DONCASTER INTERMEDIATE CARE PARTNERSHIP

OUR VISION FOR A WHOLE SYSTEM, ACCOUNTABLE CARE PARTNERSHIP MODEL TO DELIVER INTEGRATED; COMMUNITY BASED INTERMEDIATE CARE SERVICES FOR THE PEOPLE OF DONCASTER.

JANUARY 2018
DRAFT FOR CONSULTATION
1. INTRODUCTION

OUR LONG TERM VISION AND THE PURPOSE OF THIS SPECIFICATION

This draft specification is designed to inform the next stage of work to support the implementation of a new intermediate care model in Doncaster. The intermediate care redesign will contribute to delivery of the wider vision set out in the Doncaster Place plan (see left). It will focus on maximising independence, health and wellbeing, tailoring care and support to build on the individual’s strengths and local community assets and ensuring that the intermediate care offer is the best it can be when people need it.

Our new model is based on the findings from our review and the subsequent case for change which suggested that we needed a simpler, more responsive intermediate care service with greater flexibility to work jointly across organisations and with other community resources to provide holistic care, help more people stay in their own home and maintain their independence following an unplanned event, deterioration in their health, exacerbation of a long term condition or following a period of acute care.

At its simplest we have 4 key aims;

- Simpler, easier to access and more joined up
- More step up support to prevent deterioration, admission to hospital and care home admissions.
- A greater range of home based support.
- Bed or facility based support for those that can’t be safely supported at home.

The specification sets out a ‘whole systems approach’ to achieving these aims through the development of an Accountable Care Partnership model, underpinned by an integrated, holistic service offer that is person centred and asset based and promotes early intervention and prevention.

We have referred to this Accountable Care Partnership approach as the “Intermediate Care Partnership” [name to be confirmed], within which organisations have different but complementary roles, for some in strategic planning and commissioning, for some in operational delivery, and for others in community level voluntary and peer support.

The specification sets out:

1. THE JOURNEY SO FAR – the review of intermediate care, collaborative design of a new model, our work over the last year to test this and where this has taken us.

2. WHERE WE ARE GOING - Our vision for a whole systems approach underpinned by an integrated, more flexible, person-centred, model.
   - Whole systems approach. An accountable care partnership model, delivered by the Intermediate Care Partnership.
   - Person centred, integrated service model. A description of the service model the Doncaster Intermediate Care Partnership will be asked to deliver, including the key operational and enabling features. It is acknowledged that the development of this model has already begun.
and will continue over two to three years. However, we suggest what the next steps should look like - with a set of proposed requirements for the beginning of April 2018 for the key elements of the model.

3. **THE NEXT STEPS IN OUR JOURNEY** - A forward look at how the model can develop to scale up the breadth and depth of joint commissioning and delivery over the next 2-3 years in managed phases.

What follows does not set out all the detail of a traditional specification that will need to be followed to the letter. Rather, it represents an operating framework and key milestones that members of the Intermediate Care Partnership will work together to develop and deliver over the next year and beyond. Where sections relate to headings in a traditional service specification, they are included in [grey] so that the content can be mapped across if required.
WHAT IS INTERMEDIATE CARE?

National definition:

A range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

Intermediate care services are usually time limited, normally no longer than six weeks and frequently as little as one or two weeks. Intermediate care should be available to adults age 18 or over.

Plain English approved definition

National audit of Intermediate Care; NHS Benchmarking and NICE guidance for Intermediate Care 2017

Local description:

Intermediate care delivers a short burst of extra care and rehabilitation outside hospital to help people recover and regain their independence as quickly as possible. It can provide support in many situations, such as: when an older person has an illness like a water or chest infection that can easily be treated at home rather than hospital; when an existing health condition worsens; when an older person has fallen and lost their confidence; if someone is weak and needs help to settle back home following a hospital stay; or if they need ongoing treatment or rehabilitation that does not need to be provided in hospital.

Developed by the IC communications and engagement work stream for use in public and patient engagement activities (Oct 2016)

Aims of intermediate care;

[AIM]

The aims of intermediate care in Doncaster remain consistent with existing service specifications and the NICE guidelines for intermediate care (2017), ultimately it aims to;

- Support people back to optimum health and wellbeing in order to assist them towards independent living over a short period of time.
- Support people to remain at home or return home (or to their ‘own bed’) as soon as possible.
- Prevent unnecessary admissions (including readmissions) to hospital of people in crisis, who could be safely supported at home or elsewhere.
- Facilitate the timely discharge of people from urgent care services and other rehabilitation and clinical settings (e.g. from hospital for those who no longer require acute medical intervention).
- Prevent unnecessary or premature admissions to care homes of people who could be safely supported at home.
Who is intermediate care for?

NICE recommend that individuals should be assessed for intermediate care if it is likely that specific support and rehabilitation would improve their ability to live independently and they:

- are at risk of hospital admission or have been in hospital and need help to regain independence or
- are living at home and having increasing difficulty with daily life through illness or disability.


Some examples of when this may be appropriate include;

1. When a person has experienced an unplanned or critical event which has affected their wellbeing, had an impact on their independence and could have an impact on their ability to remain at home or in their ‘own bed’ (e.g. a fall)
2. When a person has experienced a significant or sudden change in their health or social situation which is having or will have a significant impact on their independence and wellbeing or their ability to remain or return home. (This could be unplanned e.g. a carer becomes unwell or they are being treated for a UTI or planned e.g. elective hip replacement surgery)
3. When a person no longer needs acute care but requires support to transition from hospital, or another bed based service back home or to their ‘own bed’ and regain their independence.
4. When a person requires short term treatment or rehabilitation that does not need to be delivered in an acute hospital setting or bed base.

Outputs from local intermediate care design workshops

Intermediate care is available to all adults over 18, although it is acknowledged that both locally and nationally it most commonly supports older people and those with long term conditions. (Average age of intermediate care service users in National Audit of Intermediate Care 2016 was 80 years).

The data from our review also confirmed that the needs of people with intermediate care are often a mixture of physical, mental health and social and it is often this complexity and the impact on function which results in lengthy hospital admissions not the clinical or medical need itself. (See the .Case for Change for a profile of needs)

Inclusion and Exclusion criteria

NICE recommend that intermediate care services...

“Do not exclude people from intermediate care based on whether they have a particular condition, such as dementia, or live in particular circumstances, such as prison, residential care or temporary accommodation.”


Our work to date also supports this flexible approach to acceptance criteria. The model that has developed via the rapid response test has been a ‘conversation’ based approach between the individual, referrer and the intermediate care team to agree what is an appropriate referral. A tool has been developed to guide this conversation and support decision making (SBAR) around acceptance of referrals. It is anticipated that this model will be developed throughout intermediate care and alongside DMBC’s community led support ‘conversation model’.
As part of this conversation it is important that a plan to meet the individual’s medical needs is agreed as there will be occasions when it is not safe for intermediate care services to support an individual whose medical needs are not stable or it may be that the expertise required to meet these needs sits outside of the core intermediate care workforce and more specialist input or specific medical assessment needs to be arranged jointly with primary care or acute services.

It is also important that the response is proportionate and where an individual does not need a statutory or secondary care response that they are signposted to alternative community led support or encouraged to self care.

**Borders for integrated services**

Intermediate Care services that are currently commissioned by Doncaster Metropolitan Borough Council are available to all Doncaster residents. However those services currently commissioned by NHS Doncaster CCG are available to people who are registered with a Doncaster GP. Although broadly these two criteria overlap, there are a number of areas particularly on the borders of the borough where people registered with a Doncaster GP are not Doncaster residents therefore not entitled to the social care element of the intermediate care offer and vice versa. Within the rapid response this has been managed on a case by case basis by liaising with the equivalent neighbouring service or the person’s own GP and if needed utilising health reablement staff to cover areas where social care do not cover to support the professionals doing the initial assessment or until the neighbouring service can pick them up.

