Adult Social Care

Intermediate Care and Short Term Residential Bed Commissioning Strategy

2013 - 2016
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Foreword

I am pleased to endorse the first Adult Social Care Intermediate Care and Short Term Residential Beds Commissioning Strategy for Leicester.

I hope it will help you to understand how important it is to have an Intermediate Care service that promotes faster recovery from illness, maximises independence and prevents premature admission to long term residential care. Intermediate care is for client groups of all ages and provides our citizens with the best opportunity to live in their own homes, as part of their communities.

At a time of challenging financial reductions and demographic pressures, preventing or delaying people from needing long term care will also help to deliver efficiency savings and ensure our available resources are targeted at those in the greatest need.

In addition to providing intermediate care, short term beds will always be needed, to provide crisis response and respite care to give carers a break from their caring role. Temporary beds are also used to assess individuals’ abilities to determine their long term support needs or to provide short term accommodation whilst a support package or an adaptation is completed at their dwelling, so they can return home.

Therefore, ensuring the supply of both Intermediate Care and Short Term Beds, that provide the right care at the right time, is essential to making the delivery of this strategy a reality.

Councillor Rita Patel
Assistant Mayor and Lead for Adults Social Care
Executive Summary

This strategy has been developed to specify how Leicester City Council intends to commission Intermediate Care and Short Term Residential Beds over the next 3 years (2013 to 2016) in order to improve the quality, effectiveness and efficiency of the existing service provision.

A review and analysis has been completed to understand the current picture of service provision and to develop evidence based strategic priorities and objectives to determine future commissioning intentions. The strategy has also been guided by national and local policy, and future demand has been based on demographic changes as detailed in the Joint Strategic Needs Assessment (JSNA)\(^2\) and the Census data\(^3\) for Leicester (2011).

A working group was established to review the current provision and to develop the strategy. A 3-month period of consultation was completed with a range of stakeholders and revisions to the strategy were made in response to the feedback received. A detailed implementation plan, which is included at Appendix 1, has also been developed; this underpins the strategy. The original working group has been re-configured to create a Commissioning Board, to provide the governance arrangements to ensure delivery of the strategy and associated actions.

What is Intermediate Care?

The term ‘Intermediate Care’ covers a wide range of services which are characterised by the following features:

- It is aimed at helping people avoid prolonged stays or inappropriate admission to acute hospital settings or residential care
- It is available to all client groups and all ages
- It features comprehensive assessment and outcome-focused rehabilitation support, aimed at maximising independence and enabling people to resume normal living
- It typically comprises multi-professional, multi-agency working
- It is time-limited, usually between 1-6 weeks
- These services are central to the delivery of a number of key national policies, including the National Service Framework\(^4\) for Older People, the National Dementia Strategy\(^5\) and the Intermediate Care ‘Halfway Home’\(^6\) guidance

What are Short Term Beds?

There will be occasions when Short Term Beds are needed for a period of time. Again, this is available to all client groups and all ages. This is not specifically about rehabilitation and can usually be characterised as the following:

- Assessment – To determine the future needs of an individual.

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\(^2\) Joint Strategic Needs Assessment – Leicester City Council (2011)  
\(^3\) Census Data (2011)  
\(^4\) National Service Network  
\(^5\) National Dementia Strategy (2009)  
\(^6\) Halfway Home Guidance
• Interim - A crisis can occur and an individual cannot stay at or return home because it may not be safe and an assessment is required to determine the long term needs. Following an assessment, an individual may need to move to alternative accommodation or receive a package of community support including adaptations in their home and may need to wait for a short period for suitable/alternative housing package to become available.

• Respite – Can be planned or unplanned. Planned respite is where a person is going into a residential placement to enable their carer to have a break. Unplanned respite can occur when a crisis situation arises; often this happens where a carer becomes unwell or is temporarily unavailable and the person they care for has to go into short term care for a period of time.

The strategic direction for modernising Adult Social Care services and delivering efficiency savings means that the way intermediate care and short term residential beds are provided needs to change. These changes are part of a wider programme of transformation and service redesign for Adult Social Care services.

The following have been identified as the key priorities for achieving the above:

1. Prevent avoidable admissions to hospital and support timely discharge
2. Decrease the number of people unnecessarily admitted to residential care
3. Improve quality of care and maximise independent living
4. Improve the skills and competence of the workforce
5. Deliver more cost effective services to meet future demand
6. Maximise people’s potential to live as independently as possible in their chosen community
7. Robust performance management and governance
1. Introduction

Adult Social Care in Leicester aims to support older people and vulnerable adults in the community by providing a range of services that promote independence and support people in their own home.

However, there will always be a need for accommodation based services to assess peoples need for on going support, or they may need building based services for a limited time, to help them recover from a period of illness or to maximise their independence for the longer term. For other people a crisis situation may have occurred and they will need short term residential care, or they may be waiting for a care package to be arranged or for an adaptation to their home to be completed. Respite care will also be needed to give carers a break from their caring responsibilities.

Therefore, Leicester City Council has identified intermediate care and the provision of short term residential beds as a key priority within the overarching transformation of Adult Social Care services. It is also a mechanism for the delivery of efficiency savings over the next three years.

Leicester City Council is committed to developing an Intermediate Care service that:

- Is available to all vulnerable client groups of all ages
- Promotes faster recovery from illness
- Is provided as part of an holistic service that is integrated with therapy, and which links with other services such as housing and community services
- Prevents premature admission to long-term residential care
- Supports timely discharge from hospital
- Maximises independent living opportunities
- Is ‘joined up’ across health and social care with a clear single point of access
- Increases access to those with complex needs, including people with dementia
- Is focused on achieving improved outcomes for individuals
- Is delivered by a workforce specifically trained to deliver rehabilitative support
- Makes optimum use of Assistive Technology
- Is high quality and based on best practice and guidance
- Has a robust performance management framework
- Operates within an agreed governance framework

The Authority is also committed to providing short term residential beds that:

- Provides flexible services that can cope with changing numbers and service user needs
- Provides chargeable planned and unplanned respite, including support for people with a dementia that is provided within a suitable environment
- Provides a crisis response service
- Provides a comprehensive assessments process for determining an individual’s future needs focussed on maximising independence

The strategy provides an overview and analysis of the existing intermediate care and short term residential beds provision, including those provided directly by the Authority and those provided by the independent sector.
It considers what the future demand will be for services, including demographic changes in the city. A gap analysis has also been included to determine what is needed, and how the need could be addressed within existing resources.
2. Definition of Intermediate Care

The Department of Health refers to Intermediate Care as being “a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, to support timely discharge from hospital and maximise independent living”.

