



Scrutiny Services

Report of the Scrutiny Review of Intermediate Care Services

February 2006

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CHAIR'S FOREWARD

Intermediate Care Services in Haringey are a good example of positive collaborative working across the NHS trusts, the Council and the voluntary sector. The vision for the service is a joint one, and Intermediate Care is provided through a range of specialist services run by different partner agencies.

The Review was particularly timely, running in tandem with Social Services own internal review, examining structures and working practices. It is hoped that the recommendations from our Scrutiny Panel will feed into the internal review. It also coincides with more emphasis being placed nationally on promoting independence and well being for older people and on providing support for them to live at home, or in community settings as far as possible, rather than in residential settings.

The Panel were very impressed with the tremendous improvements that had been made since the inception of Intermediate Care Service six years ago. More flexible support is being provided by social care and health teams, the community-based specialist equipment service, and increased home care packages and support. Services are working well towards promoting person centred care, joined up services and further developing the single assessment process for clients.

I believe that the Panel have made a set of recommendations that will further improve a good service and the quality of life for older people in Haringey.

I would like to thank my colleagues Councillor Adamou and Councillor Hoban who contributed their time and ideas. I very much enjoyed working with them and believe that this report is the result of team working. Also I would like to thank Jan Allwood, our external adviser who provided valuable professional advice and guidance to the Panel, and Carolyn Banks our scrutiny officer. Additionally I want to thank the staff from the NHS Primary Care and Hospital Trusts and Social Services and the voluntary sector who gave us their valuable time to provide evidence to the review and to host our very informative visits. The Panel was very impressed with the commitment and dedication of all staff that they met.

I commend the Panel's report and its recommendation to the Overview and Scrutiny Committee and the Executive.

Councillor Jean Brown
Chair – Intermediate Care Scrutiny Review

1. EXECUTIVE SUMMARY

- 1.1 This Executive summary outlines the work undertaken by the Panel during the course of the review and highlights the recommendations for improvement to Services.
- 1.2 The Panel's aim was to review the current arrangements by the Council and its partners for service users and carers within the Borough, in the light of the National Service Framework for Older People and the DOH guidance- Intermediate Care: Moving Forward In particular the Panel was to focus on issues relating to meeting local needs, value for money and funding levels and to make recommendations on the potential for improvement.
- 1.3 During the course of the review the Panel:-
 - Met with Social Services and PCT Service Managers
 - Met with Heads of teams involved with Intermediate Care
 - Visited the North Middlesex Hospital and interviewed the Discharge Co-ordinator, a Consultant responsible for Older Peoples Care, the First Response team and Therapists
 - Visited the Home Care Service, Rapid Response , Night service, Area and Enabling Teams
 - Met with Voluntary Sector representatives involved in service provision and who represented Carers
 - Visited and interviewed Users of the Service
- 1.5 The Panel were impressed by the commitment and enthusiasm of the teams. They saw many examples of good working practice and any recommendations should be seen in a constructive rather than critical light, designed to add value to an already good service.

KEY FINDINGS

- ❖ **Committed and dedicated staff in all teams with a positive attitude to their work.**
- ❖ **Hospital discharge processes are generally good but more focus is needed on prevention of hospital admission.**
- ❖ **There is positive joint working in some areas but strategic planning is not sufficiently co-ordinated and there is a lack of integrated management and corporate identity.**
- ❖ **There is still no single point of access to Intermediate Care Services which sometimes leads to a duplication of referral or assessment and a lack of trust between teams. Communication between services has the potential to be improved.**
- ❖ **The Single Assessment Process is beginning to embed but there is a need for more joint training. Teams should be more multi- skilled.**
- ❖ **Section 31 agreement pooled budgets are being well used.**
- ❖ **The Eligibility Criteria for Intermediate Care are too restrictive in that people under 50 are excluded and the needs of people with mental health problems are not always met.**

Recommendations:

- 1. That a 5 year Strategic Plan be developed for Intermediate Care.**
- 2. That a single point of access to Intermediate Care be developed.**
- 3. That provision be made for an Intermediate Care Co-ordinator, jointly funded and accountable across health and social care for the delivery of an integrated service, ideally with a pooled budget for the whole service.**
- 4. That a whole systems approach to joint workforce planning be adopted. Teams should work towards being multi-disciplinary to include therapy, nursing and social services staff working within a rehabilitation focus. The management structures should be reviewed to ensure that the service is able to work in more integrated ways.**

5. That partners work together to ensure the complete implementation of the single assessment process.
6. That the eligibility criteria be reviewed to enable Intermediate Care to become more person centred rather than service driven. In particular consideration should be given to the requirement of people with the more complex needs profiles and also those under 50 years of age who currently are not included within service criteria at all.
7. That consideration be given as to how the Intermediate Care Service can be supported in a more formal way by specialist mental health expertise. This would enable appropriate care packages to be developed for older people with physical needs who additionally have mental health needs. Further consideration should be given to the plans for developing Broadwater Lodge for people with dementia.
8. That the possibility of Greentrees being used for the provision of step down facilities be revisited.
9. That the current charging policy be reviewed to ensure fairness of provision across the service.
10. That the strategic partner services undertake a process mapping exercise to identify how Service Users currently access Intermediate Care and then redesign the process to ensure a clear pathway approach.
11. That the service be rebadged as a generic Intermediate Care Service.
12. That Intermediate Care Services work towards the provision of a 24 hour, 7 day a week access to Intermediate Care and identify a timescale for achieving this goal.

