**Item No. 5**

**SUNDERLAND SHADOW HEALTH AND WELLBEING BOARD** **16 November 2012**

**DEVELOPMENT OF THE STRATEGIC DIRECTION FOR INTERMEDIATE CARE IN SUNDERLAND 2012 - 2015**

**Report by Executive Director, Health, Housing & Adult Services & Chair Sunderland Clinical Commissioning Group**

## 1.0 PURPOSE OF THE REPORT

To inform the HWBB of the development of the Strategic Direction for Intermediate Care in Sunderland 2012 – 2015.

## 2.0 JOINT WORKING

For the purposes of this paper the term 'joint working' is used to reflect collaboration, co-operation and integrated working across health and social care and other key partners.

### 2.1 National Policy Context

The need for previously fragmented services to be better co-ordinated and integrated in order to provide supportive, person centred care was reinforced in the White Paper *Equity and Excellence: Liberating the NHS* (July 2010) It has received further attention with changes to the Health and Social Care Bill. These changes include a number of bodies being given duties to promote better integrated care such as the NHS Commissioning Board, economic regulator Monitor, clinical commissioning groups and health and wellbeing boards.

Joint working is also supported by the 2012 White Paper *Caring for our future: reforming care and support* which describes lack of joined-up care as the biggest frustration for patients, service users and carers.

### 2.2 Local Policy Context

Sunderland has a long and positive history of joint working to provide and commission the best possible services and options for the people of Sunderland.

This has been further reinforced by the establishment of the Shadow Health and Wellbeing Board which oversees the development of the joint Health and Wellbeing Strategy for the city.

The strategic direction embodies a number of design principles of Sunderland's Joint Health and Wellbeing Strategy, such as prevention, equity, strengthening community assets and promoting independence and self care. The joint

working approach to shape and manage cost effective interventions through integrated services is also a key design principle, and is central to the approach in developing Intermediate Care services in Sunderland.

The Sunderland Clinical Commissioning Group Clear and Credible Plan 2012-2017 detailing health's commissioning intentions and the 15 year Strategy for the City Council's Health, Housing and Adult Services, clearly promote joint working to commission the delivery of co-ordinated effective and efficient services.

## 3.0 INTERMEDIATE CARE

The principles of joint working have been applied to develop a comprehensive strategy for intermediate care in Sunderland

### 3.1 Background

The Strategic Direction for Intermediate Care in Sunderland 2012-15 (final draft attached) has been developed drawing on key national frameworks including the original intermediate care guidance issued by the Department of Health in 2001 and subsequent updated guidance in 2009 *Intermediate Care – Halfway Home*, which sets out the national requirements for intermediate care. Whilst the 2009 update provided additional clarification relating to intermediate care the fundamental principles and definitions remained unchanged. The consistencies in the two documents are as follows:

> *"Intermediate care is 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"*

### 3.2 Supporting Strategies

The Strategic Direction has been developed in response to and influenced by a range of national health and social care policies and strategies, including:

- Our Health Our Care Our Say: A New Direction for Community Services[1]
- The Local Government and Public Involvement Act 2007[2]
- Transforming Community Services: Enabling New Patterns of Provision[3]
- Think Local, Act Personal – Next Steps for transforming Adult Social Care [4]
- National Dementia Strategy[5]

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[1] HM Government and Department of Health 2006. Our health, our care, our say: a new direction for community services. Health and Social Care Working in Partnership
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4130229.pdf

[2] The Local Government and Public Involvement in Health Act 2007
http://www.legislation.gov.uk/ukpga/2007/28/pdfs/ukpga_20070028_en.pdf

[3] Department of Health 2009. Transforming Community Services: enabling new patterns of provision
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093196.pdf

[4] Department of Health November 2011. Think Local, Act Personal – Next Steps for transforming Adult Social Care
http://www.puttingpeoplefirst.org.uk/_library/PPF/NCAS/Partnership_Agreement_final_29_October_2010.pdf

[5] Department of Health 2009. Living well with dementia: A National Dementia Strategy

- Valuing people now: a new three year strategy for people with learning disabilities [6]
- Healthcare for All [7]
- Recognised, valued and supported: Next steps for the Carers Strategy[8]
- Caring for our Future : reforming care and support[9]

'Think Local Act: Personal' provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. Using this framework for intermediate care allows for the development of services that are tailored to meet individual needs, rather than provision of a range of targeted specialised services.

The recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* have been incorporated into the Strategic Direction and implementation plan.

A number of the recommendations within the Emergency Care Intensive Support Team (ECIST) Report, following an invited whole system review of services in Sunderland, will be addressed within the key activities of the Intermediate Care Strategic Direction.

The national policy drivers provide a framework for the further development of health and social care in Sunderland and the implementation of a coordinated approach to the personalisation of services across health, social care and partner agencies.

We aim to change the shape of health and social care services in the future to focus on:

- Prevention and promotion of health and wellbeing and away from an emphasis on ill health.
- Active identification of individuals at risk of developing illness, deterioration or crisis providing early intervention such as reablement and case management to support individuals to remain at home and avoid hospital admission.
- When people do need care and support, ensuring this is high quality and provided in the right setting at the right time, as close to home as possible

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http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_094051.pdf

[6] HM Government and Department of Health 2009. Valuing people now: a new three year strategy for people with learning disabilities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf

[7] Department of Health July 2008. Health Care for All
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf

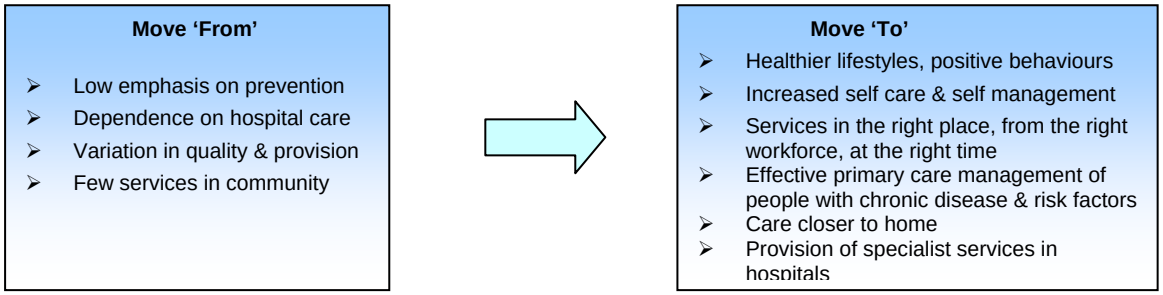
[8] Department of Health November 2008. Recognised, valued and supported: Next steps for the Carers Strategy.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122393.pdf

[9] Department of Health July 2012. Caring for our Future: reforming care and support
http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

- Providing services that are personalised to meet needs so that individuals have choice, flexibility and control over the care and support they receive.

**Figure 1** highlights the strategic shift in services and resources that we aim to achieve through implementation of our wider health and social care strategies.

**Figure 1**




### 3.3 Vision for Intermediate Care in Sunderland

Our vision for the future of intermediate care in Sunderland is:

*To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.*

### 3.4 Strategic Aims for Intermediate Care

The strategic aims are to:

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to Long Term Residential Care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

Each of the strategic aims have a number of key activities that have been drawn from engagement activities with services users, staff, carers and other partners.

## 3.5 Strategy and Working Groups

This Strategic Direction has been developed jointly by Sunderland's City Council, Teaching Primary Care Trust, Clinical Commissioning Group, Intermediate Care Partnership and other key partners from the Sunderland Intermediate Care Strategy Group.

The Intermediate Care Strategy Group has been supported by working groups and short term task and finish groups.

It is a joint health and social care strategy which details how Sunderland intends to commission and redesign intermediate care, and within that, reablement services, over the next three years (2012-2015) to meet the needs of Sunderland residents. It outlines the principles that will guide development and implementation of the Strategic Direction and also sets out aims and objectives, and plans for delivery.