It is referred to as a ‘bridge’ between hospital and home, its purpose being to maximise the potential of vulnerable individuals from all client groups of all ages. For the purposes of this strategy Intermediate Care refers to a building based service, where individuals stay for a period of up to six weeks and receive a range of co-ordinated services, such as therapy and rehabilitation to undertake basic daily living skills. This approach is designed to maximise individual’s independence to enable them to return home wherever possible.

The term ‘Reablement’ does not have a specific definition, but generally describes the use of timely and focused intensive therapy and support in a person’s home. It is available to all vulnerable client groups of all ages and is always the first option and is designed to have the same outcomes as Intermediate Care.

Leicester’s Reablement service is currently subject to a strategic review to incorporate an enablement model, which has a greater focus on community engagement skills and needs (as opposed to physical functioning). It is recognised that the Reablement service does not currently cater for those people who would benefit from a longer period or different types of support, which will also increase independence and reduce the cost of care. The review of Reablement will be closely aligned to the Intermediate Care and Short term Bed Commissioning Strategy to ensure the co-ordination and delivery of services.

The Leicester City Clinical Commissioning Group (CCG) also provides accommodation based Intermediate Care, which is based on a medical model. It is used to prevent acute hospital admission and to facilitate early discharge, where an individual requires ‘in patient’ clinical care and rehabilitation, but this does not need to be delivered in an acute hospital setting.

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7 Definition of Intermediate Care – Halfway Home Guidance (2009) Department of Health
3. **Definition of Short Term Residential Beds**

There is no national definition of short term residential beds, but they are generally used by all local authority adult social care services. In Leicester they are used for a variety of reasons, the following list is not exhaustive but gives an overview of the need for this type of provision:

- Planned respite to give carers a break
- Crisis respite
- Assessment to determine future support needs
- Interim or holding bed, awaiting a care package so the person can go home
- Awaiting adaptations
- Awaiting rehousing
- Safeguarding to provide a safe placement pending investigation
4. National Policy

There is a national drive towards developing services that are responsive to individual needs (or ‘personalised’ support). This agenda is outlined in the Putting People First Concordat (2007),\(^8\) which sets out a fundamental change in the way in which services are delivered. The directive detailed the shifting of resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and personal budgets.

The Department of Health published its original Intermediate Care guidance in 2001, which was incorporated within the “National Service Framework (NSF) for Older People” 2003. In July 2009 the updated guidance, “Intermediate Care – Halfway Home” was published.

The “Intermediate Care – Halfway Home” report published by the Department of Health in July 2009, provides the key guidance to local health and social care economies to ensure that:

- Intermediate Care is widely available to support a diverse range of service users to promote their independence in the community
- There is the widest access to Intermediate Care, underpinned by a collaborative approach
- Assessment and decision making of an individual's longer term care needs is undertaken outside of an acute setting, in a rehabilitative and enabling environment
- The number of individuals requiring readmission to hospital is minimised
- There is a reduction in the number of service users requiring formalised care
- That assessment for, and delivery of Assistive Technology, is an integral part of Intermediate Care provision

The Department of Health published “Living Well with Dementia: A National Dementia Strategy”\(^9\) in 2009. The implementation of the strategy should result in significant improvements in the quality of services, including Intermediate Care, which is accessible and tailored to people with dementia.

The National Stroke Strategy (2007)\(^10\) must also be considered in relation to the further development of Intermediate Care services. It identifies the importance of the provision of high quality rehabilitative support. Intensive rehabilitation after a stroke can limit disability and improve recovery.

In November 2010, the Government published “A vision for adult social care: Capable communities and active citizens”\(^11\). The Vision sets out how the Government wishes to see services delivered for people; a new direction for adult social care, putting personalised services and outcomes centre stage.

The Health and Social Care Act 2012\(^12\), sets out the modernisation of the NHS, with the commissioning of health services being led by GP’s. Local Authorities also took over the

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\(^8\) Putting People First Concordat (2007) Department of Health
\(^9\) Living Well with Dementia: A National Dementia Strategy (2009) Department of Health
\(^11\) A Vision for Adult Social Care: Capable communities and active citizens” (2010) Department of Health
\(^12\) Health and Social Care Act 2012
responsibility for Public Health and determining health and social care priorities for their area, via the Health and Wellbeing Strategy\textsuperscript{13} with effect from 1\textsuperscript{st} April 2013. For Leicester this includes greater joint working and increased early intervention and prevention, which includes intermediate care and reablement.

The Care Bill was published on 9\textsuperscript{th} May 2013 and details the case for reforming the social care system. reiterates the need to promote people’s independence, which includes the use of preventative measures to reduce the need for long term care, such as intermediate care and reablement.

The Health and Wellbeing Strategy 2013 for Leicester ‘Closing the Gap’ details 5 key priorities for the city and one is specially about promoting independence and supporting people in their communities wherever possible.

The Government is also reducing funding to Council’s whilst at the same time the demand for social care services is increasing, due to the requirements of an ageing population. Therefore, health and social care need to look at ways to delay or prevent people from needing long term care and support wherever possible. This requires the provision of more intermediate care, reablement and early intervention and prevention services.