2. INTRODUCTION

Background

- 2.1 Nationally Intermediate Care is available to all adults, though most who receive it are Older People. Its focus is to ensure there are appropriate services to support people when they leave hospital and to prevent people being admitted to hospital or long term care. Although people will continue to need health and social care services, improvements in disease prevention, careful management of long term conditions, and appropriate treatment and rehabilitation will improve health and independence reducing the need for people to require long term care.
- 2.2 The Panel heard that generally people wished to remain in their homes for rehabilitation or care, but it is important that the necessary packages are in place to support them.
- 2.3 The Department of Health's Public Service Agreement states that it aims to:
- Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible, by:
 - Increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and
 - Increasing, by 2008, the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.

What is Intermediate Care?

- 2.4 The Intermediate Care Service in Haringey has been in existence for 6 years. From its original inception it has been designed and delivered jointly by London Borough of Haringey (LBH) and Haringey Teaching Primary Care Trust (HTPCT). There is a history of positive joint working in Haringey between the two organisations.
- 2.5 The Department of Health document – “The National Service Framework for Older People”, Standard 3 - Intermediate Care definition 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 admissions, and also effective rehabilitation services to enable early discharge from hospital

and to prevent premature or unnecessary admission to long term residential care"

- 2.6 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 qualify as "Intermediate Care" a service should meet all of the following criteria:
- Be targeted at people who would otherwise face unnecessary prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing NHS in-patient care.
 - Be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves acute therapy, treatment, **or** opportunity for recovery.
 - Have a planned outcome of maximising independence and typically enabling patient/users to resume living at home.
 - Be 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.
- 2.7 The LAC 2001 specified that the average duration of Intermediate Care was 2-4 weeks but that it could be extended for up to 12 weeks for people with complex needs, where there is review, reassessment and the agreement of the multi- disciplinary team.
- 2.8 In essence, Intermediate Care is a time- limited service, targeted at those in hospital or at risk of admission, involving therapeutic input and aimed at maximising independence. It should form an integrated part of a seamless continuum of services linking health promotion, preventive services, primary care, services, social care, support for carers and acute hospital care.
- 2.9 Additionally Intermediate Care is an emerging concept in health care. It offers attractive alternatives to hospital care. It is care that is "in between" and arises out of Standard 3 of the National Service Framework for Older People 2002. It is designed to target resources on those people who do not require the resources of an acute general hospital but are beyond the scope of the traditional primary care team.

- 2.10 Intermediate Care should focus on three key points in the pathway of care:-
- Active rehabilitation following acute hospital stay
 - Responding to, or averting, a crisis
 - Where long term care is being considered
- 2.11 According to the DOH Health and Social Care Change Agent Team, Intermediate Care should be provided by a range of professionals, including general practitioners, Community Nurses, hospital clinicians, physiotherapists, occupational therapists, speech and language therapists' social workers, care workers trained in rehabilitation and with administrative support. They need to draw on the expertise of a wider range of health and social care professionals, other services provided by Local Authorities, and the voluntary and independent sectors. The requirement for a single record, used by everyone providing Intermediate Care to an individual, means that the single assessment process is important. Service users and their carers must be involved in taking decisions about a user's care plan and should hold a copy.

National population profile

- 2.12 Older people are the main users of Intermediate Care in Haringey with the age of 50 as the minimum eligibility criteria. Nationally since the 1930's the number of over 65's has more than doubled. Now one fifth of the population is over 60. Between 1995 and 2025 the number over 80 will increase by almost half and the number of people over 90 will double.

Haringey Population profile

- 2.13 There are an estimated 22,130 people aged 65 + living in Haringey of whom 12,724 are women and 9,406 are men. Over the next decade the number of older people in the local population is expected to remain stable both in terms of overall numbers and as a percentage of the population, although the numbers of people aged 85 or over is set to increase slightly by the end of the current decade. This is somewhat different from the national profile because there is a large incoming population of young mobile people into Haringey. However, the number of people aged 65 and above from minority ethnic communities is projected to increase. There are also significant numbers of older people 'hidden' within long-established ethnic minority communities from Cyprus, Turkey and Ireland.

- 2.14 Haringey's older population is very diverse in terms of its health and social care needs, financial circumstances and ability to access services necessary to remain healthy and independent. Intermediate Care services need to be able to respond flexibly and appropriately to this diverse range of needs

Provision in Haringey

- 2.15 In Haringey, Intermediate Care is delivered by a range of services, individually managed and funded from various sources. Further information on the specific services is available on request. The main providers are set out below. This does not include the assessment function that is the gateway into social care other than Rapid Response.

Home Care –

- *Enabling Team* – a Social Services Directorate (SSD) provided service that offers generic rehabilitation through their care workforce to maximise independent living skills. This service is currently offered free to the service user for the first two weeks, after which, a financial assessment is undertaken and a charge is levied as appropriate.
- *Rapid Response Team* – an SSD provided assessment service that responds to requests for assessment and timely provision of home care services only in order to facilitate prompt hospital discharge or avoid admission into hospital or care home.
- *Night Service* – provides a 7 day a week 24 hour service of home based care. The service has recently won the NHS Health and Social Care Queen Mother's Award for the Care of Older People for the London and South East region.

Integrated Care Team – a mixture of both Haringey Teaching Primary Care Trust (HTPCT) and SSD staff who are co-located at Stewart Crescent Health Centre. Although co-located they are not jointly managed.

District Nursing Teams – HTPCT provided service (though IC is only a part of the work they undertake). They serve all patients resident in Haringey or registered with the GP practice to which they are attached.

Greentrees - Day Hospital –managed by North Middx Hospital and Rehabilitation unit – managed by HTPCT. They provide access to multi-disciplinary assessment, review and treatment. Note comprehensive assessment takes place here and a variety of other settings i.e. acute trusts, clients own homes, nursing homes.

