MINUTES OF THE SCRUTINY REVIEW - INTERMEDIATE CARE
THURSDAY, 3 NOVEMBER 2005

Councillors Adamou and J Brown (Chair)

Apologies Councillor (none)

Also Present: Councillor (none)

MINUTE NO.	SUBJECT/DECISION	ACTON BY
SCIC01.	**APOLOGIES FOR ABSENCE** None Received	
SCIC02.	**URGENT BUSINESS** None	
SCIC03.	**DECLARATION OF INTEREST, IF ANY,IN RESPECT OF ITEMS ON THIS AGENDA:-** None Received	
SCIC04.	**EVIDENCE TO THE REVIEW** Members received a presentation from the Expert Adviser to the Panel setting out the national context of Intermediate Care and outlining essential components and proposals for the future. It was noted that since the 1930's the number of over 65's had more than doubled and now more than one fifth of the population was over 60. Between 1995 and 2025 the number of over 80's would increase by almost half and the number of over 90's would double. Older people occupied 65% of acute sector beds. Transfers from acute wards accounted for 63% of nursing home admissions and 43% of residential home admissions. Less than 3000 beds per day were occupied by people awaiting discharge and most of these beds were occupied by people with Mental Health needs. It was noted Intermediate Care needed to address the needs of people with mental health issues. Intermediate Care was seen as:- • An emerging concept in health care • May offer attractive alternatives to hospital care • Care that is "in between" • Arises out of a policy imperative • Intermediate Care is delivered by those health (*and social care*) services that do not require the resources of a general	

hospital but are beyond the scope of the traditional primary care team (BGS)

Intermediate Care should focus on three key points in the pathway of care:-

responding to or averting a crisis, active rehabilitation following acute hospital stay and where long term care is being considered

The NSF for Older People (Standard 3) defined Intermediate care as:-

To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge & maximise independent living.
(*This includes adults with complex needs and older people with mental health needs*)

There was a discussion as to who made the decision on care particularly where there was a variety of needs and if the criteria meant that they could not be accommodated by IC then the decision would be taken to provide acute care. Acute care should deliver treatment for people with complex needs and then they should move to IC following an in depth assessment linked to objectives. It was noted that in Haringey a significant number of people went to Stamford or St Ann's whilst a longer term decision was made, purely because there was not sufficient alternative provision.

The LAC 2001 specified that the average duration of IC was 2-4 weeks but it could be extended for up to 12 weeks for people with complex needs.

A whole systems approach was required which involved:

- Self Care – Advice and Carer Support
- Multi-agency prevention
- Voluntary Sector
    - Primary Care
    - Housing
    - Health and Social Services
- Community Nursing / Therapy / Social Care Support
- Intermediate / Interim / Transitional Care
- Secondary Care
    - Fast Track Medical Assessment and Treatment
    - Specialist Nursing and Therapy

It was acknowledged that acute nurses needed training on IC. The Panel noted that the ICT rehab team attended multi -disciplinary team meetings on a weekly basis.

The meeting noted that just over one third of packages were charged for

and that the home care element of IC was charged for after 2 weeks.

Key deliverables for IC were:-

- Improving discharge and transfers from hospital and promoting rehabilitation
- Reducing avoidable admissions
- Avoiding premature/avoidable dependence on long-term care

In terms of eligibility IC should be targeted at people who would otherwise face:-

- unnecessarily prolonged hospital stay
- inappropriate admission to acute in-patient care , long term residential or continuing NHS in-patient care
- Provided on the basis of a comprehensive assessment, individualised care plan, active therapy, treatment *or* opportunity for recovery.

Essential components of IC were:

- In reach to secondary care to encourage timely referral
- Single point of referral to Intermediate Care
- Free at the point of delivery
- 24 hour, 7 day access to integrated services
- Fast response, flexible and adaptable. Ready access to equipment
- Person/carer centred, not service driven
- Time limited service, individualised
- Speedy access to medical assessment/support
- Settings: own home, day hospital, day care, extra care step-up/step-down, beds in a variety of settings
- Empowered, highly skilled professionals
- Generic, well trained support workers
- Clear aims, objectives, outcomes
- SAP which links up all care sector
- Access to technology
- Ability to offer end of life care
- Evaluation, ongoing development
- Marketing, communication, joint training
- Leadership, champions
- Pooled budget

For the future there needed to be :-

- Research : Evaluate : Monitor : Feedback
    - Listen to older people's and carer's views
    - GP Practice profiles – IC referrals
    - Delayed transfers – quantity & quality

	◆ Culture Change – "hearts and minds" ● Multi-agency Training ● Involve all acute wards ● Communication / Feedback Loop / Newsletter ● Publicity Campaign for consumers This would be achieved by:- ◆ Health and Social Care colleagues working *in partnership* to further develop responsive innovative solutions to current challenges ◆ Required a *shared vision*, which involves all involved being clear about the national agenda. ◆ Joint assessment and joint management of risk ◆ The assessment and decision making about the longer term care needs of older people including older people with mental health needs should take place within an Intermediate Care setting rather than an acute general hospital In Haringey there was a series of services which incorporated IC and other areas as well were economies and improvements could be made. The service was fragmented and there needed to be more integrated management which was accountable to both the Council and the PCT. There was recognition that the Teams needed to be multi- skilled. Also it was felt that there should be input from a CP Nurse. There needed to be mechanisms in place to ensure that there were sufficient triggers into IC. RESOLVED: **1.That the following be recommended as part of the Review :** • That consideration be given to assessing and managing the risk of older people with complex needs. • That a 5 year Plan be developed for IC. • That there be discussions with the Mental Health Trust with a view to them providing designated professional support to IC such as a CP Nurse. • That a leaflet be produced on the whole system of care and other communication methods be investigated such as a video.	
SCIC05.	**URGENT BUSINESS**	

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JEAN C BROWN

Chair