\textsuperscript{13} Health and Wellbeing Strategy – Closing the Gap (2013) Leicester City Council/Leicester City Clinical Commission Group
At present Leicester City Council supports over 8,400 vulnerable adults. These include older people, people with a learning disability, people with mental health issues and people with a physical disability.

Although compared to the national average the population of Leicester is relatively young, demand for social care services will increase as the population ages. The 2011 Census data has shown an increase in the population in the City by 16.7%, which is projected to increase by a further 10% by 2020. Information from the Joint Strategic Needs Assessment (JSNA) shows there are also growing numbers of people with a learning disability, and more people suffering episodes of mental ill health.

At the same time, the Local Authority is facing the challenges of the nation’s economic downturn and the severe reductions in funding imposed by central government on the public sector. The situation is expected to get significantly worse over the coming years and therefore it is necessary to look at ways of preventing or delaying people needing adult social care services for as long as possible and developing ‘invest to save’ schemes that will provide good quality services that deliver value for money.

The Vision for Adult Social Care in Leicester was endorsed by the Executive in March 2012, and incorporates the following seven key priorities, which reflect national policy\(^\text{14}\) and good practice guidance. All have a direct link to the provision of intermediate care and the use of short term residential beds.

**Prevention and Early Intervention** - To prevent or reduce future problems by taking action before serious problems arise

**Personalisation** - The use of Personal Budgets enables people to have greater choice and control

**Partnerships** - Joint working between health, social care and other agencies is essential to support people to maintain their independence

**Plurality** - It is necessary to work with local organisations, including those in the voluntary and independent sectors, to ensure people are able to receive high quality services

**Protection** - Whilst the principles of choice and control are important, it is still necessary to protect vulnerable people

**Productivity** - Adult social care will produce a range of performance indicators and an annual ‘Local Account’ to demonstrate the delivery of quality services

**People** - Adult social care will ensure the provision of a skilled workforce, to ensure people receive quality services

\(^{14}\) A vision for adult social care: Capable communities and active citizens” (2010) Department of Health
6. Intermediate Care Pathway

The provision of Intermediate Care is part of a wider care pathway for people needing a range of care and support services. The following diagram illustrates the care pathway, including which service across health and social care would respond to specific areas of need.

- **Level 1 - Medical Led services**
  - Acute Hospital Care

- **Level 2 - Nurse Led Medical Support**
  - Inpatient Medical Rehabilitation, hospital based Intermediate Care or nursing home Intermediate Care.

- **Level 3 – Social Care led Therapy & Rehabilitation**
  - Residential Intermediate Care and home based Reablement, including physiotherapists, occupational therapy and personal care

- **Level 4 - Social care led Early Intervention and Prevention**
  - Homecare, Assistive Technology, Telecare, Direct Payments, Aids and Adaptations, Advice and Guidance on self-help and universal free services

**Number of people supported to live**

**Level 1** would include people who need to be in an acute hospital

**Level 2** relates to ‘in patient’ Health Intermediate Care, where there is a need for a medical intervention to enable the individual to get well and be encouraged to be as independent as possible

**Level 3** relates to reablement and accommodation based Intermediate Care, which provides therapy and rehabilitation to maximise an individual’s independence

**Level 4** is the provision of preventative and enablement services, which individuals access to enable them to remain independent

There will be occasions when an individual could be at Level 1 within an acute hospital setting during an episode of an acute illness. Their condition could improve where they still need a low level clinical/medical intervention for a period of time, and they would move into Level 2.
It may be possible that once their health issues have been resolved and they become medically stable that they would move into Level 3 for accommodation based therapeutic intermediate care for a period of time. They may even need ongoing assistance to maximise their independence, such as Assistive Technology, which is included at Level 4. Therefore the services available form a pathway to support the reduction in dependency and need.
7. Existing Intermediate Care and Short Term Residential Bed Provision

Intermediate Care and Assessment Beds

The Council currently has one dedicated Intermediate Care facility at Brookside Court, which has 28 beds providing rehabilitative support and therapy interventions. Personal care is provided by the Council’s internal workforce, who has been trained in health care competencies, so they are able to deliver rehabilitative and confidence building techniques. Occupational therapy and physiotherapy is provided by staff employed by the Leicestershire Partnership Trust (LPT). There is also a dedicated GP contracted by the Clinical Commissioning Group (CCG) who oversees the medical needs of all service users.

In addition, there are 12 Assessment beds at Elizabeth House, which is an elderly person’s home, belonging to the City Council. This gives a total of 40 Intermediate Care/Assessment beds provided by adult social care.

The Council’s elderly persons homes are registered with the Care Quality Commission (CQC) as long term residential care for older people and are not equipped to provide an assessment service that is focussed on supporting people to regain their independence. Staff at Elizabeth House are expected to perform a dual role, one of caring for people who are part of the ‘family’ in the home setting, the other being one of promoting and assessing an individual’s ability to undertake a range of tasks that requires them to step back from directly assisting.

This situation creates a direct conflict of interest and evidence shows that people assessed/supported whilst in an elderly person’s home environment are more likely to end up being admitted to long term residential care, compared to those who are assessed/supported within an intermediate care facility. For example, 25% of people who are assisted at Brookside Court go home without any package of care, whilst it is only 5% of people who are assessed/supported at Elizabeth House during 2012/13.

Referrals into intermediate care come via a number of routes. People who require support on discharge from hospital can be referred by a social care worker or directly via the acute hospital’s fast track referral route. Referrals for new clients in the community are made via the Single Point of Contact in social care. Existing social care clients will be referred by their allocated social worker / team.
Analysis and findings of the review into the provision of intermediate care and assessment provided by the City Council

The level of intermediate care and assessment provision in the last 2 financial years can be summarised as follows:

<table>
<thead>
<tr>
<th></th>
<th>2011/12 Bed Years</th>
<th>2012/13 Bed Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Care &amp; Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Older Persons’ Homes</td>
<td>19.8</td>
<td>20.8</td>
</tr>
<tr>
<td>External Providers</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td><strong>19.8</strong></td>
<td><strong>20.8</strong></td>
</tr>
</tbody>
</table>

In order to translate the number of weeks care, adult social care has provided/commissioned into a requirement for beds, the number of weeks care have been divided into purchased/beds occupied by 52 i.e. if adult social care had purchased 52 weeks care in total that is one “bed year” and therefore 1 bed required, 104 weeks = 2 “bed years” and so on.