It is likely this will be an issue for some of the other areas of opportunity within the place plan, therefore a more formal agreement about how boundary areas are managed in integrated health and social care services will need to be put in place going forward
2. THE JOURNEY SO FAR

**Intermediate Care Project Overview**

<table>
<thead>
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<th>April - October 2016</th>
<th>November 2016 - March 2018</th>
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**PHASE 1 REVIEW OF INTERMEDIATE CARE**

A comprehensive review of intermediate health and social care services in Doncaster was conducted between 2015 and early 2016 to;

- Analyse performance of the current intermediate care system.
- Clarify local need for intermediate care.
- Identify key elements required in the future service model for Doncaster.

It involved a range of activities, including;

- In depth, multi-disciplinary and multi-agency study of the needs of statistically significant sample (1027) of people referred to intermediate care in 2014.
- Visits to current services and 51 interviews with key stakeholders
- Desktop analysis of data relating to current IHSC services (including benchmarking data from National Audit of IC)
- Interviews with 58 people using intermediate care services about their experiences.
- Findings from the hospital discharge pathway study. *Qualitative study lead by Sheffield Hallam University following people and their carers from discharge, through intermediate care and home for 12 months.*

The review found;
Current services are too complicated and difficult to navigate.
Lots of duplication - Similar services doing similar things to support people with similar needs.
Not enough step up support to prevent admission and maintain people at home.
People who used services and their carers generally expressed a preference to be treated and supported at home with appropriate community services rather than hospital.
More bed based services than in other areas.
That by utilising the intermediate care bed base resource differently more people could be supported at home in order to reduce activity in acute care.
Most people who use intermediate care are over 80 and have complex, health and social care needs. integrated, flexible services to meet this need.
Not all teams could work with Dementia and Cognitive impairment - despite growing need.
Don’t routinely address low level mental health needs, loneliness and social isolation.
Commissioning and contracting arrangements contribute to complexity and disjointed provision.


**PHASE 2: DESIGNING A NEW MODEL FOR INTERMEDIATE CARE**

In phase 2 the intermediate care team used the findings from the review and a set of design principles to work with partners to develop the vision for future intermediate care and design a more efficient model which will provide the four integrated responses (rapid, short term, medium and bed based) identified in the review and put a greater emphasis on maintaining independence and social networks, preventing hospital admission and utilising community assets.

The design work stream included the following activities;

- Learning from others events - showcasing what others are doing around the country.
- Six intermediate care design workshops involving expertise from across a range of relevant service areas and professionals.
- Engagement with individual service areas and professionals not able to participate in the workshops. E.g. mental health, pharmacy, housing,
- A series of staff engagement sessions with existing teams.
- Further analysis of the intermediate care review data.
Joint session with the Hospital Discharge Pathway project to meet participants and hear their stories in person.
Joint work with Co-create to engage citizens.

A summary of the proposed model based on this work was presented at project board in September 2016 and the implementation of this new model was incorporated into the delivery of the Doncaster place plan.

Later in this document the outputs from the design phase are presented including the refinements made as a result of the testing phase.

PHASE 3: TESTING A NEW MODEL FOR INTERMEDIATE CARE

It was agreed to test and refine this model between November 2016 and April 2017. This includes working together to test elements of the model with existing teams, preparing staff for transition and further involvement of patients and the public in refining the model.

This involved a number of test projects which have been scoped by providers in response to a series of challenges set by commissioners to encourage collaboration and test some of the aspiration in the Doncaster place plan.

The projects included:

1. **Simplifying Access**- Bringing together more access points in preparation for a place based Single Point of Access (SPA)
3. **Integrated rehab and reablement**- Developing and testing an integrated reablement and rehabilitation pathway in preparation for transition to a single health and social care service model.
4. **Shared competency framework**, carrying out a workforce audit and developing a joint workforce development plan
5. **Integrated Digital Care Record Proof of Concept**.
6. **Integrated health and social care dashboard for intermediate care**.
7. **Developing and testing a new integrated approach to commissioning, contracting and delivery**.

These projects are all at different points in their implementation. A summary of progress made in some of these areas is included on the following pages.

The partnership have also been working with Co-Create to build on the patient and public engagement carried out as part of the review. A report of this activity is available here. The findings of this work have been used to inform the content of this specification and will be taken forward into implementation by the Intermediate Care Partnership.
WHERE WE WERE
At least six ways to access intermediate care, depending on who is making the referral and location of the person who needs the service at the time of referral.

Simplifying Access
WHERE WE ARE NOW
As Doncaster already had a Single Point of access (SPA) for some health services the decision was made to use this to gradually test streamlining access to more intermediate care services.

We now have access to most services required to provide an urgent community intermediate care response accessible through the RDASH SPA including social care reablement. Plans are now in place to start to bring the more routine responses through SPA from mid December 2017. Although relatively small scale this work has been helping to test the future direction of travel regarding integrated access points.

Integrated Rehabilitation and Reablement (Medium Term)
WHERE WE WERE
Outcomes for reablement generally positive reducing need for ongoing care and patient feedback very positive.

Review suggested potential for more people to benefit from home based reablement rather than bed based.

Separate health and social care reablement teams supporting people with similar needs. (previously based in same building but recently separated) – potential to reduce duplication.

Single point of access and triage in place for step down referrals but not for step up. (Two separate intermediate care offers – RAP and AGU)

Disjointed community therapy offer across three organisations, duplication of referrals and delays in accessing some elements. No therapy input into STEPs.

More step down activity than step up.

Home from Hospital service provided by AGE UK offering low level step down support but not for step up. (Two separate intermediate care offers – RAP and AGU)

Health routinely offered full 6 week package and for upstream assessment and input

More step down activity than step up. Review suggested potential for more people to move money around the system.

WHAT WAS GOOD ABOUT THE SERVICE YOU RECEIVED?

Quickly organising everything, giving confidence to the person at home. (Carer) Feedback from CICT client

I have had the right level of support, as I have improved they reduced what they did for me so I could be totally independent. Feedback from STEPs client

Daily exercises from the Physio worked well, to get me moving and being able to get about using my frame. Feedback from CICT client

There is a need to improve practical help to get out and about and provide additional support to (re)start socialising/activities. Social isolation & loneliness is an issue for many

WHERE WE ARE NOW
Joint health and social care triage for all referrals for rehabilitation and reablement. (launched 11th December 2017)

Three month test of this planned to better understand demand before changing referral process permanently.

Started to look at joint health and social care assessment process.

Future integrated model has been scoped by inter agency working group, along with an outline implementation plan. Waiting project management resource to support this and outcome of options appraisal (below)

Options appraisal re DMBC’s future role in provision of intermediate care underway.

Health reablement (CICT) to start to use same call monitoring software as STEPs to enable comparison of activity data.

Therapy services from three provider organisations working together to streamline pathways and ensure access for stream assessment and input into reablement care plans across health and social care.

Home from Hospital beginning to take step up referrals.

Teams are starting to align and prepare for change.

WHERE WE ARE NOW
- Most step up intermediate care services not able to provide rapid/ urgent response, some responses days not even hours.
- Separate health and social care responses.
- Separate ECP service was able to offer urgent clinical response but was not linked into intermediate care offer or an MDT response.
- Different access points for all the step up responses.
- Easier for GPs and YAS to send someone to ED where there was a better co ordinated, rapid response available (RAFT). This type of assessment was not available before reaching E.D.
- No lower level social support available as part of the step offer – AGU UK only providing Home from Hospital.
- Timely access to community therapy was also an issue.