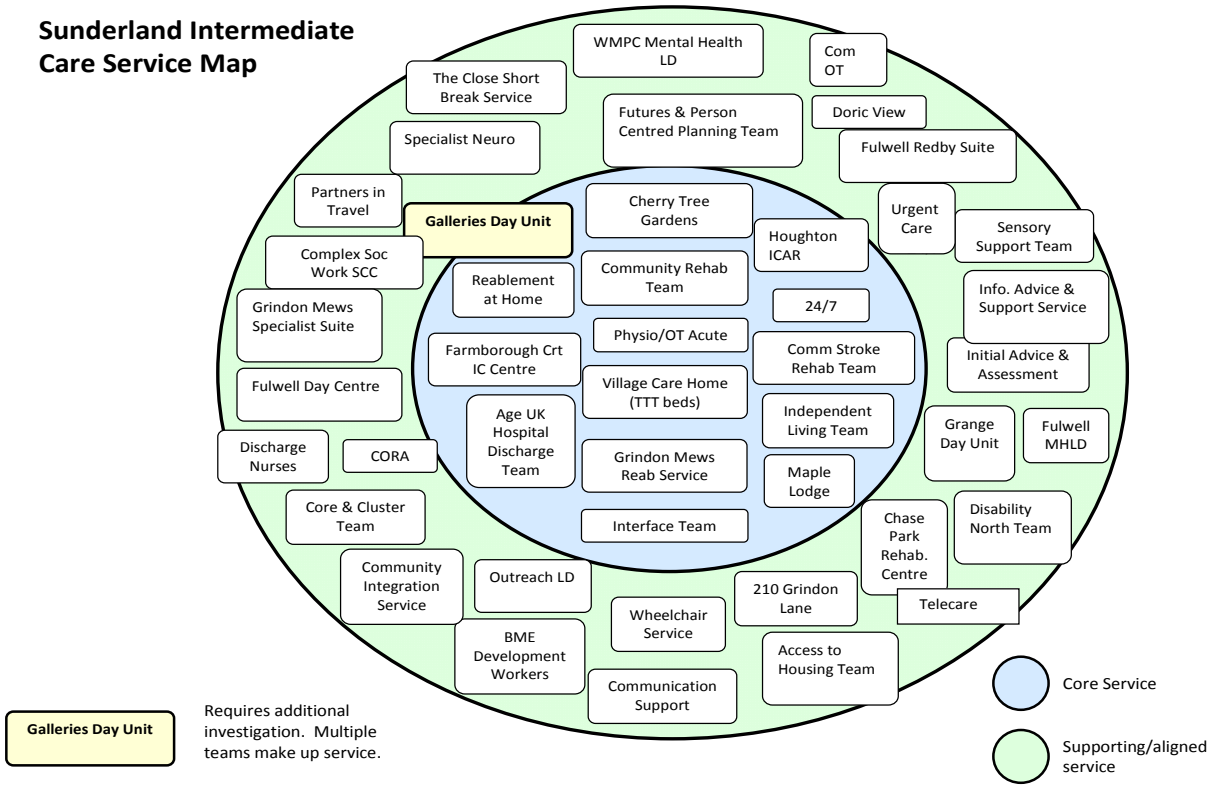
## 3.6 Current Services

A self assessment exercise was initiated in Sunderland, with services believed to be providing intermediate care options in order to provide clarity and identify any gaps in provision. The outcome of the review resulted in the development of **Figure 3** below, which depicts the feedback from the self assessment exercise in terms of a set of 'core' intermediate care options, with surrounding 'supporting services', reflecting the current picture in Sunderland. These services are delivered by a range of providers, within health, local authority and the third sector.

As a result of their organic development over ten years, services are delivered at a variety of facilities or by various teams, and at times this can prove difficult to navigate. It was noted that there are some duplications in function which is not conducive to a streamlined pathway.

Services are working hard to deliver and support the intermediate care agenda, despite the mosaic of providers and teams and have developed strong links where possible, but few can describe the whole system or articulate how this is accessed.