Bed Years could therefore be defined as “the total number of beds required in a single location to deliver the equivalent amount of care currently commissioned or directly provided through the Councils Elderly Persons Homes”.

The following table sets out the usage of the 40 Intermediate Care Beds over the last 4 months and shows there is a current requirement for approximately 30 Beds. The increase over the 4 month period can be attributed to improved referral rates from the Unitary Hospitals within the city, following a revision of the referral protocol and better co-ordination with Adult Social Care.

<table>
<thead>
<tr>
<th>Month</th>
<th>Beds Available</th>
<th>Usage</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2013</td>
<td>40</td>
<td>30</td>
<td>83</td>
<td></td>
</tr>
<tr>
<td>June 2013</td>
<td>40</td>
<td>27</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td>40</td>
<td>28</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>August 2013</td>
<td>40</td>
<td>34</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>40</td>
<td>31</td>
<td>77</td>
<td></td>
</tr>
</tbody>
</table>

Although, the Council has 40 intermediate care/assessment beds and the average usage is 31 beds, this excludes the demand for respite which increases the need for more beds and is explained later.

It should be noted that is not possible to extend Brookside Court, due to its location and the building has structural problems, which makes its long term usage unviable.

The review identified a number of areas of good practice that reflects the national guidance and local priorities. However, the review also revealed areas for improvement, where change would provide a more consistent and cost effective service. The areas for
improvement have been translated into actions (as detailed on page 21) if implemented over the next 3 years will deliver a co-ordinated and cost effective Intermediate Care service that promotes and support independence.

The following information provides an overview of the key findings of the review:

**Areas of Good Practice**

- There are experienced staff based at Brookside Court, including those with a clinical background
- Staff are trained to the Health Competency Framework
- Some of the service provide integrated therapy where health therapists provide treatment programmes that are then delegated to social care staff to undertake
- The average length of time for Brookside is 5 weeks, which is below the national average, which makes the service cost effective
- Outcomes for people who received intermediate care at Brookside Court were positive. For example of the 120 people who were supported during 2012/13
  - 30 (25%) went home fully independent without further services
  - 40 (33%) went home with on going home care support (minimum packages)
  - 30 (25%) went home with community based reablement services
  - The remaining people went into hospital, residential care or died
- Some person centred planning exists, such as personal profiles for individuals as they enter Brookside Court. The profile includes good and bad days and what is important to the individual, which helps to better understand how they can be supported to retain their independence
- On average 25% of people using the service home without any support package
- The service is able to support the Integrated Crisis Response Service
- Allocated care management workers are attached to the intermediate care beds, which provides consistency and social work support to individuals
- Specialist dementia home care starts in October 2013

**Areas for Improvement**

- There is a lack of bed capacity to support increased future demand
- Access into the current service is fragmented and inconsistent, due to the referral process, which leads to poor vacancy management
- Where the service is provided within the Councils elderly persons homes, the outcomes are not so good, as people stay too long or are admitted to long term residential care. This can be attributed partly to the dual role that staff are required to undertake
- The current system is expensive
- There is a lack of management information or specific targets, which makes it difficult to monitor the effectiveness of the service
- There is little use of Assistive Technology to support long term independence
- Person centred planning needs to be embedded across the service to promote independence
• A lack of generic job descriptions prevent opportunities for greater flexible working across the different disciplines
• Staff skills need to be increased for some client groups, such as those with a mental health issue
• There is a lack of alternative housing options, such as Extra Care\textsuperscript{15} to support long term independence

\textsuperscript{15} Halfway House (2009) Department of Health
8. Short Term Residential Beds and Respite

The elderly person’s homes, owned by the City Council currently provide short term residential care, which are usually used whilst an individual is waiting to be moved to alternative accommodation or waiting for an adaptation or home care package to enable them to return to their own home. On occasion they are used as a place of safety due to safeguarding issues.

Respite is also provided at the homes for older people, which is usually planned and enables carers to have a break. For other client groups, such as learning disabilities or mental health, specialist support is usually provided in the independent sector.

The level of Interim residential support and respite provision in the last 2 financial years can be summarised as follows:

<table>
<thead>
<tr>
<th></th>
<th>2011/12 Bed Years</th>
<th>2012/13 Bed Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Older Persons’ Homes</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>External Providers</td>
<td>36</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td></td>
<td>56</td>
</tr>
</tbody>
</table>

The largest user group who utilised these services were people with a dementia which accounted for 32% of users followed by physical disability at 28%. This is indicative of the future demand that is associated with an aging population, where there will be increasing numbers of people with a dementia and physical disability relating to frailty.

Analysis and findings of the review of Short Term Interim Residential Beds and Respite

The review identified a number of areas of good practice in the provision of interim beds. However, the review also revealed areas for improvement, where change would provide a more consistent and cost effective service. The areas for improvement have been translated into actions (as detailed on page 22) if implemented over the next 3 years will deliver a co-ordinated and cost effective service.

