Draft Darlington Intermediate Care Plus Strategy
ACTION PLAN
2011-2014

NHSCDD, DBC and GPCC are committed to investing in a unified Intermediate Care Plus framework model and have agreed to develop a joint commissioning strategy which will look to commission jointly a service for the population of Darlington that provides the following outcomes:-

- 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

The following action plan has been developed to meet these outcomes however health and social care will need to deliver care in a way that not only demonstrates clear outcomes for improving the health and wellbeing of individuals but be cost effective and efficient, demonstrating real value for money

Key Actions

Ref	Actions	Resources/Funding Streams	Outcome	Date for completion
1. Commissioning				
1.1	**Agree a new Borough Wide model for intermediate care plus ensuring consistent access, eligibility, elements for services available, and outcomes for service users**	**Commissioner and project resource.**	**Agreed and approved Strategy**	**October 2011**

1.2	**Map current and future investment to ensure cost effective services, and develop a joint performance and financial framework**	**Commissioner /finance/business analyst and project resource.**	**Future intermediate care provision meets identified needs and achieves desired outcomes of preventing hospital/care homes admission, supports early discharge and promotes and maintains independence**	**April 2012**
1.3	**Commission and implement new model of low level hospital support from the 3rd sector. Evaluate pilot to support re-ablement funding bid**	**Re-ablement funding (to make an outline business case to continue pilot) 20k recurrent for three years**	**Pilot a Prevention and Supported Hospital Discharge Scheme aimed at supporting people to live independently in their own homes and supporting people before, during and after a period in hospital. People are supported and re-admissions reduced.**	**August 2011**
1.4	**Develop Intermediate Care Bed Facility and medical support.**	**Current budget for health beds and 160k social care funding for 2 years.**	**Meet GPCC pathfinder targets. Prevention of non-elective admissions.**	**December 2011**
1.5	**Develop Partnership agreements for integrated services which include single point of access, etc**	**Commissioner/ provider/legal and project resource.**	**Partnership agreements in place for sustainable services to meet strategic outcomes of the IC Plus Strategy**	**April 2012**
1.6	**Develop a joint specification for intermediate care for an integrated 24/7 model of care**	**Existing IC budgets for Heath and Social Care, and utilisation of additional reablement funding. Review V4M/efficiencies**	**New model fully implemented with agreed performance framework to monitor and evidence outcomes.**	**Sept 2013**

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2. Operations				
2.1	**Implement dementia collaborative changes to 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)**	**With IC Teams budget** **Implications for teams and TEWV to be identified in 1.2**	**People receive equity of access to assessment and services where eligible.** **Reduction in hospital admission to for those with long term conditions and increased support for independent living.**	**December 2011**
2.2	**Implementation of integrated team and support functions building on the dementia collaborative and partnership agreement to be developed.** **Develop implementation plan based on gap analysis to support consistent pathway**	**With existing resources and Value for Money (V4M) following the 1.2 exercise.**	**Delivery of seamless pathway through intermediate care services with robust links to wider teams and community.** **People are supported.** **Reduction in non- elective admissions to hospital and people being funded through for long term adult social care.**	**Sept 13**
2.3	**Review community equipment available to intermediate care teams**	**Existing budget for Community Equipment.** **Driver/Fitter project 35K** **Budget within Adult Social Care £17.5k.**	**Timely equipment and assistive technology to be delivered and installed to support the intermediate care pathway and Intermediate Care Plus Strategy Outcomes.**	**April 2012**

2.4	**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 of Lifeline service to compliment intermediate care pathway.**	**The expansion of delivery of Telecare 244k Social Care Funding to fund.** **Project resource.**	**Increase of out of hour's Mobile Response staff for people with Lifeline and Telecare systems.** **Prevention and crisis intervention at night, emergency response e.g. falls, anxiety attacks toileting etc. sitting with people waiting OOH GP and assessing for and immediate installation of Telecare.**	**April 2012**
Ref	**Actions**	**Funding Streams**	**Outcomes**	**Date**
3. Care Home				
3.1	**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).**	**13.5k social care funding. Recurrent for two years, with additional funding of 13.5k for care homes who wish to proceed to GOLD status**	**People are support to be cared for at home. Reduced non- elective admissions to hospital.** **Contributes to delivery of End Of Life Care Strategy Implementation - increased quality of care for EOL, choice of place for EOL.**	**September 2013**
3.2	**Develop Admission avoidance model based on Project for Dementia Collaborative.** **Analysis of emergency admission data.** **To include review of medical support and IC plus pathway for care homes.**	**Commissioning /contracts/business analyst/ project management.** **Funding if required to be identified**	**People are supported to be cared for at home where admission is avoidable or discharged when medically stable.** **Meets GPCC pathfinder targets for reduction of non-elective admissions.**	**March 12**