate care is fragmented and it does not deliver an integrated whole systems model. There is evidence of some duplication of service provision and gaps in the services available leading to confusion for referrers and service users receiving a disjointed service.

Intermediate Care within a Broader Framework (Plus) of Transitional Services

In developing the strategy, it has become clear that intermediate care is linked and works with other key, transitional services such as stroke, falls, speech and language and respiratory services. Specialised services when required are crucial in ensuring that an individual's care is person-centred, that their personal care pathway through intermediate care results in timely referral and assessment by other key services, and is therefore necessary for joint working protocols and 'Partnership Agreements' to be robust to ensure that this takes place.

In addition, the need to link with a range of community services during and at the end of an individual's period of intermediate care is also vital, in helping to promote and sustain independence. These services are especially important with older people who are more likely to live on their own, or have been bereaved, and suffer personal difficulties which may include ill health which are likely to increase their risk of depression, loss of confidence about going out, motivation and isolation.

In view of this, it is not just the secondary health and social care services which need to be directly and formally linked to the intermediate care pathway. There is a need to ensure that in commissioning all other community providers, demonstrate a commitment and drive to 'integrate' within the IC Plus model, in changing the delivery of care and support across health and social care to help people remain living at home.

A focus on discharge planning which is proactive in referring and signposting people who have experienced intermediate care to wider community services will mean that people are supported on exiting the pathway through preventative services that promote and maintain independence and wellbeing e.g. advice and information, floating support, leisure activities/clubs, social support networks, and may be instrumental in helping to delay or prevent the future need for intermediate care, or access to long-term care or acute hospital in the future.

The research for this strategy has identified a need for a local model to ensure that wider transitional services and intermediate care are intrinsically linked. This is to ensure robust and timely referral and interventions, and that case co-ordination is seen as a core function of intermediate care supported by the 'Partnership Agreements' agreed by each of the relevant services. This principle will deliver a person-centred service which establishes any core, underlying social, health or environmental issues which can be addressed either directly by the intermediate care team or by wider, community services such as falls, stroke, respiratory services, or aids and adaptations.

The integration model across all community services is important to resolve the underlying cause of the need for intermediate care, seeking to prevent a reoccurrence of the same initial presenting factor.

6. RESOURCES AND FINANCE

In line with the economic downturn the financial drivers for both NHS County Durham and Darlington and Darlington Borough Council have been focused on achieving efficiency and quality in regard to delivering core health and social care services. There is also an increasing focus on delivering care in a way that promotes choice and control and care closer to home whenever possible. To achieve the outcomes outlined within this strategy it is recognised that the use of existing resources will need to be carefully evaluated and some reconfiguration will result, thereby delivering the strategy outcomes within existing resources. NHS County Durham and Darlington's Refreshed 5 Year Strategy for 2009/10 – 2013/14 clearly shows the focus of future spending patterns for the NHS.

This model, if carefully planned and successfully implemented will make a significant contribution towards QIPP targets. Quality, innovation and productivity will be achieved through co-ordination, integration, responsiveness and ensuring the best possible use of resources. Prevention will be ensured through inter-agency care management planning. Current services are fragmented, lack contingency cover and the customer journey is complex and difficult to navigate.

The service will also, with time, self fund through the redistribution of current spend. Data was extracted from all acute hospitals in Durham and Darlington for the period 1 April 2009 until 31 March 2010 for those patients who had an emergency admission who have a long term condition and are over the age of 65. During this period there were 10,084 admissions at a cost of £23,455,522. The ambition of this service is to reduce the number of overall emergency admissions for people with a long term condition by 10% in Year 1 and 40% by years 3 and 4. This would result in a reduction of emergency admissions by 1084 and reduce the cost by £2,345,000 in year 1 and at a cost reduction of approximately £9.4 million in years 3 and 4. The Pathfinder Programme objective of a reduction in non-elective admissions of the over 65's and also zero length of stays will form part of the overall drive for this strategy.

The data provided is broad based and will be further refined. It covers more than 800 admission codes and, looking at the range of conditions, it is considered that the above targets are reasonable as the majority of conditions could be successfully managed by this service in a community setting.