Areas of Good Practice

- The authority provides interim beds and respite care and is able to respond in a crisis situation
- Planned respite is chargeable and generates an income for the Council
- Carers are supported to continue in their caring role
- Hospital discharges are facilitated quicker into a safe environment following an acute episode
- Hospital re-admissions are prevented
- Individuals are supported to remain in the community
- Support is provided whilst the individual is awaiting adaptations, re-housing or a support package at home
• An assessment in an alternative environment provides an opportunity to identify longer term needs

Areas for Improvement

• The cost of providing the service from the Council’s elderly persons homes is more expensive than the independent sector (the Council’s homes have been used due to the high level of vacancies)
• The service lacks flexibility, resulting in potential efficiency opportunities being missed
• The approach to short term care is inconsistent, leading to delays in moving on
• The current arrangements create a conflict for the workforce, as staff are primarily focussed on assisting and caring for people, rather than promoting independence
• There is not a clearly defined care pathway for individuals to enable a smoother move between services
• There are not clear roles and responsibilities for staff
• Performance targets are not consistent across the homes and there is no clear governance arrangements
• The management and delivery of services are inconsistent, leading to differing levels of support and quality
• The standards are compromised, thus resulting in a variety of support
9. Strategic Objectives and Priorities

The following sets out our key strategic objectives for the development of intermediate care services and associated commissioning intentions. This is the nub of the strategy and describes what we intend to do over the next three years to improve services.

The strategic objectives and associated commissioning intentions are aligned with the aims and objectives of the national guidance on intermediate care and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis.

1. Prevent avoidable admissions to hospital and support timely discharge

Rationale for change

- The current provision is fragmented, costly and has scope for efficiency
- The system is not truly integrated and the delivery of support is inconsistent

Actions

- To create a single point of entry for all short term provision
- Develop intermediate care and short term beds under one roof provided by a dedicated staff group
- Provide a range of integrated services to support the above, including therapy and community nursing

Intended Outcome/s

- Individuals will receive appropriate care and support in the right place at the right time, which will optimise their potential for recovery and recuperation
- Decrease the number of people unnecessarily admitted to long-term care
- Provision of an integrated crisis response service that becomes part of the intermediate care pathway where appropriate
- Provides a cost effective service

2. Prevention of re-admission to hospital with an integrated response from therapy, nursing and social care

Rationale for change

- There is currently a high level of admissions to long-term residential and nursing care directly from hospital. In 2011/12 almost 2/3 of new admissions to long-term care came directly from hospital.

Actions

- Establish targets and a trajectory for the reduction of numbers of patients who are admitted directly to long-term care from an acute setting
• Ensure assessment and decision making takes place in an intermediate care environment, rather than in an acute setting, following the opportunity for rehabilitation, recuperation and recovery
• No one should be transferred from an acute hospital setting to long-term residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement
• Implement a unified assessment process with appropriate information shared between partners
• Determine a clear reablement pathway that links reablement with the self-directed support processes

Intended Outcome/s

• The number of people being admitted to long term residential or nursing care should reduce, with more people being given a period of rehabilitation to maximise their independence
• More informed decisions being made with users on their future support needs
• Prevention of duplication in collection of information from users

3. Improve quality and maximise independent living

Rationale for change

• The existing approach to short term care services is fragmented and inconsistent, leading to delays in people being assessed and inappropriate long term care placements
• A greater focus needs to be given to seeking alternative options, such as Extra Care housing
• Better use needs to be made of Assistive Technology to promote independence
• Inappropriate decisions are made on long term provision when individuals have been in an acute setting

Actions

• Commission intermediate care and short term beds under one roof
• Develop a person centred planning approach to service provision, which includes a range of options for maximising independence
• Invest in Assistive technology and ensure it is integrated in the whole systems approach

Intended Outcome/s

• A co-ordinated and consistent approach and access to a range of services designed to promote independence will increase the overall quality of the provision
• The services under one roof will provide economies of scale, consistency and a streamlined service
4. Improve the skills and competence of the workforce

Rationale for change

- The existing model of intermediate care and short term residential beds creates a conflict for the workforce. Staff are currently expected to perform a dual role of providing direct care, whilst trying to rehabilitate people (step back from direct care) in the same environment, which does not achieve the same outcomes as a staff role with a single, clear focus.

Actions

- Develop intermediate care and short term beds under one roof, so the workforce is focussed on maximising independence
- Staff to have a generic job description where possible to provide greater flexibility to delivering a range holistic services
- Ensure the workforce has the necessary skills to deliver the above
- Ensure access to the specialist skills, such as mental health needs

Intended Outcome/s

- Investing in the workforce to delivery rehabilitative services to maximise independence will reduce admissions to long term residential care and reduce the need for home care
- Delivering the service from one location will create economies of scale

5. Delivery of a cost effective services to meet future demand

Rationale for change

- The current provision is fragmented, costly and has scope for efficiency
- Within the current and future financial climate, it is essential we provide best value services within budgetary constraints

Actions

- Develop a service that is co-ordinated and removes duplication of costs
- Ensure a robust financial monitoring system is in place to ensure services are delivered within a best value process
- Ensure charging mechanisms are in place where appropriate
- Ensure the provision of a flexible service to ensure optimum usage
- Consider partnership opportunities to maximise income by joint working

Intended Outcome/s

- The service will be delivered within existing resources and will reduce the cost of long term residential care and home care packages, which will contribute towards the overall efficiency savings for social care over the next three years
6. Maximise people’s potential to live as independently as possible in their chosen community

Rationale for change

• Evidence suggests that the majority of older people want to remain independent for as long as possible. However, some people have been prematurely placed into long term residential care, because their existing home is no longer suitable and there has been a lack of alternative options.

Actions

• Implement the Independent Living and Extra Care Strategy (2012 to 2015) to ensure the provision of suitable housing options that promote and support independence
• Develop a dedicated Intermediate Care step down service to ensure that people are able to move through the system in an appropriate and timely manner
• Invest in Assistive Technology to support people to remain in their own homes
• Telehealth has the potential to support independent living, promote patient self-management and reduce the need for repeat hospital admissions

Intended Outcome/s

• The provision of suitable alternative housing options and the use of Assistive Technology will mean that people can remain independent for longer within their community.

7. Robust performance management and governance

Rationale for change

• The review process established the lack of consistent management information, which made it difficult to analyse trends and costs across the service. There were also weaknesses in target setting for some key aspects of the service, and therefore opportunities for efficiencies could not be adequately tracked.