Falls Co-ordinator- a joint appointment, HTPCT and SSD funded through a section 31 agreement pooled budget for delayed transfers of care. The Coordinator is developing a care pathway for falls which better integrates services to provide effective care for people who have experienced falls.

Cranwood Residential home Intermediate Care Unit – an SSD and HTPCT funded unit with therapy staff provided by the HTPCT. This unit provides intensive residential rehabilitation. However it is temporarily closed and due to re-open after refurbishment in August 2006.

Stamford Lodge Nursing Home – Stamford Nursing Centre provides some independent nursing “stepdown” beds reserved to enable timely and more gradual transfer from an acute hospital setting back to the patient’s home.

Cooperscroft Residential Home – residential “stepdown” beds to enable timely transfer from an acute hospital setting back to the patient’s home

60+ service funded by Supporting People (SSD) and provided by an independent provider. This service provides practical help and support for short episodes to enable people to return to, or maintain their tenancy of their own home.

3. PARTNERSHIP WORKING AND A WHOLE SYSTEMS APPROACH

Management Structures

- 3.1 The Panel considered the existing management structures of the Intermediate Care Teams across Health and Social Care to be somewhat fragmented. For example there are individual managers for the care management, rapid response and the rehabilitation teams. Their line management is then through the structures of their individual organisations. Although there is very positive close working at all levels, regardless of organisational accountability, there is still a long way to go towards the integrated teams envisaged in the original concept of Intermediate care, and there is little evidence that the service user can access a range of specialist services rather than one which would be enabled by an integrated approach. Notionally Intermediate Care is multi- disciplinary. The specialist teams also operate within a rehabilitation model, and the panel felt that these two factors inhibited the ability of services to work together to best effect.
- 3.2 The Panel received supporting evidence for this from voluntary organisations working with the teams, who felt that, at a strategic level, promotion of an integrated approach was lacking and that was why the service did not always operate quite as smoothly as it might
- 3.3 In an ideal Intermediate Care service there would be more structured integrated meetings, planning and pooled budgets. There would be more joint planning meetings, better resourced care pathways and an avoidance of assessment duplication (ie from Hospital, Rapid Response, Agency and Social Work)

- 3.4 It was recognised that further developing services and working more innovatively in response to the government agenda of giving people real choice, creates budget pressures. Additionally the Panel recognised that the creation of a truly integrated team would require the ability of staff to manage the cultural change needed to bring the two organisations together, and this would not be easily achieved.
- 3.5 The panel felt that the evident high quality of service offered by all the separate teams would be much enhanced by a whole systems approach involving all of the following key elements:-
- ◆ 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
- 3.6 At a strategic level the designation of a jointly appointed Intermediate Care Co-ordinator accountable across health and social care for the delivery of an integrated Intermediate Care Service should be considered. This would ensure the integration of the multi-disciplinary service, and enable it to develop as one team. These improvements to team working would then further maximise independence for Service Users by enabling a more person-centred approach though, clearly, management structures within the whole team would need to be reviewed accordingly.

Duplication of services

- 3.7 Evidence from the Voluntary Sector indicated that funding streams and remits overlap and there are times when some services feel that they are being asked to carry out the functions of others.
- 3.8 Feedback from meetings with clinicians highlighted difficulties of consultation across services, driven by some lack of trust in each other's assessment skills and lack of information sharing. Joint assessment training and full implementation of the Single Assessment process (SAP) would eradicate these problems. This training is planned and scheduled.

Multi-disciplinary Teams

- 3.9 The Panel heard that there are three different support worker components across the various teams, Home Care Enabling Support Workers, Rehabilitation Assistants and Rehabilitation Support Workers. The differences between each role were unclear to the Panel and are probably minimal, which suggests they could perhaps be generalised in an integrated service
- 3.10 One other vision for the future expressed to the Panel would involve the development of staff from Intermediate Care to undertake therapeutic interventions for older people and to link with home care services. The service would be focused on the care pathway and wrap around the older person, rather than the service user needing to fit into the criteria of the individual service.
- 3.11 The panel felt that, even if the latter solution is some way off, some effort should be made to generalise, through training, the work of the various types of para-professional support workers mentioned above in order to make their response to user need more flexible and to reduce the need for changes of personnel for users.

Information sharing

- 3.12 The lack of a shared database or infrastructure is a major obstacle to sharing information and to reducing duplication of assessment, as well as to the development of the Single Assessment process. This is a national, as well as a local problem. Local authorities and NHS institutions are operating on incompatible IT systems.
- 3.13 As the focus moves to the prevention of inappropriate admission the need to measure the effectiveness of this work will increase. The Panel heard of a need for improved communication between teams that deliver therapy and those delivering care elements. This should improve once the Single Assessment Process, already under development, is really embedded.

Discharge Planning

- 3.14 Feedback from questions highlighted the need for more effective hospital discharge planning. Effective and timely referral of service users to the range of primary care services and care packages is not yet as good as it could be.

- 3.15 The Panel heard examples of people leaving hospital still needing the involvement of other services to assess and manage aspects of their care (e.g. continence packages), which had not been arranged before discharge. Valuable time is lost within Intermediate Care, retrospectively 'sorting out' these aspects of care before actual rehabilitation can begin.
- 3.16 Consideration should be given to ensuring that in the two local hospitals, dedicated health and social care personnel are in place for effective discharge planning. A Social Worker is already permanently based at the Whittington for discharge planning, but the Panel was pleased to hear of current negotiations to nominate one care manager/ social worker for hospital discharge duties at the North Middlesex hospital, which, if implemented as a strategy, should reduce the duplication and make discharge more seamless and timely there.