Intermediate Care Beds

There are some key issues to be resolved regarding the number and type of Intermediate beds available in Darlington to accommodate future population expectations. There is a recognition that there is no Community Hospital and that CDDCHS currently provide 15 Health Care Beds which include intermediate care, crisis intervention, respite, symptom control, step down and step up. In order to address these issues a needs assessment is required for a bed facility alongside other domiciliary elements of intermediate care. This information will assist in developing the intermediate care team skill mix as well as services in order to meet local need.

7. CURRENT AND FUTURE DEMAND

The following information has been collated from various data bases and needs to be read as headline information. Without the balanced perspective of other information, which lies behind this data, it does not allow adequate assessment of the impact of data quality in association with the strategic commissioning outcomes.

A priority action from this commissioning strategy is to develop robust performance management data by designing a 'balanced scorecard' that allows for a measurement system that will enable DBC, the NHSCDD and CCG to clarify the vision and strategy for an intermediate care plus model.

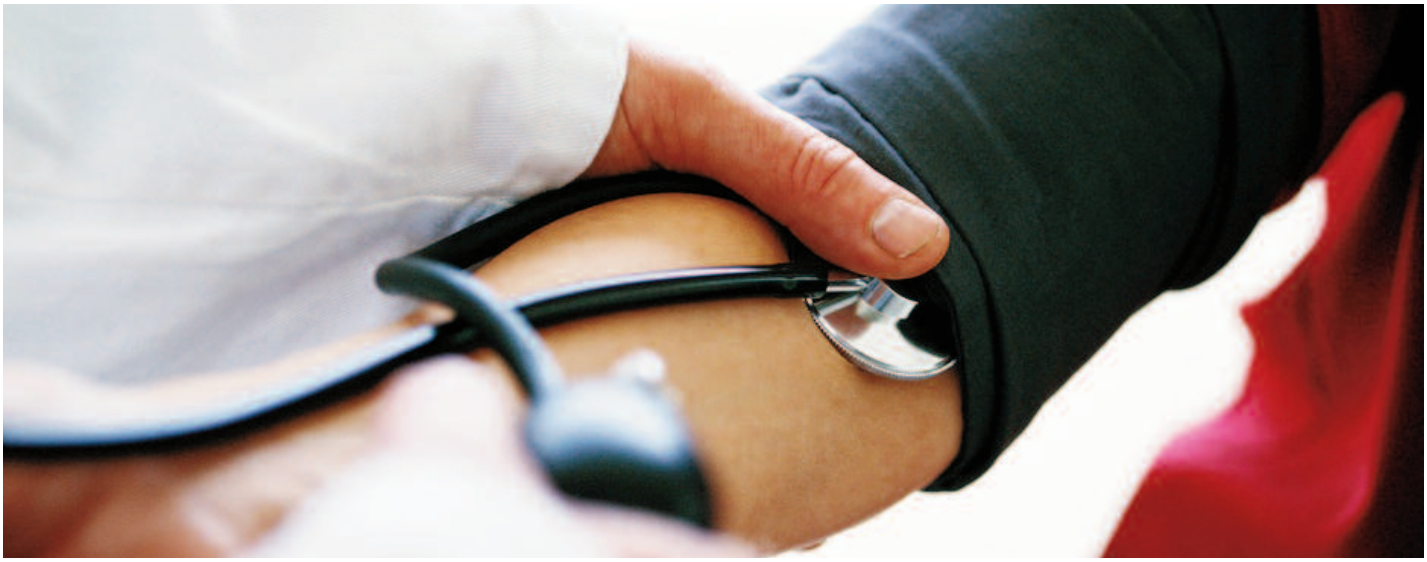
Estimating the current and future demand for Intermediate Care Services is a complex exercise as it very much depends on how Intermediate Care Plus is defined and what services are included. It also requires mapping of the needs of those individuals who are not currently accessing health and social care services, as well as those who are already known to service providers. Intermediate Care services are accessed by people with a wide range of different conditions, at different levels of need, and across all adults. For the purpose of this strategy, current and future demand for Intermediate Care services has been estimated by undertaking an assessment of the needs of the Darlington population. The assessment of need is based on a balance of national and local data and consists of demography, incidence and prevalence, and local and service user data.