Actions

• Develop and implement a robust performance management framework to ensure that future Intermediate Care provision meets identified needs and achieves desired outcomes
• Monitor the ongoing requirement for spot purchasing from the independent sector in order to inform future commissioning requirements
• Ensure that intermediate care has a robust governance framework
• Commission a longitudinal study with Health to track the impact of the redesign of Intermediate Care services on:
  • Admissions to long-term residential care
  • Hospital readmissions
  • Impact on the cost of Home Care based packages of care
Intended Outcome/s

- The provision of robust management information will be able to demonstrate value for money and the delivery of an efficient service.
10. Future Demand

This section highlights key facts about the demographic changes in Leicester that have informed the development of this strategy and details the future demand for Intermediate Care and Short Term Residential Beds.

Demographic data - The 2011 Census population estimate for Leicester City is 329,900:

- An increase of 47,000 (16.7%) since the last census in 2001
- 37,200 (11.3%) of the population are aged 65 and over, a decrease of 700 (-1.8%) in the over 65s since 2001
- 24,300 (7.4%) of the population are children under 5, an increase of 5,200 (27%) in the under 5’s since 2001
- The overall population of Leicester has grown at a faster rate than that of England and Wales since 2001

Mental Health - there are significantly higher proportion of the population registered with a mental illness than in England or the East Midlands, and the trend is getting worse. By 2030 there is likely to be a 16% increase in 18-64 year olds with a common mental health disease and 7% increase in those with two or more diseases

Older People - there are fewer older people than nationally, but complex needs, isolation, poverty, frailty, increasing dementia. Increasing numbers of older people, mostly women caring for others. Prevention, early diagnosis, care or carers, integrated care pathways, collaboration between health and social care are key issues.

Dementia - 2700 people suffer with dementia, which will increase to 3,700 people by 2030. There are 800 new cases a year being diagnosed. There are 70 younger people with dementia. Early diagnosis, care of carers, integrated care pathway, collaboration between health and social care are key issues.

A detailed analysis of current demand shows there is a requirement for approximately 60 intermediate care and short term residential beds across the City by 2015. Therefore, any new facility needs to meet current demand, but also needs to provide flexibility in the medium term to address both demographic growth and any other policy or socio economic changes.
The following table identifies projected growth for intermediate care and short term residential beds by 2030, based on existing provision adjusted for population change. The table is based on the latest population statistics and reflects a 14.7% increase in the over 65 population of the City by 2020, and a 43.7% increase by 2030:

<table>
<thead>
<tr>
<th>Year</th>
<th>Intermediate Care &amp; Assessment</th>
<th>Other Short Term Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>2015</td>
<td>30</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>2020</td>
<td>35</td>
<td>35</td>
<td>70</td>
</tr>
<tr>
<td>2025</td>
<td>40</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>2030</td>
<td>45</td>
<td>45</td>
<td>90</td>
</tr>
</tbody>
</table>
11. **Health**

The Leicester Clinical Commissioning Group (CCG) currently provides intermediate care that is based on a clinical/health model.

Discussions have taken place with health colleagues to ensure the Council’s Adult Social Care Intermediate Care and Short Term Residential Beds Strategy (2013 to 2016), sits comfortably alongside the plans of the Leicester Clinical Commissioning Group (CCG) for the development of health based intermediate care services.

The CCG are in the process of consolidating their intermediate care provision onto one single site in the city. At present they use several locations, including community based hospitals in the County, which means that city patients are often placed in areas some distance from their family and support networks.

It is agreed that it is not appropriate to develop a single joint health and social care intermediate care facility at the present time, partly because the CCG may locate its new facility on one of the hospital sites in the city, which would not be a setting conducive to social care residential services seeking to help people return to independence.

However, health and social care will continue to implement the care pathway as detailed on page 14 to ensure the best outcomes for individuals.
12. Proposed Model/Options for Delivering an Improved Service

The review and analysis of the existing intermediate care and short term residential bed services has highlighted that good practice exists, which reflects national policy and that there is an on-going need for the service as demand will increase in future years.

However, the review has also highlighted that the current model of delivery is fragmented and opportunities to deliver efficiencies are being lost.

Demographic changes alongside financial constraints, means adult social care has to reshape its intermediate care and short term residential beds provision to create a flexible model, that will not only provide bed spaces, but also the ‘wrap’ around services, such as minor adaptations, assistive technology, housing advice, community equipment etc. Therefore, the following analysis highlights the key elements for a new model that will deliver a flexible and cost effective service.

The proposed service model will provide: -

i. 24/7 support, which will focus on:
   • Planned respite care
   • Crisis response
   • Interim support
   • Assessment
   • Intermediate care/promoting independence

ii. Reablement day provision where users receive a promoting independence service in a resource centre to enable them to remain in the community, focussing on;
   • Assessment
   • Therapy intervention
   • Activities of Daily Living skills

iii. Resource Unit
   • Drop in service
   • Assistive Technology suite
   • Equipment and adaptations
   • PCs to access the Councils website for resources, self-assessment
   • Shop selling Assistive Technology, equipment etc.
   • Early Intervention and Prevention advice, information, support
   • Memory Café
   • Practical Help at Home service

However, this service model will only work if it operates from one location. By co-locating intermediate care and short term beds together, it will provide an opportunity to achieve consistency, a streamlined care pathway through social care and health and economies of scale.
A flexible model would also achieve the following;

- Consolidated all intermediate care and assessment beds onto a single site which will allow more effective management of bed numbers and referrals and will reduce the number of vacant beds
- Allow closer links with the Council’s reablement service, providing greater efficiencies through integrating/flexible working
- Provide opportunities for partnership working with health, such as the provision of mental health assessment beds, which could generate income for the Council
- Provides planned chargeable respite services to fill spare capacity

The de-commissioning of the existing arrangements and investment in a single flexible resource facility will provide a more efficient person centred approach to rehabilitating people to maximise their independence.