Access to therapies

- 3.17 This area is problematic due to national and local short supply of specialist professional therapists. The Intermediate Care Team is often seen as the only route within Haringey to accessing specialist physiotherapy and occupational therapy assessment and treatment for older people. Therefore the Intermediate Care team receives a number of referrals of Service Users who require longer- term rehabilitation rather than a time limited intervention. But the demand for longer term rehabilitation cannot be met within Intermediate Care resources. Intermediate Care therapists plan and implement a programme of rehabilitative goals for Service Users within an eight-week period only. But the lack of services to refer onward to makes it difficult for the therapists to confidently discharge these clients from the Intermediate Care team.
- 3.18 Social Services Occupational Therapists focus on assessment for equipment and adaptations in order to fulfil statutory responsibilities. As they are the only occupational therapy provision within primary care, access to rehabilitation is limited by their necessary prime focus on adaptations work.
- 3.19 This situation can only be corrected by ensuring that more specialist therapists are trained and introduced into the system as a whole. This requires a national initiative. Locally, budgeting for some more therapist posts would provide an interim local solution.

Training

- 3.20 In the panel's discussions and meetings it was evident that there is limited understanding of roles between teams within the Intermediate Care umbrella.
- 3.21 The Panel noted that there had been some joint training on the Single Assessment process that had brought the two services together and more training is planned for the future. Joint training is still the exception rather than the rule and does not involve hospital staff, so more work is needed on devising a training model which can involve staff from all services together. It was felt that further training would really encourage the development of a shared vision and values.
- 3.22 The co-ordination of joint visits to clients takes time, but is valuable for jointly addressing issues or ensuring consistency of approach. The Panel heard that the IC team has particularly valued the opportunity to link with the enabling support worker team within Home Care, e.g. following discharge from Cranwood, to ensure that skills to maximise independence are maintained and that people have support to develop their confidence once back at home.
- 3.23 Many of the clients seen by the Intermediate Care team do not have a care manager from within the team, and a significant proportion has no care manager at all involved, thus a significant amount of care co-ordination may be undertaken by team members.
- 3.24 In summary, it was acknowledged that there is room for further development in joint working with the HTPCT, both at strategic and at local level, and improved information sharing. There needs to be more joint health and social services training, involving hospital-based staff as well, and current work on pooled budgets and joint funding needs to be built upon. The generic worker concept needs to be further developed.

Location of Teams

- 3.25 The various teams are housed in a variety of locations. The ideal would be to co-locate teams to maximise joint working and this would assist in building trust. The reality is that there needs to be some exploration as to where workers are best placed. Currently, the situation sometimes seems to impede progress towards Intermediate Care goals. However, this problem is under active consideration by partner services. There is already a plan, for instance, to bring in the nurses with the Enabling Team to the Grange, where Home Care is based. The Panel felt it may

also be appropriate to consider moving physiotherapists and occupational therapists there as well.

- 3.26 There is an argument for co-locating the Rapid Response Team with the Intermediate Care team. This was tried before with a mixed response. There was some evidence that no improvement to service provision ensued. But the panel felt that the over-riding advantage of having the home care assessors located with Home Care is the immediacy of accessing the home carers and the major contribution this would make to Intermediate Care integration.
- 3.27 Improvement also needs to be made in admission avoidance, and the more effective working between GPs, District Nurses and community Social Work teams and Intermediate Care Services outlined above would help considerably in achieving this improvement.

IT systems

- 3.28 There are currently no shared IT systems between NHS and LBH, although staff based in Intermediate Care at Stuart Crescent do have access to the LBH database. Since it is clear that, both nationally and locally shared IT is some way off, the panel was pleased to hear that services are now working towards a corporate set of patient held records which will mean less duplication on assessments.
- 3.29 The lack of IT systems is also one of the main barriers to successful implementation of the SAP management information system across the Intermediate Care teams. This is a national issue, and cannot be addressed locally until the national introduction of the care records system.