This section has been produced using information from Darlington's Single Needs Assessment (2010) [7] and local statistical information held with health and social care teams. It highlights key facts that have informed the development of this strategy.

7. Darlington single needs assessment 2010/2011

Key Facts

- The borough population is around 100,400. Is it estimated that by 2015 over 19% of the population will be of the retirement age (65+). This is slightly above the national average of 17%.
- The very elderly age group (85+) is set to increase at an even greater rate from approximately 2400 people in 2010 to 3500 in 2025 (a 46% increase).
- There are four extra care facilities with 156 beds in Darlington. For the period 09/10 46 individuals moved on, disaggregated into 19 deaths and 27 moving on to care home accommodation. The utilisation rate for this period was 96%.
- There are 1,141 registered residential/nursing beds in Darlington, of which 922 are being occupied by people aged 65 and over. 548 of these placements have been commissioned by DBC. This number is projected to increase to 565 by 2013 and 659 by 2020.
- In 2009/10 there were 140 new admissions to long-term nursing (23) and residential care (117). Of these, approximately 60% of people where admitted to long-term care directly from hospital.
- Of the 140 new admissions to long term residential or nursing care in 2009/10, 115 had a community based support package prior to admission.
- Dementia prevalence in Darlington is higher than nationally and regionally. In Darlington the number aged 65+ suffering from Dementia is predicted to rise from 1,281 in 2010 to 2,261 in 2030. An increase of 77%.
- As of March 2009 Darlington Adult Social Care supported 3,300 service users, 60% of them were aged 75+ and 79.4% of service users have physical disabilities.
- Chronic Obstructive Pulmonary Disease (COPD) mortality rates are significantly higher in Darlington than England (2006-2008 pooled).
- Stroke and Cardio Vascular Disease (CVD) prevalence is higher in Darlington than England



In summary, the Single Needs Assessment 2010 and other local data sources highlight Darlington as having a growing population of older people and a population with relatively poor health status. Older people and people with poor health are more likely to develop long term conditions which lead them to require health and social care services which puts a significant strain on resources.

To manage a predicated increase in demand it will require a dramatic and radically approach in service planning and investment, not only on core intermediate care services but on 'specialist' and non statutory care services which supports the intermediate care pathway, enabling people to maximise their independence and decrease their reliance on costly acute and social care services.

In planning Intermediate Care and Reablement Services, it is important to be mindful of the differing health status and age profile of people living in the Borough and aim to locate services in areas where need is greatest.

Almost two thirds of admissions to long term residential/nursing care in 2009 to 2010 were made directly from hospital. This would suggest that aspirations to reduce long term care admissions is achievable through targeted intermediate care services. Good practice dictates that no one should be admitted directly into long-term care from hospital (unless there are exceptional circumstances) without first being offered a period of Intermediate Care and/or Re-ablement.

8. BROAD ACTIONS TO MEET OUTCOMES

1. The prevention of crisis situations through earlier intervention and joint working; including timely and appropriate access to specialist services, preventing avoidable admissions to hospital and support timely discharge.

Individuals will receive their care in the right place, at the right time. We will reduce the cost of acute hospital care and manage increasing projected demand.

- Agree a new Borough wide model for intermediate care plus
- Review intermediate care for cost effectiveness and plan future investment across Health and Social Care
- Strengthen working relationships with specialist and community health services, including Long-Term Conditions, Falls and Stroke.
- Develop integrated Intermediate Care Teams to facilitate joint working, flexible and responsive service delivery for Darlington
- Develop clear and consistent referral pathways between intermediate care and Accident and Emergency, the Medical Assessment Unit and Primary Care.
- Identify a Single Point of Access (SPA) accessible to all referrers and which is promoted widely.
- Develop an 'integrated' health and social care I.T system.
- Redesign Intermediate Care to provide in-reach to care homes and hospital.
- Review and develop the capacity to provide a rapid response component of the Intermediate Care Service to provide urgent community based assessment and immediate intervention in people's homes.