The assessment element of the facility will create a suitable environment, with the support of the right staff, to complete robust assessments of people’s abilities and needs. There is also the possibility of health using part of the facility to provide specialist assessment for people with mental health issues, including people with a dementia. Any spare capacity will be used to provide planned respite care.

Further savings are anticipated through a reduction in inappropriate hospital admissions, timely discharge from hospital, a decrease in the number of people admitted to long-term care, and a reduction in the use of ongoing home care.

The estimated annual running costs of a 60 Bed Intermediate Care facility would be approximately £1.3m per annum compared to existing expenditure on short term beds of £2.2m. Short term beds are currently delivered from Brookside, the Council’s Elderly Persons homes and the Independent Sector. The potential saving will arise through more efficient delivery of short term care on a single site including:

- A reduction in void levels
- More efficient staffing levels at a single site
- Maintenance and utility savings associated with one site
- More efficient working arrangements with the NHS/CCG

In addition a single dedicated facility is likely to bring about significant savings to the Council and the NHS through preventing premature admission to residential care, reduced care package sizes and preventable hospital re-admissions.
The analysis of future demand identifies the need for up to 90 beds by 2030. However, this calculation is based purely on anticipated growth in the over 65 population and takes no account of any other changes in service delivery in the next 20 years. It would not be advisable to create a facility of this size as it would be underutilised for a number of years.

Therefore, it would be more appropriate to create a 60 bed facility, which would provide the required number of intermediate care beds, with the remaining spaces being used for respite. As the demand for intermediate care increases then the in-house respite provision can be decreased and provided in the independent sector.
13. **Equalities**

An Equalities Impact Assessment (EIA) has been developed to identify specific groups accessing intermediate care and short term residential beds that would benefit or be detrimentally affected by any change to the service. The following issues have been highlighted during consultation:

- People with dementia will require specialist support and care
- A higher proportion of White British currently access the service
- Those over 85 appear to benefit the most
- People with a need for physical intervention benefit more than those with mental health
- The existing provision does not cater for all religious and race needs
- Mental health and dementia must be catered for in future provision
- Data on equality needs improving

In order to address these areas of concern, the following will be addressed:

- All relevant protected characteristics will be fully considered when developing and planning the service
- The new model will provide a consistent and coordinated approach and access to a range of services to promote independence. In turn, this will improve overall quality of support
- A robust performance management system will be able to demonstrate value for money, an equality service and an effective service
- A comprehensive learning and development programme will be delivered to ensure staff are competent in all areas of quality and equality.
14. Conclusion

The development of this strategy has highlighted the importance of the provision of intermediate care and short term residential beds as there will always be people who will need accommodation based services for a limited period of time. This need can arise to help them to recover from a period of illness or to help them rebuild their confidence to undertake daily living skills to maximise their independence.

Demographic information highlights that the need for these types of services will increase, as the population of the city grows older. Evidence also shows that the use of intermediate care services reduces the likelihood of individuals being admitted to long term residential care prematurely, which will reduce the cost to adult social care finances.

There will also be occasions when a crisis situation may have occurred and an individual will need to move into short term residential care, to enable their needs to be fully assessed. The provision of flexible respite care is also important to give carers a break from their caring responsibilities. This can be planned, where a carer can pre-arrange for the person they care for to be accommodated for a period of time and unplanned where an individual can be accommodated if a crisis situation occurs e.g. if a carer becomes is admitted to hospital.

The current intermediate care and short term residential bed service provided by Leicester City Council has some positive aspects, but the model of delivery is inconsistent and fragmented. This can be attributed to the referral process and the delivery of the service across several sites, which includes the use of the Council’s elderly person’s homes. As the homes do not provide the right environment to rehabilitate and support individuals to regain their independence. The existing approach leads to inefficiencies and high voids levels, which makes the service unnecessarily expensive.

Therefore, a new model is required that will provide an holistic service that is integrated with therapy and supports maximises independence and prevents premature admission to long-term residential care. Ideally the service should be flexible and delivered from one site to maximise the opportunity to provide rehabilitation, therapy and other services that will support long term independence.
## Appendix 1. Implementation Plan