Single Point of Access

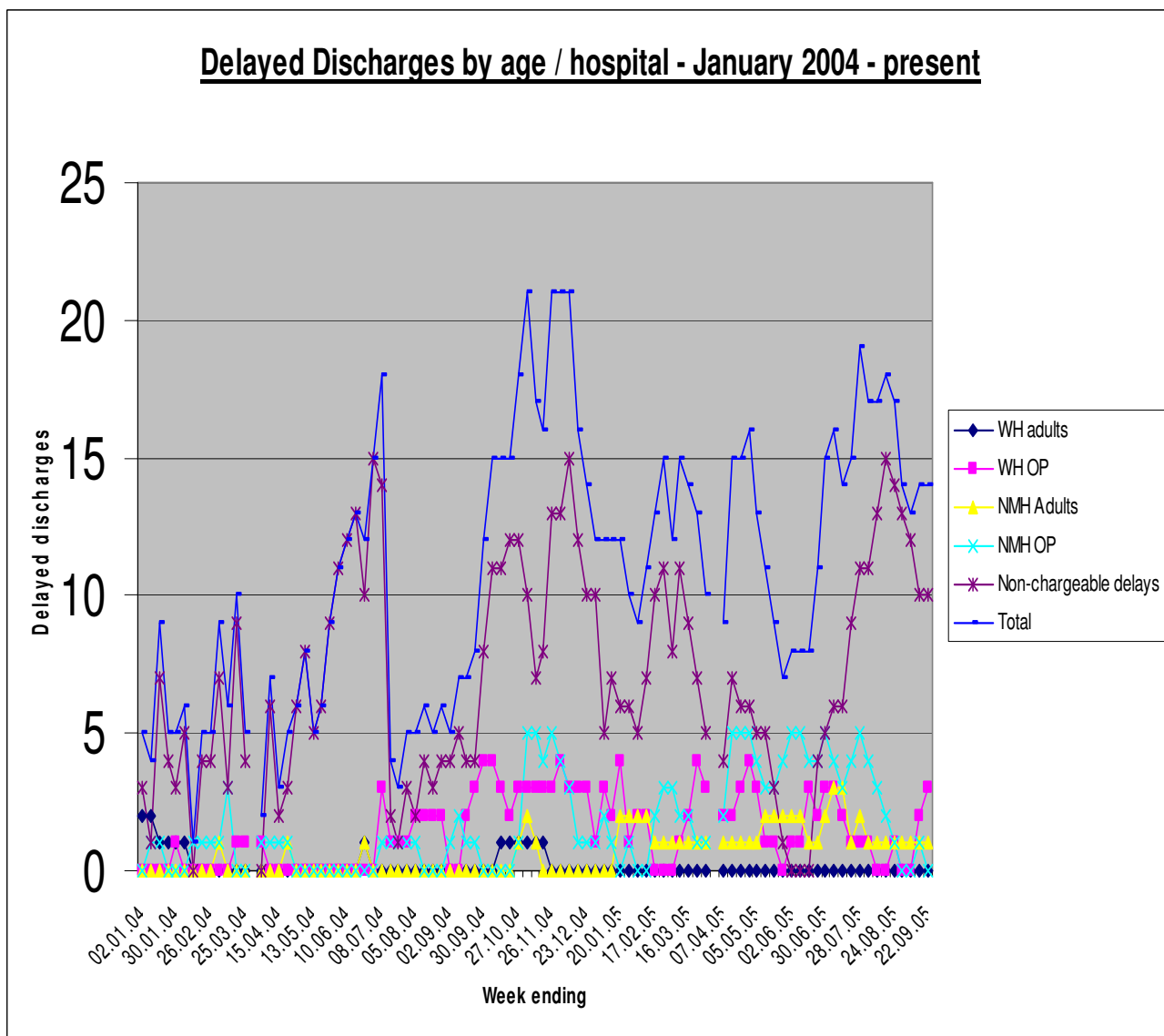
- 3.30 There is as yet no single point of access to all Intermediate Care services. This has the effect of delaying referrals and subsequent action. This is particularly problematic for service users in hospital outside Haringey. The Panel's information was that there are several points of access to Intermediate Care, notably Stuart Crescent, The Grange and District Nurses.
- 3.31 The Panel considered that the service could be more effective if the access point were streamlined. It would facilitate a more user - centred approach, especially if combined with other integrative strategies covered elsewhere in the report.

- 3.32 This view was supported by the First Response Team at the North Middlesex hospital. They were concerned that, despite improvements in collaborative working, it could still take up to 3 days to access a care package. This means up to three unnecessary days in hospital for the older person. This team has recently been established in order to streamline hospital discharges. They target people over 65 when they are still in Accident & Emergency (A&E) and through the first 4 days in hospital after admission. Their objective is to shorten the length of stay and get people back home as quickly as possible
- 3.33 If the 'single point of access' were developed further, it would strengthen initial assessment, enabling a more timely response, with onward signposting of patients to appropriate Care services, thereby reducing unnecessary time spent in hospital.
- 3.34 The review Panel had limited success in accessing the views of GP's but from those that responded the consensus view was that Intermediate Care was of limited use, largely due to having no single access point and they did not have either the time or in some cases the knowledge of the appropriate team for direct referral of their patients. It was also the case that GP's refer patients to Health Advisers for Older people or the district nursing service, who will make an onward referral to intermediate care services where this is appropriate for the patient. The services when accessed were felt to be good.

Single Assessment Process

- 3.35 The Intermediate Care service in Haringey delivers care in the framework of the Single Assessment process. This has been developed locally across organisations and is now in use, despite the lack of compatible IT systems. As the use of the single assessment process and the client held records within Haringey become fully embedded the quality of information and assessments should reduce the duplication of information and provide better co-ordination of care for the client.

Hospital Discharge



3.36 The chart above shows performance on delayed transfers since 'reimbursement' began in January 2004. This is the system whereby local authorities are liable to payment to the NHS trusts for delays in discharging of patients due to difficulties in completing the care package. In the pooled budgets set up in 2004/05 and 2005/06, thresholds of 96 delayed transfer days per hospital per month were set by government - in other words Local Authorities could only run up a total of 192 delayed days per month in all hospitals before having to pay compensation. This figure was calculated from performance in the months leading up to January 2004. Since then, Haringey has maintained a good (and frequently excellent) performance on delayed transfers. Performance at the Whittington in 2005/06 has been excellent, the North Middlesex a little less impressive:

- **April:** Whittington: 64 days; North Middlesex: 110 days - total = 174 days
 - **May:** W: 27 days; NM: 130 days - total = 157 days
 - **June:** W: 57 days; NM: 200 days - total = 257 days
 - **July:** W: 27 days; NM: 132 days - total = 159 days
 - **August:** W: 7 days; NM: 75 days - total = 82 days
- 3.37 Quicker hospital discharge has been the main thrust of Government policy initiatives over the last 5 years. Locally the Whittington hospital has a very positive partnership with Haringey Primary Care Trust and Social Services in ensuring a seamless hospital discharge service to Haringey patients.
- 3.38 Each ward in the Whittington hospital has a weekly multi-disciplinary meeting where discharge planning takes place. The Whittington Hospital has a dedicated Haringey social worker (part of the Integrated Care Team) based on site, who attends all multi-disciplinary meetings and acts as the liaison for all Haringey residents. This role is seen as an essential component to seamless care, and is much valued by hospital and patients alike.
- 3.39 It was noted that the First Response Team at North Middlesex responsible for discharge planning seems to have no dedicated social worker input, but works with a range of care managers liaising with the hospital from their borough base. The Panel felt that the difference in the two systems might account for the difference in delayed discharge figures, but lack of research time and appropriate expertise prevented further investigation on this issue. It is suggested that Intermediate Care service professionally reviews this issue at an appropriate time
- 3.40 It was noted that the highest proportion of people whose transfers from hospital were delayed were those with dementia. The Panel were concerned about this, as previous evidence had indicated a less than adequate mental health expertise input to the Intermediate Care team. Again, time prevented further investigation of this.