It is very important to know that you can get help when you need it.

In the past, there would have been a chance we would take someone to ED as we wouldn’t know for certain if they could be safe if things got worse.

Rapid Response
WHERE WE WERE
WHERE WE ARE NOW
Rapid response pathway launched 25th Jan 2017. It brings together 5 health and social care providers to offer a single co-ordinated response to prevent need for conveyance to hospital and admission where appropriate. Can respond within 2 hours when needed. Open to referrals from YAS, GPs and other HC professionals. AGE UK part of rapid response offering low level social support.

Some sharing of staff across services via rotas. Jan-Nov 2017 442 referrals received and 358 were accepted onto the pathway. 78% of the patients accepted by the Rapid Response service have been supported at home.

Feedback from those who have used the service has been overwhelmingly positive with 86%* reporting that it had helped them feel safer at home.

WHERE WE ARE NOW
- Two separate commissioners, separate budgets.
- Some arrangements in place to work together through BCF.
- No clear understanding of the financial envelope for or cost of delivering intermediate care across the system.
- Separate contract management arrangements with each organisation.
- Limited flexibility to move money around the system.

WHERE WE ARE NOW
WHERE WE WERE
- No new services have been commissioned since the review and no changes made to contractual arrangements.
- Testing has been done within scope of existing specifications and existing contractual arrangements.
- Intermediate care redesign included as part of SDP schedules for DBTH and RDOG contracts 2017-19.
- DMB services remain in house provision and don’t have a contract. Options appraisal has begun regarding future of DMB as an intermediate care provider.
- Agreed the scope, mapped the funding streams and identified costs for intermediate care with providers – this is currently being reviewed and confirmed by Place Plan Finance Group.
- Difference in how health and social care cost services have been highlighted and still need to agree way forward regarding inclusion of indirect costs.
- New joint commissioning structure being implemented and joint commissioning agreement signed between DMB and NHS OCGC.
- Started to test a more collaborative approach to commissioning with group of providers via a series of challenges to work together to develop test projects with project team support.
WHERE WE ARE GOING?

OUR VISION FOR A WHOLE SYSTEMS APPROACH UNDERPINNED BY A PERSON-CENTRED, ASSET BASED SERVICE MODEL.

THE DONCASTER INTERMEDIATE CARE PARTNERSHIP - A WHOLE SYSTEM APPROACH

The Doncaster Intermediate Care Partnership represents those organisations that have played an active role in developing this vision. Currently the Partnership is an informal collaborative of people and organisations involved in commissioning, planning, delivering and developing intermediate care and related services in Doncaster. Its membership has grown out of the intermediate care project board and related work streams and includes all of those organisations who have contributed time and effort to the last twelve months of testing.

The intermediate care project board is a monthly meeting where the intermediate care partners meet formally. Initially it was responsible for steering the review and more recently for approving test plans, monitoring the progress of test projects and steering the implementation of the intermediate care delivery plan. It is chaired by NHS Doncaster CCG on behalf of the commissioning partners. Over the past 6 months a more informal intermediate care provider forum has been trialled alongside the formal board meeting, to provide a space for jointly exploring issues and opportunities in more detail and to involve a greater range of operational staff. A series of supporting work streams have been in place over the past 12 months with integrated teams working together to implement the various test projects. Some of the BCF testing monies have been used to fund backfill and release a number of small number of operational staff from across key organisations in the partnership to lead the work with support from the project team. These leads currently meet on a weekly basis to review progress and keep work on track.

It is anticipated that these forums, the existing work streams and the leads for them will need to be reviewed to meet the needs of the next phase and to fit in with the emerging ACP governance arrangements.

In order to support the testing and prototyping activities, a more formal partnership arrangement has been established between the commissioning organisations and those currently involved in operational delivery of intermediate care (see following page for details of membership) and this has been supported by a memorandum of understanding which runs up to March 2018. The partners who signed up to this are the ones who will initially drive joint commissioning, joint operational delivery and the implementation of the next stage of the intermediate care whole system model in 2018.

However the membership of the Doncaster Intermediate Care Partnership is not fixed. Over time we anticipate that the membership will change and include a wider range of organisations, at each of the three levels set out on the following page.

As Team Doncaster progresses the plans for accountable care, the intermediate care partnership is well placed to make the transition from the current informal joint working arrangements to a more formal accountable care partnership model and along with the ‘complex lives alliance’ to pave the way for other transformation programmes within the place plan.
MEMBERSHIP AND SCOPE

The organisations currently represented on the intermediate care board fall into three broad categories;

1. STRATEGIC PLANNING AND COMMISSIONING
Joint investment in improving outcomes whilst reducing demand on acute health and long term social care support.
- NHS Doncaster Clinical Commissioning Group
- Doncaster Metropolitan Borough Council - Performance, Commissioning, Transformation and Public Health

2. OPERATIONAL DELIVERY
Integrated delivery by key organisations with joint responsibility for operationalizing the whole system specification and delivering against the outcomes framework.
- Doncaster and Bassetlaw NHS Teaching Hospitals Foundation Trust (DBTHFT)
- Doncaster Metropolitan Borough Council – Adult Social Care provision.
- Flyde Coast Medical Services (FCMS) - ECP service
- Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH)
- AGE UK

3. WIDER SYSTEM PARTNERS
A wider ecosystem of organisations and individuals who provide care and support to people who may require intermediate care or interface with the intermediate care pathway. This support is both formal and informal, commissioned and emerging directly from the community. This ecosystem also creates a platform for engagement with the views and experiences of people in the community, their carers and those who refer into intermediate care services.
- Primary Care Doncaster GP Federation
- St Ledger Housing
- Local Pharmacy Committee
- Home Care Strategic Lead Providers
- Healthwatch
- Yorkshire Ambulance Service (YAS)

Membership is not fixed, and will change and grow over time.
SCOPE - YEAR ONE

There are a number of services in Doncaster have been clearly identified as core intermediate care services whose only function is delivery of intermediate care. There is also some other services which provide an element of intermediate care, but also deliver other functions often linked to intermediate care but not considered core. This overlap is usually with the wider unplanned and urgent care services. Over the course of the review and design much debate has taken place about how this is reflected in the scope and how the subsequent costing reflects these dual roles.

Based on this work to date commissioners are proposing that the following services and current providers of Intermediate Care in Doncaster and are included in the initial scope of this specification. This needs to be confirmed by providers ASAP.