2. People receiving timely and co-ordinated short term care at home or closer to home enabled to live independently, reducing unnecessarily admission to long term care, particularly following a hospital stay.

Assessment and decision making about peoples long term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery

- Implement new pathway to ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement.
- Review current intermediate care bed provision and commission a service to meet future intermediate care plus needs.
- Support independent care home providers to manage people who live there to access intermediate care.
- Develop a unified assessment process, trusted by all with appropriate information shared between partners.
- Ensure that individuals with more complex needs (i.e. dementia) have equity of access for assessment and rehabilitation, prior to decisions being made about their longer-term needs. (Linked to Long Term Conditions Strategy).
- Integrated service to determine a clear assessment pathway which links to self-directed support processes.
- Partner organistions to agree clear eligibility criteria, protocols and pathways through partnership agreements.

3. People having control over their lives; involvement in their care and choice over their treatment

Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community.

- Develop the pathway to provide an integrated continuum of service provision.
- Develop a person centred 'menu based' approach to service provision.
- Invest and embed usage of Assistive Technology and 24/7 response to support people to remain in their own homes. (Linked to Assistive Technology Strategy 2011 -2014)
- Review community equipment available to intermediate care teams
- Review and commission low level hospital support from the 3rd sector.
- Invest in the Gold Standards Framework (GSF) training programme for care homes to support people being able to die in their place of choice. (linked to the End of Life care Strategy (2008 -2012).

To accomplish the above actions, the model needs to include appropriate specialist and timely medical assessment and input, at the triage point and during the intermediate care period.

It is recognised that some people will have repeat occurrences of intermediate care due to their increasing age and frailty, but it should be a key principle of the model that these episodes are mitigating and prevented wherever possible.

At the end of the intermediate care period it is also necessary to ensure robust discharge planning and exit strategies in order that people do not become delayed in the system unnecessarily or access free intermediate care services longer than their needs require.

In being able to meet these outcomes health and social care will need to deliver care in a way that not only demonstrates clear outcomes for in improving the health and wellbeing of individuals but cost effective and efficient services that demonstrate value for money.

The joint commissioning strategy will need to map current and future investment to ensure cost effective services, and develop a joint performance and financial monitoring framework to ensure that future intermediate care provision meets identified needs and achieves desired outcomes delivered within the defined budget.

9. CONCLUSION

Intermediate Care Plus is a lynch pin in the strategy for managing the projected rise in the older population and the increased numbers of people with long term conditions living longer with more complex needs. The challenge facing the Local Authority and the NHS is to commission a high standard of care and support within the current financial constraints and growing demand. One of the key aims of this strategy is to provide care closer to home where investment and/or redirection of resources will be required if a range of integrated community 'intermediate care plus' services are to be effective in Darlington.

The risk to achieving the strategic aims is not 'integrating' due to financial pressures and lack of commitment which will lead to continued gaps in intermediate care services.

Intermediate Care Plus is a model that will help in meeting this challenge by enhancing community services and, after initial investment and overtime funded by savings resulting from reduced emergency admissions to hospital care and to long term care will contribute to delivering efficiencies.

It is therefore vital that the Council and NHS integration remains a key component of the system for the future.

A clear plan for care which runs across health and social care boundaries with fewer hand-offs, should provide an enhanced patient/user experience and enable quality and outcomes to be better measured along a whole pathway. However, it is also clear that the prize of holistic and personalised services, delivered close to home, must include access to those wider universal services including leisure, housing, and the independent and voluntary sector, which are not necessarily included in typical integrated approaches.

The IC Plus model will need a commitment, and willingness with collective ownership from all stakeholders involved if 'intermediate care plus' becomes the new currency for community care. The result will mean people along the care continuum will have access to a new range of intermediate care services at home or in care settings, that will promote their independence through an enhanced streamlined pathway. The benefits for all concerned will be increased quality of care and support preventing avoidable admissions to hospitals, facilitate timely discharge and minimising premature dependence on long term care in both hospital and community settings, and reduce the use of ongoing home care providing higher quality, person-centred services.