Prevention of hospital admissions

- 3.41 From the information obtained it did not appear that Intermediate Care services were currently as successful in the prevention of unnecessary admission to hospital. Their main focus is on discharge from hospital. However a pilot is being developed using pooled budget funding to further reduce the number of unnecessary hospital admissions to assist in meeting the government performance targets for the Primary Care Trust (HTPCT). These have been derived from the 'National Service Framework for Older People' objectives of:

- reducing hospital admission, and
 - achieving no growth in the numbers of re-admissions
- 3.42 The Panel noted that on occasions pressures on acute hospital beds can mean that some people requiring care and treatment are directed towards long term care inappropriately, when a spell in Intermediate Care would have delivered a more appropriate longer-term outcome for them. This is particularly so in non-specialist Older People's wards. The Older People's physicians are aware of this and are working to address this.
- 3.43 Evidence from a GP indicated that on occasions it can be difficult to obtain a home based assessment to prevent hospital admission, and this led GP's to refer patients direct to hospital. The role of the day hospital needs to be more clearly signposted for GP's. The Panel welcomed proposals to develop 'step-up' provision for such cases and noted that this should assist in prevention of inappropriate admission. The panel also heard from Metropolitan Care and Repair regarding their hospital homelink project which was aimed at facilitating hospital discharge and preventing re-admission by focussing on solutions to disrepair and a lack of essential services within the homes of elderly Haringey residents.
- 3.44 Having immediately accessible Intermediate Care services that GPs, ambulance services and others can refer appropriate users to reduces hospital admissions. However these services do need to be accessible on a 7/24 basis and currently, that is not the case. They are only accessible during the working day
- 3.45 Medical cover to Intermediate Care services has been an area that has presented some complex issues to be resolved; this has been reflected across the country. There is a natural reluctance from GP's to manage patients who would previously have been cared for in hospital for a longer episode of care, without there being some recognition of the additional work load that this creates in primary care. Allied with this is the fact that Intermediate Care residential and nursing home services are sometimes geographically remote from the location of the GP practice where clients are registered, and GPs are reluctant to take responsibility for patients because of this, Cranwood is such an example. The Panel hopes that a workable local solution to this difficulty can be established. When Cranwood reopens, it is planned to provide medical cover in an alternative way that will not require the same amount of financial resources as previously. This may be through a specialist nurse route, or through patients retaining the service of their own GP, should they require medical services, or through a

combination of the two approaches. The panel endorses this approach.

RECOMMENDATIONS

- That a single point of access to Intermediate Care be developed.**
- That provision be made for an Intermediate Care Co-ordinator, jointly funded and accountable across health and social care for the delivery of an integrated service ideally with a pooled budget for the whole service.**
- That a whole systems approach be adopted to joint workforce planning. Teams should work towards being multi-disciplinary to include therapy, nursing and social services staff working towards a rehab led mode. The management structures should be reviewed to ensure that the service is able to work in more integrated ways.**
- That partners work together to ensure the complete implementation of the single assessment process.**
- That the service be rebadged as a generic Intermediate Care Service**
- That intermediate care services work towards the provision of a 24 hour, 7 day a week access with a timescale for achieving this development.**

4. ASSESSING NEEDS AND CHOICE

- 4.1 Voluntary Sector representatives considered that choice for Service Users not always available in practice. At present there was very little flexibility and choice given to clients regarding their care packages. The view was expressed that people were referred to Intermediate Care according to available resources and tight eligibility criteria, and that clients are unaware of who makes the decisions on their care packages. The Panel heard that clients wanted consistency in terms of service provision.
- 4.2 Integration between different agencies needs to be strengthened to ensure that service users are not discharged without the home support packages being in place in line with DOH guidance on discharge planning. It was noted that in Haringey a significant number of people went to Stamford whilst a longer term decision is made, purely because there is not sufficient alternative provision.

- 4.3 The possibility of a leaflet being produced on the whole system of care and other communication methods was suggested possibly including a video for the use of voluntary sector and other providers.
- 4.4 It was suggested that although Age Concern had made referrals to Intermediate Care unless the need was urgent users had to wait a considerable time for an initial assessment. Consequently Intermediate Care was not promoted by the Voluntary Sector as a service.
- 4.5 Plans for developing clear pathways will ensure that patients are directed more clearly through care systems, and developing these is a priority to ensure more appropriate management of unscheduled care. The Panel proposed that a process mapping exercise be undertaken to identify how patients currently access the service and to redesign the process to ensure clear pathways.
- 4.6 The service tries to be needs based by taking a person centred approach to assessment and care planning, however, this will always be limited by the resources available to meet those needs and the eligibility criteria applied to services.
- 4.7 The Panel heard that there could be difficulties in situations where patients choose to be treated privately, an option that is likely to increase with the Choice agenda that came into effect on 2 January 2006. This increases the need for good discharge planning and highlights the importance of a single point of access to Intermediate Care.
- 4.8 The Panel visited and talked with Service Users in their own homes and registered universal satisfaction with the service provided. This was most gratifying and a tribute to the dedication of all Intermediate Care teams which the panel found in abundance in its contacts throughout this review.