<table>
<thead>
<tr>
<th>The Doncaster Services currently in scope;</th>
<th>Provider</th>
<th>Commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Intermediate Care (CICT) &amp; Unplanned Care Team (split tbc)</td>
<td>RDaSH</td>
<td>DCCG</td>
</tr>
<tr>
<td>Short Term Enablement Programme (STEPs)</td>
<td>DMBC</td>
<td>In-house</td>
</tr>
<tr>
<td>Home from Hospital Service</td>
<td>AGE UK</td>
<td>DMBC</td>
</tr>
<tr>
<td>Positive Steps</td>
<td>DMBC</td>
<td>In-house</td>
</tr>
<tr>
<td>Hazel and Hawthorn wards</td>
<td>RDaSH</td>
<td>DCCG</td>
</tr>
<tr>
<td>Fred and Ann Green Rehab Centre – General Rehab Beds only.</td>
<td>DBTHFT</td>
<td>DCCG</td>
</tr>
<tr>
<td>Integrated Discharge Team (IDT)</td>
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</tr>
<tr>
<td>Rapid assessment and Prevention team (RAPT)</td>
<td>DBTHFT</td>
<td>DCCG</td>
</tr>
<tr>
<td>OPMH Hospital Liaison</td>
<td>RDaSH</td>
<td>DCCG</td>
</tr>
<tr>
<td>Emergency Care Practitioners (split tbc)</td>
<td>FCMS</td>
<td>DCCG</td>
</tr>
<tr>
<td>Community Geriatrician Service</td>
<td>DBTHFT</td>
<td>DCCG</td>
</tr>
<tr>
<td>Evergreen Falls Service</td>
<td>RDaSH</td>
<td>DCCG</td>
</tr>
<tr>
<td>Respiratory Early supported Discharge (Home from Hospital) service</td>
<td>DBTHFT</td>
<td>DCCG</td>
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Contractual arrangements;

- DCCG - Standard NHS contract with RDaSH for the services they provide on the above list (Intermediate Care redesign also included in current SDIP) April 2017- 2019
- DCCG- Standard NHS contract with DBTHFT contract for the services they provide on the above list (Intermediate Care redesign also included in current SDIP) April 2017- 2019
- DCCG- Standard NHS contract with FCMS for the services they provide on the above list.
- DMBC provided services are in-house so there is no contract as they are not commissioned services.
- DMBC - contract with AGE UK for Hospital at Home Service- recently extended to April 2019. (tbc)

Note- a number of sub contracts exist within this scope which will need to be considered including contracts with GPs and Pharmacy services.

FUTURE SCOPE

It is noted that within year 2 of this specification additional services may come into scope. These may include;
- Windermere ward – RDaSH
- Community therapy services –DMBC, RDaSH and DBTHFT
- CAP Beds
- Magnolia

As described above there is significant overlap between intermediate care, urgent and unplanned care, with many interdependencies. Longer term it could be that these two areas of opportunity come together to develop a whole system approach to urgent and intermediate care.
THE BLUEPRINT [specification]

The following vision describes a set of core operational and support features that together make the most of the skills and experiences of partners across the Intermediate Care Partnership, as well as within the community. Critically, the model builds upon the progress that has already been made through testing and the need to formalise integrated delivery arrangements.

It describes two things:

1. The long term vision for the intermediate care service model.
2. The version of the service model that the Doncaster Intermediate Care Partnership will be asked to deliver from the beginning of April 2018 (Year 1)

LONG TERM VISION
[SCOPE]

The vision is to move away from the current configuration of two community teams, four bed based services (with over 100 beds), two hospital based assessment teams with six access routes, delivered by four providers and separate health and social care teams, providing more step down than step up support.

To a more streamlined, integrated health and social care, whole system offer, providing these key operational features or responses;

- Simplified access and a single assessment process
- An increased and more flexible community offer providing a range of responses;
  - rapid response
  - short term/ more intensive interventions.
  - Integrated rehab and reablement (medium term)
- A smaller integrated health & social care bed/ facility based offer.

So that the intermediate care offer is;

- Simpler, easier to access and more joined up
- Delivering more step up support to prevent deterioration, admission to hospital and care home admissions.
- Offering a greater range of more responsive home based support.
- Able to offer Bed or facility based support for those that can’t be safely supported at home.
Intermediate care will be delivered by an alliance or partnership of intermediate care providers (see pages 12 and 13) who will be required to;

- Deliver the above responses as single, integrated pathway to ensure seamless, risk managed care, with reduced duplication of assessment and diagnostics and enhanced communication. (See page 17 for proposed high level pathway).
- Ensure intermediate care is managed and lead in a way that promotes and facilitates integrated working and empowers staff and people using the service.
- Provide an integrated, jointly appointed and singularly managed, multi-skilled intermediate care workforce delivering robust health and social care outcomes and high levels of service user satisfaction.
- Ensure that the composition of intermediate care teams reflects the different needs and circumstances of people using the service.
- Implement a robust system to measure performance of the care pathway to demonstrate quality, value for money and sustainability.
- Participate in the on-going work developing the capability to share service user level data between health and social care.
- Ensure the care pathway is flexible enough to incorporate and promote any technological innovations.
- Implement a single assessment process and use of individualised care plans.
- Contribute to the on-going development of the capability to share data at an individual level between health and social care organisations. This maybe further interoperability or for some elements of the redesigned service it maybe agreeing to use a single recording system.
- Facilitate accurate recording of individual outcomes to show improvement in individual quality of life following involvement of the intermediate care service.
- Reduce unnecessary handover/contacts with separate health and social care staff.
- Improve support for carers in intermediate care to enable them to carry out their caring role effectively.
- Deliver a community based service, working alongside primary care services and within localities but providing in-reach into acute services to facilitate discharge from urgent care and hospital admissions.
- Deploy staff flexibly across intermediate care and other services, where possible following the person from hospital to a community bed-based service or directly to their home.
- Offer intermediate care in the most appropriate setting to safely meet the needs of individuals, with an integrated approach to access and assessment that promotes the exploration of options to work together to safely support someone in their own home environment first before escalating to a bed based or more intensive service offer.

The intermediate workforce should be skilled in;

- Providing responsive assessment and time limited, evidence based interventions to
  - Enable an individual to maximise, maintain or regain their independence.
  - Rehabilitate and enable an individual to regain function where possible.
  - Promote recovery from illness.
Enable adaption to a recent change in physical, cognitive, psychological or social functioning as a result of a long term condition or critical illness.

- Developing out of hospital solutions tailored to meet the needs and personal goals of individuals, building on existing support networks and collaborating with other community services.
- Consider all options to safely support someone in their home environment first before transferring them to a bed based service.
- Take an ‘asset based’ approach building on what the person already has access to and what is available in their neighbourhood in order to maintain their social networks.
- Recognise the needs of informal carers and ensure they play a central role in developing and delivering intermediate care plans.
- Routinely utilising technology to support and enhance the delivery of intermediate care & support plans (e.g. telehealth, telecare and other digital solutions).
- Taking a multi-disciplinary/ multi-agency approach to care planning.
- Working flexibly to meet physical, mental health and social care needs.
- Ensuring care is co-ordinated while a person is with the service and making arrangements for on-going care co-ordination and navigation where required on discharge from the service.

[Interdependencies with other services/providers]

In order to meet the needs of the people they are supporting, intermediate care staff will need to engage with and access a range of other services, community resources, specialist assessments and interventions. Commonly used examples include;

- General Practice
- podiatry
- pharmacy
- mental health and dementia services
- specialist and longer-term rehabilitation services
- housing services
- voluntary, community and faith services
- specialist advice, for example around cultural or language issues.
- homecare providers
- end of life services
- transport
- diagnostic services

The intermediate care partnership will be required to develop access routes to these type of services and encouraged to explore innovative ways of working collaboratively with wider partners and referrers to encourage an environment which allows for ‘flexible draw’ on skills and expertise between providers so that care is experienced as seamless.
Original reference; Half Way Home.
Adapted by Doncaster intermediate care providers & partners as part of design workshops in 2016, reviewed and updated at place plan workshop Dec 2017
DELIVERY MODEL

The intermediate care partnership will have the flexibility to collectively agree the best service configuration to allow them to deliver this specification. The operational features outlined refer to the responses that the service must provide, they are not intended to prescribe a team structure e.g. one team per response. It is anticipated that there will be workers and teams who need to be able to provide input into a range of responses.