<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTION</th>
<th>LEAD OFFICER</th>
<th>RESOURCES</th>
<th>TIMESCALES</th>
</tr>
</thead>
</table>
| 1. Prevent avoidable admissions to hospital and support timely discharge | - To create a single point of entry for all short term provision.  
- Commission intermediate care and short term beds under one roof  
- Provide a range of integrated services to support the above, including therapy and community nurse interventions  
- Develop a streamlined pathway between acute, primary and social care  
- Ensure services that are required in the longer term are timely, appropriate and targeted. | Director for Adult Social Care and Safeguarding  
Director for Care Services and Commissioning  
Director for Care Services and Commissioning  
Director for Adult Social Care and Safeguarding  
Director for Adult Social Care and Safeguarding | Re-configure existing provision  
ASC Capital Plan  
Leicester City Clinical Commissioning Group/Leicestershire partnership Trust  
Leicester City Clinical Commissioning Group/Leicestershire partnership Trust/Adult Social Care | 2014  
2013/14  
2013/14  
2013 |
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTION</th>
<th>LEAD OFFICER</th>
<th>RESOURCES</th>
<th>TIMESCALES</th>
</tr>
</thead>
</table>
| 2. Decrease the number of people unnecessarily admitted to long-term care | • Establish targets and a trajectory for the reduction of numbers of patients who are admitted directly to long-term care from an acute setting  
• Ensure assessment and decision making takes place in an intermediate care environment, rather than in an acute setting, following the opportunity for rehabilitation, recuperation and recovery  
• No one should be transferred from an acute hospital setting to long-term residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement  
• Implement a unified assessment process with appropriate information shared between partners. | Director for Adult Social Care and Safeguarding/ 
Director for Care  
Director for Adult Social Care and Safeguarding/ 
Director for Care  
Director for Adult Social Care and Safeguarding/ 
Director for Care  
Director for Adult Social Care and Safeguarding/ 
Director for Care | Re-configure existing service model  
Re-configure existing service model  
Re-configure existing service model  
Re-configure existing service model  
Re-configure existing service model with the Leicestershire Partnership Trust | 2013  
2014/15  
2013  
2013  
2013 |
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
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<th>LEAD OFFICER</th>
<th>RESOURCES</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Improve quality and maximise independent living</td>
<td>• Determine a clear reablement pathway that links reablement with the self-directed support processes.</td>
<td>Director for Adult Social Care and Safeguarding / Director for Care</td>
<td>Re-configure existing services</td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td>• Commission intermediate care and short term beds under one roof</td>
<td>Director for Care Services and Commissioning</td>
<td>Change existing model of service delivery, to include use of capital monies</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td>• Develop a person centred planning approach to service provision, which includes a range of options for maximising independence</td>
<td>Director for Adult Social Care and Safeguarding / Director for Care</td>
<td>Re-configure existing services</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td>• Invest in Assistive Technology and ensure it integrated in the whole systems approach.</td>
<td>Director for Care Services and Commissioning</td>
<td>Change existing model of service delivery, to include use of capital monies</td>
<td>2013/14</td>
</tr>
<tr>
<td>4. Improve the skills and competence of the workforce</td>
<td>• Commission intermediate care and short term beds under one roof, so the workforce is focussed on maximising independence</td>
<td>Director for Care Services and Commissioning</td>
<td>Change existing model of service delivery, to include use of capital monies</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td>• Staff to have a generic job description where possible to provide greater flexibility to delivering a range holistic services</td>
<td>Director for Care Services and Commissioning / Leicestershire Partnership Trust</td>
<td>Change existing JD's/City Learning/ HR</td>
<td>2014</td>
</tr>
<tr>
<td>OBJECTIVE</td>
<td>ACTION</td>
<td>LEAD OFFICER</td>
<td>RESOURCES</td>
<td>TIMESCALES</td>
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</tbody>
</table>
|           | • Ensure the workforce has the necessary skills to deliver the above  
<p>|           | • Ensure access to the specialist skills, such mental health needs. | Director for Care Services and Commissioning | Re-configure existing training provision | 2013 |
|           | <strong>5. Delivery of a cost effective services to meet future demand</strong> | Director for Care Services and Commissioning | As above | 2013 |
|           | • Develop a service that is co-ordinated and remove duplication of costs. | Director for Adult Social Care and Safeguarding/ Director for Care | Re-configure existing services | 2014 |
|           | • Ensure a robust financial monitoring system is in place to ensure services are delivered within a best value process. | Director for Care Services and Commissioning/ Finance | Re-configure existing monitoring information | 2013 |
|           | • Ensure charging mechanisms are in place where appropriate. | Director for Care Services and Commissioning/Finance | Re-configure existing services to ensure charging occurs | 2013 |
|           | • Ensure the provision of a flexible service to ensure optimum usage. | Director for Care Services and Commissioning | Re-configure existing services | 2013 |
|           | • Consider partnership opportunities to maximise income by joint working. | Director for Care Services and Commissioning/ Leicestershire Partnership Trust | Re-configure existing services on conjunction with partners | 2013/14 |</p>
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTION</th>
<th>LEAD OFFICER</th>
<th>RESOURCES</th>
<th>TIMESCALES</th>
</tr>
</thead>
</table>
| 6. Maximise people's potential to live as independently as possible in their chosen community | • Implement the Independent Living and Extra Care Strategy (2012 to 2015) to ensure the provision of suitable housing options that promote and support independence.  
• Develop a dedicated Intermediate Care step down service to ensure that people are able to move through the system in an appropriate and timely manner.  
• Invest in Assistive Technology to support people to remain in their own homes.  
• Develop the provision of specialist home support services, including dementia | Director for Care Services and Commissioning  
Director for Adult Social Care and Safeguarding/ Director for Care | Re-configure existing services | 2014/15 |
<p>| | • Ensure Telehealth has the potential to support. independent living, promote patient self-management and reduce the need for repeat hospital admissions. | Director for Care Services and Commissioning | Change existing model of service delivery, to include use of capital monies | 2013 |
| | | Director for Care Services and Commissioning | Change existing model of service delivery, i.e. home care | 2013 |
| | | Director for Care Services and Commissioning | Change existing model of service delivery, to include use of capital monies | 2013 |</p>
<table>
<thead>
<tr>
<th>OBJECTIVE</th>
<th>ACTION</th>
<th>LEAD OFFICER</th>
<th>RESOURCES</th>
<th>TIMESCALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Robust Performance management and governance</td>
<td>• Develop and implement a robust performance management framework to ensure that future Intermediate Care provision meets identified needs and achieves desired outcomes.</td>
<td>Director for Adult Social Care and Safeguarding/ Director for Care</td>
<td>Re-configure existing monitoring information</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td>• Monitor the on-going requirement for spot purchasing from the independent sector in order to inform future commissioning requirements.</td>
<td>Director for Care Services and Commissioning</td>
<td>Re-configure existing monitoring information</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td>• Ensure that Intermediate Care has a robust governance framework.</td>
<td>Director for Adult Social Care and Safeguarding/ Director for Care</td>
<td>Re-configure existing monitoring information</td>
<td>2013</td>
</tr>
<tr>
<td></td>
<td>• Commission a longitudinal study with Health to track the impact of the redesign of Intermediate Care services on:</td>
<td>Director for Adult Social Care and Safeguarding/ Director for Care</td>
<td>Procure external support (£1000)</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td>• Admissions to long-term residential care</td>
<td></td>
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<td></td>
<td>• Hospital readmissions</td>
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<td></td>
<td>• Impact on the cost of Home Care based packages of care</td>
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