RECOMMENDATION

- That the strategic partner services undertake a process mapping exercise to identify how patients currently access the service and then redesign the process to ensure a clear pathway into Intermediate Care.**

5. CAPACITY AND ELIGIBILITY CRITERIA

- 5.1 The introduction of 'Payment by Results' has further supported the emphasis on secondary care to provide acute assessment and treatment, ensuring timely discharge to reduce unnecessary delay in the transfer of patients back to primary care. This combined with a primary care imperative to support people to remain in their own home where possible, rather than in long term care. Consequently, people with complex needs or who are at a much earlier stage in their recovery from illness are potentially in need of Intermediate care.
- 5.2 This increasing demand means the various teams struggle to respond to the need for a fast response to see people immediately they are discharged from hospital or as an alternative to inappropriate admission. As throughput from the acute hospitals becomes more rapid the teams will need to have the capacity to respond promptly if they are to fulfil their remit of supporting people to leave hospital earlier and preventing admission. However the Panel heard that teams were already working at maximum capacity and having to rely upon support from other teams and outsourcing to agency staff.
- 5.3 There is potential through the redesign of services, linked with investment to increase capacity.
- 5.4 The Panel heard that Telecare is not yet being exploited to its full potential. Telecare is as much about the philosophy of dignity as it is about equipment and services. Equipment is provided to support the person in their own home and tailored to meet their own needs. It can be as simple as a basic community alarm service, able to respond in an emergency and provide regular contact by telephone. It can include detectors which would monitor in-home motion, falls, fire and gas leaks and trigger a warning to a response centre. In 2006 the Government will be funding the Prevention Technology Grant .to local Health and Social Care economies. The money will not be ring-fenced, which underlines the importance of health and social care planning jointly and in advance for it to ensure it is used appropriately to support and enable people to remain safely in their own homes.
- 5.5 With practice-based commissioning due to commence in April 2006 it is important that doctors are on board with Intermediate Care as this is likely to lead to an increase in referrals from GP surgeries. There is a need to ensure that primary and social care provision is accessible and robust. The Panel welcomed the development of a nurse post to focus on admission prevention. The post is funded by the WSCP delayed discharge pooled budget. The role of the nurse is to facilitate the District Nurses assessment in order to prevent admission, promote the

district nurses expanded role to GP's and the acute trusts; to work closely with care managers and train district nurses to undertake a risk assessment of the care environment so that home care can be provided without the need for a second visit from the home care team. There is a need for GP's to be confident that their patients are well provided for in the community rather than in a hospital setting.

- 5.6 The question of the ineligibility of people under 50 with sudden onset and other long-term disabling conditions arose on a number of occasions and from a variety of sources during the review. The number of people under 50 not provided for is small. A pilot scheme had been set up 4 years ago to provide Intermediate Care to Under 50's but was disbanded due to low numbers. It was suggested that this be revisited in reviewing the eligibility criteria, to include this target group in the existing service. If resources allow, developing Intermediate Care for the Under 50's within the general Intermediate Care umbrella would seem to be a more cost effective solution. It was suggested to the Panel that an analysis might be commissioned possibly from Public Health.
- 5.7 The panel felt that, given that the relatively small number of such cases, and a proportion of those patients often require just a short spell of treatment to address changes in their condition, or to avoid admission, or some short-term rehabilitation treatment, consideration should be given to their being included in the Intermediate Care eligibility criteria. They should be able to access this very good service with all the inter-team communications and relationships in place.
- 5.8 The Intermediate Care service has a Falls Co-ordinator. However, the development (or review) of falls pathways and protocols in Haringey would enable Intermediate Care to make clearer the role of the Intermediate Care team in falls prevention, although increased capacity would be needed if the team were to be a focus for providing assessment and rehabilitation for people in their own homes who have fallen or are at risk of falling.
- 5.9 The possibility of Greentrees providing further 'step down' facilities for Intermediate Care was suggested to the Panel but no firm proposals were put forward. However, the Panel felt this issue should be considered.

People with Mental Health needs

- 5.10 The Panel was informed of "The Older People's Inquiry" from the Joseph Rowntree Foundation's Older People's Programme which

concluded that older people valued that little bit of help to enable them to retain choice, control and dignity in their lives.

- 5.11 The Panel noted that the number of people with mental health needs is growing as the age profile of Older People changes. Additionally there is an increasing number of unsupported older people, those families do not live close by them and increasingly elderly people over 80 may well have children over 60 years old with their own particular needs.
- 5.12 However specialist mental health input to our Intermediate Care service for Older People with Mental Health needs is perceived by some stakeholders as still needing development. There is a Community Mental Health Team for Older People and Age Concern advised that they themselves refer clients to it. This is not the case with all referring agencies, so some work still needs to be done to spread the word of availability to all Intermediate Care teams and GP practices and perhaps to institute some training in dealing with and referring mental health needs of clients to the CMHTOP.
- 5.13 The Panel heard that it would be desirable to develop Intermediate Care provision for people with dementia at Broadwater Lodge giving them a more appropriate environment to experience rehabilitation. But at present there is no budget capacity to undertake this work and this proposal was under threat. This is the kind of provision that would further enhance provision to enable more patients with that condition to function adequately at home rather than in institutions. It should be considered for future plans.
- 5.14 North Middlesex Hospital stated that there is insufficient liaison between them and the Mental Health Trust in this area. There is a limited CPN liaison service available for patients presenting at A&E, generally only for limited hours and this had led to patients being admitted to hospital, possibly unnecessarily, due to lack of proper assessment of their mental health needs. Also the therapists at the North Middlesex considered Intermediate Care criteria an issue, in that stroke, multiple sclerosis and motor neurone disease patients under 50 are not eligible for Intermediate Care on discharge from hospital. (see above)
- 5.15 The Panel felt that there is a need for mental health outreach work with Intermediate Care clients. The Home Care team has established a working group to look at developing a mental health outreach team and an examination of how to plug the gaps is, therefore, in hand. It was noted that Home Carers had informal training on Mental Health from Social Workers and any particular concerns are routinely referred to the Social Services Mental Health Team at Cumberland Road.