Through the collaborative design work and testing that has already taken place a number of key elements have been identified which are useful considerations for the delivery model, including;

- Fewer separate teams to reduce some of the existing duplication and hand offs.
- The delivery model will need to complement the emerging locality based neighbourhood teams, in order to maintain community connections and existing networks of support.
- There will be some functions that are best delivered centrally due to economies of scale, for example the more intensive responses (rapid and short term).

The model depicted below summarises the current thinking and has layers or ‘petals’ of increasing intensity of intermediate care that overlay onto the person’s own resources and community assets to provide the appropriate level of extra care and support to maintain independence.

Central assessment and navigation service, providing...

1. **Single point of contact and assessment.**
2. **Rapid response** (see and treat or see and solve)
3. **Short term/ intensive response** (see and keep in ‘own bed’)
4. Co ordination of reablement/ rehab plans -delivered in localities/ neighbourhood teams.

Provides an overview of intermediate care caseload and closely linked into acute capacity management processes.

Community based with a presence in A&E and on the wards to pick up face to face referrals.

Integrated health and social care bed base-linked to localities. Aligned very closely or staffed by some of the same team as deliver the rehab/ reablement response as would be offering similar interventions but in a ‘borrowed bed’.

Longer term the aim is to develop locality based model for bed base, which may mean 4 bed bases, one for each locality as demonstrated above. However the next phase of modelling and locality profiling may suggest that a different number of bases may work better to meet the needs.
In summary the key operational features and the supporting or enabling features required are listed in the table below;

<table>
<thead>
<tr>
<th>Key Operational Features</th>
<th>Support/Enabling Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplified access and single assessment process</td>
<td>Shared outcomes framework and joint performance monitoring</td>
</tr>
<tr>
<td>Community based Intermediate care offering the following responses;</td>
<td>Partnership governance and leadership</td>
</tr>
<tr>
<td>➢ Rapid Response and short term interventions</td>
<td>Single Workforce Strategy</td>
</tr>
<tr>
<td>➢ Integrated health and social care rehabilitation and reablement (medium term)</td>
<td>IT systems and interoperability</td>
</tr>
<tr>
<td>Facility or Bed Based intermediate care offer.</td>
<td>Joint commissioning and contracting arrangements</td>
</tr>
</tbody>
</table>

Over the coming year we would like to see individual intermediate care services come together more formally to respond to this and within the next 2 years we will be looking to commission a single intermediate care service from the partnership.

TRANSMISSION FROM CURRENT SERVICE CONFIGURATION TO NEW MODEL

It is acknowledged that there will be a period of transition from one model to another. The diagram below maps the existing services onto the key operational features of the new model and provides a very basic overview of the transition required and which has already begun as part of the testing.

In order to transition fully the community, step up offer will need to be enhanced to enable a reduction in the intermediate care bed base. In order to achieve this additional funding will required to fund some double running. Some initial funding from the BCF has been used in 17/18 and will need to be confirmed for a further year (see later section on the financial envelope).
**KEY OPERATIONAL FEATURES**

**SIMPLIFYING ACCESS AND CO-ORDINATING INTERMEDIATE CARE.**

*Click table to enlarge view*

<table>
<thead>
<tr>
<th>LONG TERM VISION:</th>
<th>NEXT STEPS:</th>
<th>WHAT DOES YEAR ONE LOOK LIKE 2018/19</th>
</tr>
</thead>
</table>
| Single point of access for intermediate care services to;  
  • Receive referrals (phone and e-referral)  
  • Log relevant information.  
  • Carry out an initial screen/ triage.  
  • Identify what needs to happen next and dispatch the appropriate response.  
  • Transfer/signpost referrals not for intermediate care to the right place.  
  There is also a need for the co-ordination and review of any intermediate care plans set up following assessment.  
  Where a person has an existing care co-ordinator they will maintain this responsibility while a person is with the intermediate care (e.g. community nurse, Admiral Nurse) but they will have a link with an intermediate care case manager/named worker.  
  If a person does not have an existing care coordinator, an intermediate care key worker or case manager will be allocated and they will be responsible for ensuring the care plan is delivered, reviewed and plans for discharge are in place when the goals have been achieved.  
  This central service will also have responsibility for maintaining an overview of the whole intermediate care caseload and will be closely linked into acute capacity management processes.  
  It links closely with the redesign of the social care front door and community led support model and will need to continue to evolve in conjunction with developments in these.  
  | 1. Partnership to agree implementation plan and timeline for streamlining access to next cohort of intermediate care services via SPA in 2018/19 (see list to right). This will need to link with outcomes of 2, 3 and 4.)  
  2. RDaSH to scope internal work plan for developing SPA (as part of plans to bring more RDaSH services in).  
  3. DMBC to appraise options for development of their front door access model and agree implementation plan.  
  4. Urgent Care Lead at DCCG is working with providers to map future access to urgent care in order to meet the recently published national guidance.  
  | Access to;  
  • Step up beds  
  • ACT referrals for intermediate care (STEPS) move to SPA.  
  • ECP service (not other FCMS urgent care services)  
  • Community Physiotherapy  
  • Pharmacy technician (tbc) move into the single point of access.  
  Communication campaign with referrers and public to inform of changes to referral processes.  
  RDaSH review of SPA complete and DMBC redesign of front door being implemented – IC access redesign to compliment these plans.  
  Daily operational meetings are well established so that community services are clear about their capacity, demand and pressures so that they can link in with acute operational meetings.  
  |
Community intermediate care will assess, initiate, maintain or complete a course of treatment, rehabilitation or reablement that requires supervision or regular interventions but where the individual can be supported at home.

Three elements to the home based offer;
1. Rapid response.
2. Short term, intensive interventions.
3. Integrated rehabilitation and reablement programmes (referred to as medium term in the intermediate care review)

All of these elements will include a mixture of health, social care, voluntary sector and other community services in order to meet the diverse and fluctuating needs of people who require support from intermediate care services.

### RAPID RESPONSE

**LONG TERM VISION:**
Multi-agency response providing assessment and brief interventions at home e.g., ‘see and treat’ or ‘see and solve’ then discharge. Or following assessment it may be decided that there is a need for further intermediate care input (short or medium term) and therefore a ‘see and keep’ response would be offered. The evidence from testing suggests that the response time should be agreed case by case as part of the clinical conversation with the quickest response time being within 2 hours, 4 hours for less urgent and within 24 hours for more routine. This is consistent with national guidance and other similar services. Referrals accepted from health or social care professionals, GPs and Ambulance Service.

Initially it will bring together existing intermediate and urgent care services to provide a co-ordinated response with a dedicated triage and co-ordination function. Over time bespoke rapid response practitioner roles should be developed.