Glossary

Acute Care	Specific care for diseases or illnesses that progress quickly, feature severe symptoms and have a brief duration.
Assistive Technology	The term 'assistive technology' refers to 'any device or system that allows an individual to perform a task that they would otherwise be unable to do, or increases the ease and safety with which the task can be performed' (Royal Commission on Long Term Care 1999). It is designed to maintain or improve someone's independence such as Telehealth and Telecare. Assistive technology ranges from very simple tools, such as calendar clocks and touch lamps, to high-tech solutions such as satellite navigation systems to help find someone who has got lost.
Care Package	Help people to stay at home with services based upon individual need. Clients can choose the type of support they want.
Care Plan	A single, overarching plan that records the outcome of discussion between the individual and the professional. It could be electronically stored or written on paper. It should be accessible by the individual in whatever form is suitable to them.
Carer	A carer spends a significant proportion of their life providing unpaid support to family or potentially friends. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.
Commissioning	The means to secure the best care and the best value for local citizens. It is the process of translating aspirations and need, by specifying and procuring services for the local population, into services which: • deliver the best possible health and well-outcomes, including promoting equality; • provide the best possible health and social care provision: and • achieve this within the best use of available resources.

Complex	A term used to describe people who have an intricate mix of health and social care needs. Because of their vulnerability, simple problems can make their condition deteriorate rapidly, putting them at high risk of unplanned hospital admissions or long-term institutionalization.
Holistic	Used in medical terms as treatment which deals with the whole person, not just the injury or disease.
Home	For the context of this strategy references to an individual's home means 'an individual's usual place of residence'. This includes owner occupiers, rented accommodation, sheltered housing, extra care, care homes and prisons.
Integrated Care	NHS and local authority health responsibilities are managed together so that care trusts can offer a more efficient and better integrated service.
Intermediate Care	Integrated services for people that promote faster recovery from illness, prevent unnecessary hospital admissions and maximise independent living.
Long Term Conditions	Those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies.
Multidisciplinary	A team made up of professionals across health, social care and third sector who work together to address the holistic needs of their patient service users/clients in order to improve delivery of care and reduce fragmentation.
Pathway	The route followed by the service user into, through and out of NHS and social care services.
Personalised	Personalised care is about putting individuals firmly in the driving seat of building a system of care and support that is designed with their full involvement and tailored to meet their own unique needs.
Primary Care	The collective term for all services which are people's first point of contact with the NHS, e.g. General Practitioners, dentists.
Re-ablement	Re-ablement aims to help people accommodate their illness or condition by learning or relearning the skills necessary for daily living - it encourage and supports people to do as much as they can for themselves, doing tasks with individuals rather than for them. For some, it could be supporting them with

	personal care or making meals, while for others it could be helping them to get out of the house and taking part in social activities, or helping them with rehabilitation programmes (e.g. physiotherapy, occupational therapy).
Rehabilitation	Rehabilitation is a goal orientated and time limited process aimed at enabling a person to improve/restore a person's physical, mental and social functioning. It can also aim at providing a person with tools to deal with their loss of and change in function
Secondary Care	The collective term for services to which a service user is referred to by a consultant. Usually this refers to NHS hospitals in the NHS offering specialised medical services and care.
Service Model	
Service Users	Anyone who uses, requests, applies for or benefits from health or local authority services.
Single Assessment Process [SAP]	Process that ensures older people's care needs are assessed thoroughly and accurately.
Telecare	A continuous, automatic and remote monitoring of real time emergencies over time in order to manage the risks associated with independent living
Telehealth	The delivery of healthcare at a distance using electronic means of communication – usually from service user to clinician eg a service user measuring their vital signs at home and this data being transmitted via a telehealth monitor to a clinician
Urgent care	"medically necessary services that are required for an illness or injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours." In other words, what the medical definition of urgent care means is that an injured or sick person who may suffer from irreversible complications or even death if his injury or illness is not treated in a timely manner is care required immediately or classified as "urgent." So any injury or illness that has the potential to become something more serious, or even deadly, is considered a basis for receiving urgent care.

An inclusive approach

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Darlington Joint Intermediate Care Plus Strategy

2011-2014

DARLINGTON BOROUGH COUNCIL

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