- 5.16 Also Home Care is working closely with the CMHT and the Independent Sector to look at how best to provide a service that, through monitoring and provision of practical and emotional interim support can prevent hospital or residential admission for clients with Mental Health Needs. Again, service development requires funding, though services may be able to be developed within budget through reconfiguration of present service structures.

Charges and Budgets

- 5.17 The Panel noted that just over one third of packages are charged for and that the home care element of Intermediate Care is charged for after 2 weeks, as is the re-enablement element. Confirmation was received from the Department of Health that if the service is badged as Intermediate Care it should be free at the point of delivery. The Panel also noted that there is a discrepancy in the charging policy as provision at Cranwood is free for 6 weeks, so those patients who are admitted to Cranwood are not charged, whereas others discharged to other homes or their own homes are.
- 5.18 Given that this is a time-limited service (up to 6 weeks maximum in most cases, and less in some) the Panel felt that progress was required towards making this a service free at the point of delivery. Clearly there are resource issues here, but the desirability of this policy change being implemented when resource re-allocation becomes possible was felt to be incontrovertible. Currently, the inequalities in charges levied are indefensible.
- 5.19 The Panel noted that referrals made from Intermediate Care for adaptations as part of rehabilitation by the Handyperson scheme are provided free of charge, but referrals from elsewhere were normally charged for. The panel felt this to be a further anomaly which needs reviewing with an eye to fairness of provision.
- 5.20 In respect of equipment, Haringey Integrated Community Equipment Service (HICES) is now meeting its performance targets. However the service needs to continually develop and there is more work that could be done around the procurement of appropriate equipment and trusted assessors. Additionally demand for equipment is growing and as initiatives which prevent admission and speed hospital discharge are developed, this needs to be taken into account in planning progress in this service team.

RECOMMENDATION

That the eligibility criteria be reviewed to enable Intermediate Care to become more person centred rather than service driven. In particular consideration should be given to the needs of people with more complex needs profile and also those under 50 years of age who currently are not included within service criteria at all.

That consideration be given as to how Intermediate Care can be supported in a more formal way by a specialist mental health input to provide appropriate care for older people with physical needs who additionally have mental health problems. Further consideration should be given to the plans for developing Broadwater Lodge services for people with dementia.

That the possibility of the use of Greentrees for the provision of 'step down' facilities be revisited.

That the current charging policy be reviewed in the light of the Panel's findings to ensure fairness of provision across the service.

6. Conclusions

- 6.1 The Panel saw much to commend Intermediate Care services in Haringey that was the result of a positive approach by staff across all the teams in the Intermediate Care partnership. They acknowledged that the vision in setting up the services was jointly owned by the Council and the Haringey Teaching Primary Care Trust. However, a holistic plan of action for the future is needed setting out aims and objectives for the next five years.
- 6.2 For the future there needs to be a more integrated management accountable to both organisations, working in partnership to further develop responsive innovative solutions to current challenges. Also there should be joint assessment and management of risk using Intermediate Care as a route to more independence for Service Users for longer. There is currently a divergence of team working across the two services with the two teams being to some extent co-located, but having limited opportunities to work in a person-centred way. Additionally the lack of an IT system that works across health and social care settings creates issues in terms of the use of the Single Assessment Process (SAP), duplication of processes and information sharing and inefficient use of resources.

- 6.3 The lack of a single point of access (SPA) can also lead to a duplication of assessments and a lack of trust between the teams. This needs to be developed further so that all referral points are able to access Intermediate Care in a simple but effective manner. As SAP becomes more embedded, a more individual approach to assessment and care planning processes will be developed.
- 6.4 In terms of training there are opportunities available to reduce education costs and improve interdisciplinary working across both organisations by bringing together staff to train on common ground.
- 6.5 The age criteria of 50 means that clients under 50 with sudden-onset and other disabling conditions are prevented from benefiting from the service. This is also true of clients with mental health conditions or dementia and the Panel considered that this should be reviewed.
- 6.6 The Panel acknowledged that much work has been done and effective services developed that ensure that people leave hospital promptly but safely. There is still some progress that could be made in terms of working better to prevent unnecessary hospital admission and maximising overall levels of independence through rehabilitation.
- 6.7 To conclude, a good Intermediate Care service should be, or have:-
- ◆ In reach to secondary care to encourage timely referral
 - ◆ A 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
 - ◆ Be deliverable in a variety of settings: own home, day hospital, day care, extra care step-up/step-down, beds in a variety of residential settings
 - ◆ Empowered, highly skilled professionals
 - ◆ Generic, well trained support workers
 - ◆ Clear aims, objectives, outcomes
 - ◆ SAP which links up all care sectors
 - ◆ Access to appropriate technology
 - ◆ Ability to offer end of life care
 - ◆ Evaluation, ongoing development
 - ◆ Good marketing, communication and joint training
 - ◆ Leadership, champions

- ◆ Pooled budgets

6.8 That is the national vision. The panel felt that the Intermediate Care Service in Haringey has a great deal of this in place, and needs to retain the vision and continue to move towards full realisation for all our people who may need the service.

RECOMMENDATION

That a 5 year Strategic Plan be developed for Intermediate Care, based on the vision described above.