Three parts to the rapid response;
1. Rapid access to an integrated health & social care assessment in the home environment, directly from the community to prevent admission.
2. In-reach into/ presence on A&E to assess and facilitate discharge from A&E, MAU, CDU, FDAS, Ambulance Bay and Urgent Care Centre to facilitate discharge.
3. In reach into acute wards and other bed based services to assess health and social care needs and facilitate discharge. (the team would have a presence at the acute hospital)

**NEXT STEPS:**

**IMMEDIATE ACTIONS**
Upto 1st April 2018.

1. **Complete one year test of rapid response and write up evaluation** (Feb 2017)
2. **Confirm extension of BCF funding for further year.**
3. **Continue to develop rapid response**
   - Work with care homes to determine appropriate offer.
   - Ongoing work with YAS to develop pathway for other amber patients.
   - Standardise hours offered by all elements of response.
   - Develop in reach into A&E and wards.
4. **Agree priorities for 2018/19.**
5. **Formalise links to DToc High Impact Changes work plan as it is agreed.**

**WHAT DOES YEAR ONE LOOK LIKE 2018/19**

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Multi-agency response providing assessment and brief interventions at home e.g., ‘see and treat’ or ‘see and solve’ then discharge. Or following assessment it may be decided that there is a need for further intermediate care input (short or medium term) and therefore a ‘see and keep’ response would be offered.</td>
<td>Recurrent funding for rapid response identified. Workforce development plan agreed with integrated roles being developed and single management structure to reduce duplication.</td>
</tr>
<tr>
<td>Initially it will bring together existing intermediate and urgent care services to provide a co-ordinated response with a dedicated triage and co-ordination function. Over time bespoke rapid response practitioner roles should be developed.</td>
<td>Hospital based RAPT, RDaSH IDT in reach and Rapid Response come together as one service taking referrals from community, A&amp;E and hospital and providing a ‘SWOOP ’ function (see below).</td>
</tr>
<tr>
<td>Three parts to the rapid response;</td>
<td>Implement iDCR and contribute to evaluation and electronic single assessment launched and being tested.</td>
</tr>
<tr>
<td>1. Rapid access to an integrated health &amp; social care assessment in the home environment, directly from the community to prevent admission.</td>
<td>Paperwork reviewed and streamlined.</td>
</tr>
<tr>
<td>2. In-reach into/ presence on A&amp;E to assess and facilitate discharge from A&amp;E, MAU, CDU, FDAS, Ambulance Bay and Urgent Care Centre to facilitate discharge.</td>
<td>Recommendations from evaluation are being implemented.</td>
</tr>
<tr>
<td>3. In reach into acute wards and other bed based services to assess health and social care needs and facilitate discharge. (the team would have a presence at the acute hospital)</td>
<td>Daily MOTs/ Operational meetings are embedded (across 7 days) and links with daily ops meetings in acute established.</td>
</tr>
</tbody>
</table>

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**Note1:** this includes the ‘crisis response’ as described in the NICE guidance for intermediate care.

**Note2:** points 2 and 3 are similar to the description of a ‘SWOOP’ team which is being discussed as part of DToc work.
### SHORT TERM/ INTENSIVE RESPONSE

#### LONG TERM VISION:
A more intensive, wrap around, intermediate health & social care response that could support a patient at home for a very short period to avoid an acute admission or facilitate discharge from hospital. It should be a combined health, social care and voluntary sector provision that could provide very frequent calls or 24 hour supervision using sitters, telecare and telehealth for between 24 to 72 hours.

For example:
- Carrying out observations & supporting patients to take analgesia regularly for acute pain following a fall.
- Intensive rehabilitation & reablement after surgery
- Supporting the ‘discharge to assess’ model
- ‘Sitters’/ befriender to provide reassurance following a fall or settle back in after an admission.
- Support with ADLs while antibiotics for chest infection or UTI start to work.
- Supporting people with exacerbation of COPD.
- Intensive assessment in home environment over a 24-48 hour period to inform future care package/ identify needs.
- Support someone to stay at home when their carer is taken ill.

This type of response is sometimes referred to as ‘hospital at home’ or ‘own bed instead’ as it provides the type of response currently provided by bed based intermediate care services in someone’s home.

<table>
<thead>
<tr>
<th>IMMEDIATE ACTIONS</th>
<th>WHAT DOES YEAR ONE LOOK LIKE 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upto 1st April 2018.</td>
<td></td>
</tr>
<tr>
<td>Continue to offer 72 hour support alongside rapid response and include in evaluation (Feb 2017)</td>
<td>Testing the extension of service to 24 hours/ increased intensity of support with capacity from bed base (or further testing monies) and evaluating to identify impact on patient outcomes, longer term need and cost.</td>
</tr>
<tr>
<td>Formulate links between this work stream and development of discharge to assess model as part of DTOC High Impact Change work.</td>
<td>Increased use of telehealth and telecare.</td>
</tr>
<tr>
<td>Link with Bed Base working group as there maybe opportunities to release some bed based resource to test extending current offer over 24 hours and/or increasing intensity.</td>
<td>Developing the sitter/ befriender role with voluntary sector.</td>
</tr>
<tr>
<td>Continue to develop respiratory pathway and confirm if respiratory early supported discharge should be in scope.</td>
<td>Reduction in step down referrals from hospital as more people are being supported at home.</td>
</tr>
</tbody>
</table>

#### NEXT STEPS:

Note: this includes the ‘crisis response’ as described in the NICE guidance for intermediate care.

### INTEGRATED REHABILITATION AND REABLEMENT (MEDIUM TERM INTERVENTIONS)

#### LONG TERM VISION:
‘Medium term’ describes the non-emergency arm of the community intermediate care offer. It builds on the offer provided by STEP’s (social care reablement) and CICT (health reablement) who provide up to 6 weeks social rehabilitation and reablement as step up or step down support.

The review indicated that in the future an integrated health and social care team would be better placed to meet both the health and social care needs of people who require this type of response and reduce duplication.

In the future this response will need to include:
- Therapists, nurses and social workers working with a joint team of health & social care re-ablement workers to deliver and review intermediate care support and care plans.
- Access to Geriatricians for advice and expert opinion— with the option of review by the Geriatrician, when a patient requires it.
- Better and more timely access to therapy skills and expertise.
- Falls assessment as an integral part of this service response.
- Length of this response should be based on need – so less than 6 weeks where appropriate and more if needed.
- Low level, practical community based support should also be part of this offer (voluntary sector provision)
- Services and workers skilled to assess and respond to low level mental health needs, loneliness and social isolation with links into social prescribing and community led support.

There will be a core team with ‘flexible draw’ on a number of other services/ professionals as required.

Ideally this service should be able to respond within 2 days. Increase in capacity in particular growth in step up activity.

<table>
<thead>
<tr>
<th>IMMEDIATE ACTIONS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Upto 1st April 2018.</td>
<td></td>
</tr>
<tr>
<td>1. Continue to test &amp; evaluate joint triage (Dec 17- March 18).</td>
<td>Closer integration of STEPs and RDaSH’s community intermediate care team as agreed in implementation plan – see right.</td>
</tr>
<tr>
<td>2. Collect agreed data set and present in dashboard.</td>
<td>Workforce development plan agreed, along with any necessary consultations etc.</td>
</tr>
<tr>
<td>3. DMBC to complete options appraisal re future delivery model.</td>
<td>Single management arrangements in place.</td>
</tr>
<tr>
<td>4. Update draft implementation plan in response to outcome of 2 and 3.</td>
<td>Testing single assessment process.</td>
</tr>
<tr>
<td>5. Continue with Falls service redesign.</td>
<td>Increased therapy input into reablement plans.</td>
</tr>
</tbody>
</table>

Single route of referral.

Closely linked to rapid response and short term interventions.

Productivity gains starting to be identified as a result of reducing duplication and integration

Links with mental health, dieticians and any other key partners established.

Partnership with Home from Hospital developed further and links with social prescribing made.

Falls service fully integrated with intermediate care.

Note: this includes both reablement and home based IC as described in the NICE guidance for intermediate care - we are proposing that in the future this should be an integrated service offer.
## BED BASE

### LONG TERM VISION:

A smaller bed base - supported by a more intensive, flexible, community based intermediate care offer.

A step-up or step down unit (or units) in a care environment with input from a range of health professionals (physical and mental health). Will either initiate or finish a course of treatment where the frequency or complexity cannot be managed in the home or where the service user has problems with activities of daily living, including transfers, mobility and safety which cannot be safely addressed by home-based support. A significant proportion of this bed base needs to be equipped to safely assess and meet needs of patients with Dementia, Delirium and cognitive impairment.

This will be an integrated health and social care bed base;
- Able to flex around patient need to meet physical, mental health & social care needs.
- Mental health expertise as an integral part of the staffing establishment.
- Offering short term assessment (few days) and medium term interventions (up to 6 weeks).
- Access via the same single point of access and assessment as the community IC service, so people are only admitted when it is not possible for community IC to support them at home.
- In-reach by community IC service into the bed base to facilitate discharge and support patients in their own homes ASAP.
- Linked into neighbourhood/locality teams.
- Aligned to CAP bed provision (potentially jointly commissioned) and to explore the potential to have flexibility to step up to CAP and down to IC in the same bed.

There should be a wait of no more than 2 days for an Intermediate Care Bed (NICE guidance Intermediate Care 2017)

### NEXT STEPS:

<table>
<thead>
<tr>
<th>IMMEDIATE ACTIONS Upto 1st April 2018.</th>
<th>WHAT DOES YEAR ONE LOOK LIKE 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Bed Base working group to begin to jointly review and agree plans for a system wide approach to developing the bed base.</td>
<td>Reduce existing bed base by 20 beds (tbc). Initial focus on units where there has been reduced occupancy across the past year (Hawthorn) and those where beds have been temporarily closed or there are opportunities for beds to be used differently. (MMH Rehab). Agree savings with commissioners and redirect resource into community offer, initially to cover recurrent costs of rapid response and fund further development of community &amp; step up offer.</td>
</tr>
<tr>
<td>2. Mapping of current bed base underway by above group and initial proposal due by March 18.</td>
<td>Test different model of health input into existing social care bed base including both physical and mental health expertise.</td>
</tr>
<tr>
<td>3. Continue data collection on bed base as part of dashboard.</td>
<td>Move away from medically led/hospital based bed base and start to scope more community based models.</td>
</tr>
<tr>
<td>4. Agree reduction for year 1 and savings plan (see right) as part of contract discussions.</td>
<td>IC partnership to work together to model future bed base, and develop specification for community based beds alongside CAP bed provision. This may involve increasing scope to include Windermere and other units.</td>
</tr>
<tr>
<td>5. Review of health input into Positive Steps underway and plan to test different approach to be agreed Feb 2018.</td>
<td>Start to monitor 2 day wait.</td>
</tr>
<tr>
<td>6. Ensure bed base plans link with community plans.</td>
<td>Strengthen links between community intermediate care and bed base - bring access to step up beds via SPA.</td>
</tr>
</tbody>
</table>

**Year 2** – commence transition to new bed base model.
LONG TERM VISION:  NEXT STEPS: 
IMMEDIATE ACTIONS Upto 1st April 2018. WHAT DOES YEAR ONE LOOK LIKE 2018/19

### SUPPORT/ENABLING FEATURES

**SHARED OUTCOME FRAMEWORK AND JOINT PERFORMANCE MANAGEMENT SYSTEM**

Click table to enlarge view

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<thead>
<tr>
<th>What Does Year One Look Like 2018/19</th>
<th>Immediate Actions</th>
<th>Next Steps:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A clear, quantifiable way of identifying and measuring progress and distance travelled by people who use...</td>
<td>1. Initial draft of outcomes framework developed with performance team and public health – to be consulted on and agreed alongside other areas of opportunity.</td>
<td>Commence monitoring against agreed outcomes.</td>
</tr>
<tr>
<td>• An outcomes framework for the whole system co-developed and owned by the whole Partnership membership - commissioners, providers, service users, community and voluntary organisations.</td>
<td>2. Sign off outcomes framework for year one and include in contracts.</td>
<td>Produce monthly joint dashboard for use by all members of the alliance and reporting to key groups/boards.</td>
</tr>
<tr>
<td>• Incentives within a performance management framework that encourage collaboration with a focus on maintaining independence, preventing further deterioration, 'own bed instead', retaining community connections and addressing social isolation.</td>
<td>3. Align CCG Delivery plan and dashboard with agreed outcomes framework.</td>
<td>Agree appropriate patient reported outcome measure for whole system and plan to implement at key point in the intermediate care pathway.</td>
</tr>
<tr>
<td>• Clear and accessible performance dashboards and engaging methods of identifying and communicating key successes, challenges and issues to be addressed at whole system level and in component elements of the model.</td>
<td>4. Identify ongoing dedicated performance and intelligence support for intermediate care.</td>
<td>Work collaboratively to share develop appropriate methods of data collection and analysis.</td>
</tr>
<tr>
<td>• A clear set of tangible measures reflecting the real lived experience of and outcomes for people who use intermediate care services - set out in the outcomes framework and shared across services.</td>
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### SINGLE WORKFORCE AND LEARNING STRATEGY:

Click table to enlarge view

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>A single workforce strategy for intermediate care with a shared competency framework that reflects the needs and circumstances of the people who use the service.</td>
<td>1. Event on 22nd January 2018 to launch the development of a Doncaster wide workforce strategy. (Led by Alistair Strachan)</td>
<td>The partnership will work together to develop a strategy for developing the intermediate care workforce across the next 2 years.</td>
</tr>
<tr>
<td>The development of trans-disciplinary roles and trusted assessor models to provide more flexibility to meet a variety of needs and increase efficiency. i.e. reduce number of people involved and/or number of visits needed.</td>
<td>2. Based on the outcome of 1 agree how intermediate care work will fit into this wider work.</td>
<td>Agree implementation plan for the workforce strategy and begin to implement.</td>
</tr>
<tr>
<td>Shared training strategy, joint induction programmes and regular opportunities to learn together across the partnership.</td>
<td>3. Revisit draft competency framework developed following review and last years skills review so that relevant parts of this can be taken forward by the partnership.</td>
<td>Continue with monthly MDT case reviews (led by Community Geriatrician) and develop to include wider partners/other services.</td>
</tr>
<tr>
<td>People who use the service and their carers are routinely involved in review and evaluation of intermediate care and there is a culture of learning from the experiences of those who use services.</td>
<td>4. Complete rapid response year one evaluation.</td>
<td>Maintain an integrated approach to evaluation, with regular opportunities for joint review and feedback formally and informally.</td>
</tr>
<tr>
<td>Ongoing learning, evaluation and reflection on both outcomes and process, supported by robust data collection through integrated or shared information systems and an action learning culture, striving to continuously iterate and improve the service.</td>
<td></td>
<td>Link into wider place plan strategy and resource for evaluation.</td>
</tr>
<tr>
<td>Action learning methodology to review effectiveness of collaboration across the partnership and inform next steps.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
IT SYSTEMS AND INTEROPERABILITY:

To be finalised – updated version to be circulated.

PARTNERSHIP GOVERNANCE AND LEADERSHIP:

Robust and progressive multi partner governance and leadership arrangements for the Partnership and for specific functions (commissioning and provision.

To be finalised- updated version to be finalised.
### INTEGRATED COMMISSIONING AND CONTRACTING:

**LONG TERM VISION:**
To have a pooled health and social care budget for intermediate care and a single contract with an alliance or partnership of providers, in line with the ambition outlined in the Doncaster place plan.

**NEXT STEPS: IMMEDIATE ACTIONS BEFORE APRIL 1st 2018**

| 1. | Finalise scope with providers and complete review of funding/ costing work (in progress via finance group) |
| 2. | Confirm what a pooled budget will include – direct/ indirect costs (currently there is a difference between health and social care approach to costings) |
| 3. | Consider how double running money (BCF funding) is incorporated in coming year - redesigning service to release the recurrent funding needed could be outcome of 2018/19 so additional BCF funding not required in 19/20. |
| 4. | Based on outcomes of 1, 2 & 3 confirm **combined** budget for 2018/17. |
| 5. | Understand implications of DMBC as both a provider and commissioner and future intentions (options appraisal underway) |
| 6. | Understand any initial procurement implications. |
| 7. | Agree joint specification/ schedule format and draft from this document. |
| 8. | Appoint commissioning lead (joint post) & identify joint contracting lead. |
| 9. | Alliance to commence joint financial modelling around the bed base. |
| 10. | Confirm outcomes. (see draft) |
| 11. | Establish ACP strategic joint commissioning meeting. |

There are two possible options for 1st April 2018

**OPTION ONE:**
Aligned budget with joint commissioning agreement and a jointly appointed commissioner. Contracts remain as they are with a partnership agreement to support closer joint working.

**OPTION TWO:** A formal pooled budget, joint commissioning agreement and aligned contracts *(or shared schedules/ SDIPs)* outlining year one requirements and shared outcomes.

*Note: At workshop on 15th Dec the consensus was that a true pooled budget was needed ASAP- feedback was that we need to stop talking about it and make it happen.*
FINANCIAL ENVELOPE

The financial envelope for the services included in scope has been calculated to be around £17.6 million. This figure is currently being reviewed and confirmed as part of the work of the Place Plan Finance group.

There are a number of inefficiencies in the current intermediate care model and the case for change identified the potential to streamline the pathway to reduce this and increase productivity. For example by reducing duplication and fewer separate teams.

The results form the latest national audit of intermediate care (2016/17) also demonstrated that the current health home based IC service is significantly more expensive than other similar services and has lower than average activity levels. Whereas the social care reablement service is closer to the national average in terms of spend but sees significantly more referrals than the national average for social care reablement. There are of course some caveats regarding data quality but this supports the findings of the review that there is the potential to increase efficiency by implementing an integrated health and social care model for reablement based on the existing social care pathway and approach to activity management and reviewing need.

We also know that the cost per service user of bed based services over home based intermediate care services is significantly more, both nationally (see right) and locally. Locally we have some particularly expensive models of bed based intermediate care and these were not the models identified as meeting the majority of needs in the review.

The latest national audit of intermediate care 2016/17 also indicated that Doncaster continues to have more beds and a higher spend on beds per 100,000 than the national average (see graphs to the left). Which when combined with the findings from the review, where over half those who were admitted to an IC bed base could have been supported at home with a more flexible community offer, further supports using the financial envelope differently. For example: Re-directing some of the bed base resource to increase funding for home based alternatives, as proposed in the original case for change.
Therefore the intention is to implement the new service model within or just under the existing financial envelope for intermediate care. By increasing home-based intermediate care activity and in particular the amount of step up activity the evidence suggests that the benefits and savings will be realised in other parts of the health and social care system, in particular reductions in A&E attendances, unplanned admissions and care home admissions for over 65s. It is recognised that the changes needed to make a significant impact in these areas is wider than just intermediate care and will be dependent on other delivery plans and transformation work streams. (For example; DCCGs Primary Care Strategy, Urgent Care, Dementia and Community Delivery Plans and DMBCs Community Led Support)

In early 2017 targets for reducing acute activity were scoped and associated savings plans for two years were agreed (see below). So far in 2017/18 there has been reductions in activity in some of these areas in particular around falls which was the initial focus for rapid response suggesting that more could be achieved as the full model is rolled out. In 2018/19 there will be a requirement for intermediate care to continue to contribute to the following identified savings in acute services and on-going social care costs and this will be one of the outcomes that the intermediate care partnership will monitored against.

**QUIP targets for 2017-2019 associated with Intermediate Care.**

<table>
<thead>
<tr>
<th>Activity</th>
<th>17/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in ambulance conveyance (2.5% 17/18 &amp; 7.5% 18/19)</td>
<td>£456</td>
<td>£58,824</td>
</tr>
<tr>
<td>Reduced A&amp;E attendances other-patients not conveyed (5% 17/18, 15% 18/19 of over 75s.)</td>
<td>£193</td>
<td>£24,897</td>
</tr>
<tr>
<td>Reduce on elective admissions by 2.5% in total including XBDs (reduced LOS)</td>
<td>£759</td>
<td>£925,617</td>
</tr>
</tbody>
</table>

*(Please note 2018/19 targets are about to be reviewed so final these figures may change)*

In addition to the redesign of intermediate care is intended to contribute to the ongoing reduction in numbers of people going into care homes and their length of stay. As with the above acute activity this is a benefit that will span a number of project areas with a contribution from intermediate care and as yet no specific target has been allocated to this.

Impact on homecare will need to be monitored closely as well. Although the increased reablement capacity should reduce need for homecare packages, the shift from bed base to home based may on other occasions create new demand for home care. Therefore the net impact is likely that there will not be any significant reduction.

**Testing:** Additional funding has been agreed through the Better Care Fund (BCF) to test some of the new model. This funding has enabled the service to be tested without impacting on the funding for other services. DCCG and DMBC commissioners have worked with providers to make best use of existing resources to reduce duplication across the whole system and to minimise the additional resource required and the testing is currently being evaluated to determine its effectiveness, any financial and activity impact on current services and any recurrent costs required going forward. The recurrent impact of the test will need to be funded by the redesign of other parts of the intermediate care service, for example fewer separate teams and a reduction in the bed base as described above. Some of the BCF funding has also been used to progress integrated IT solutions, a workforce review and other work to facilitate implementation.
In order to transition fully from the current model to the new model the community, step up offer will need develop further to ensure a reduction in the intermediate care bed base is possible. In order to achieve this additional funding will be required to fund some further double running. It is proposed that the testing money continues for a further 12 months and is added to the intermediate care envelope for 2018/19 with the requirement that within that year the intermediate care partnership work together implement the redesign and release the recurrent funding so that in 2019/20 the funding for double running is no longer required.
THE NEXT STEPS IN OUR JOURNEY
GROWING THE DONCASTER INTERMEDIATE CARE PARTNERSHIP
(OUTLINE ROUTE MAP ONLY)

STAGE ONE
January – March 2018
• Establish joint leadership arrangements (providers), set up integrated contracting meeting and identify joint commissioning lead.
• Finalise and agree year one specification for inclusion in 2018/19 contracts.
• Confirm target for & savings from reduction in bed base in year one.
• Identify project resource to support implementation/ transformation.
• Sign off outcome model.

STAGE TWO
April 2018- March 2019
• Delivery of year one arrangements (as set out in specification/included in contracts) by the Doncaster Intermediate Care Partnership, made up of existing core partners – with partnership agreements in place for commissioning and delivery.
• Continue to grow community intermediate care offer and start to reduce bed base to release recurrent funding to support this growth.
• Further simplification of access and streamlining of teams.
• Develop a system wide, integrated workforce development plan and establish single management structure.
• Partnership to work together to scope & model plans for system wide redesign of the bed base, linked to wider estates strategy.
• Implement joint contract management arrangements reviewing against shared outcomes.

STAGE THREE
April 2019 onwards
• Formal integrated commissioning and delivery of Intermediate Care by an alliance of providers to be in place from April 2019.
• Implement next stage of bed base redesign.
• Increase scope to reflect work in year 1.
• Implement system wide workforce plan and develop relevant integrated roles.
• Identify further efficiencies/opportunities to increase productivity.
References/ supporting evidence

- NICE guidelines for Intermediate Care.
- Half way Home
- National Audit of Intermediate Care 2016/17
- Commission for Older People
- Case for Change