## Figure 3




## 3.7 Ideas for Change

The self-assessment process initiated a number of ideas for change as did engagement events that took place throughout the development of the Strategic Direction.

Information was also drawn from the national and local policy contexts described earlier in this paper.

## 3.8 Future Model

The overarching Model for Intermediate Care Services will be one where the emphasis is on delivering care closer to home as illustrated in the diagram below **Figure 4**.

**Figure 4**

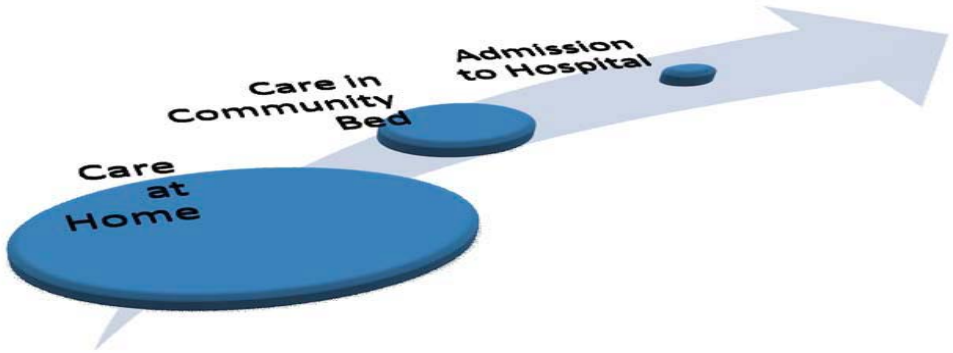
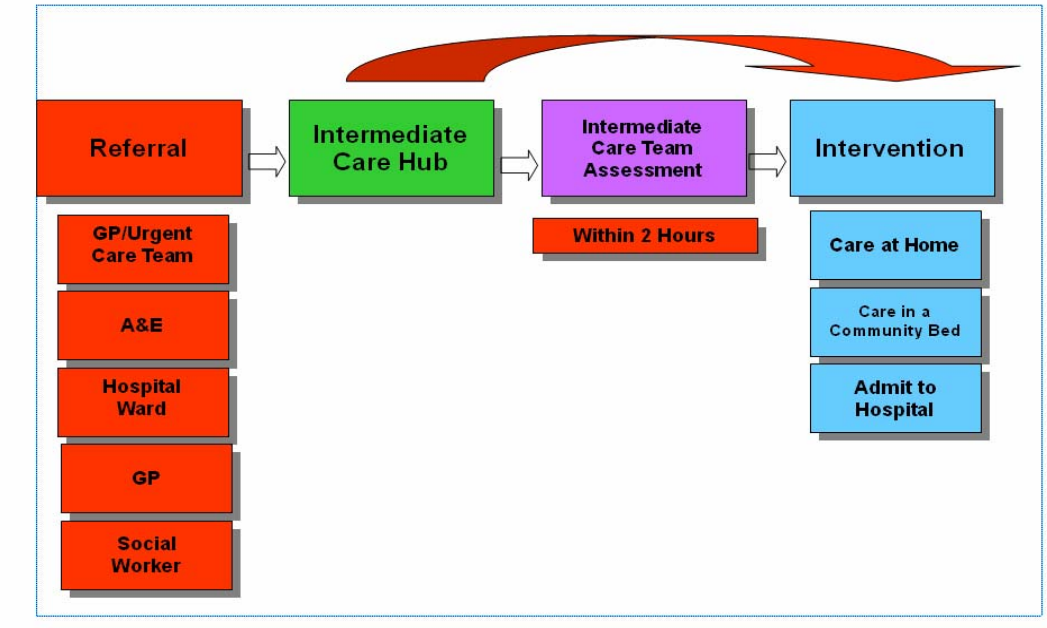





**Figure 5** shows the flow through the intermediate care services via the Intermediate Care Hub where multi-agency assessment takes place ensuring the person receives the right intervention in a timely manner.

**Figure 5 – Flow through the Intermediate Care Services**



### 3.9 Strategic Objectives for Intermediate Care

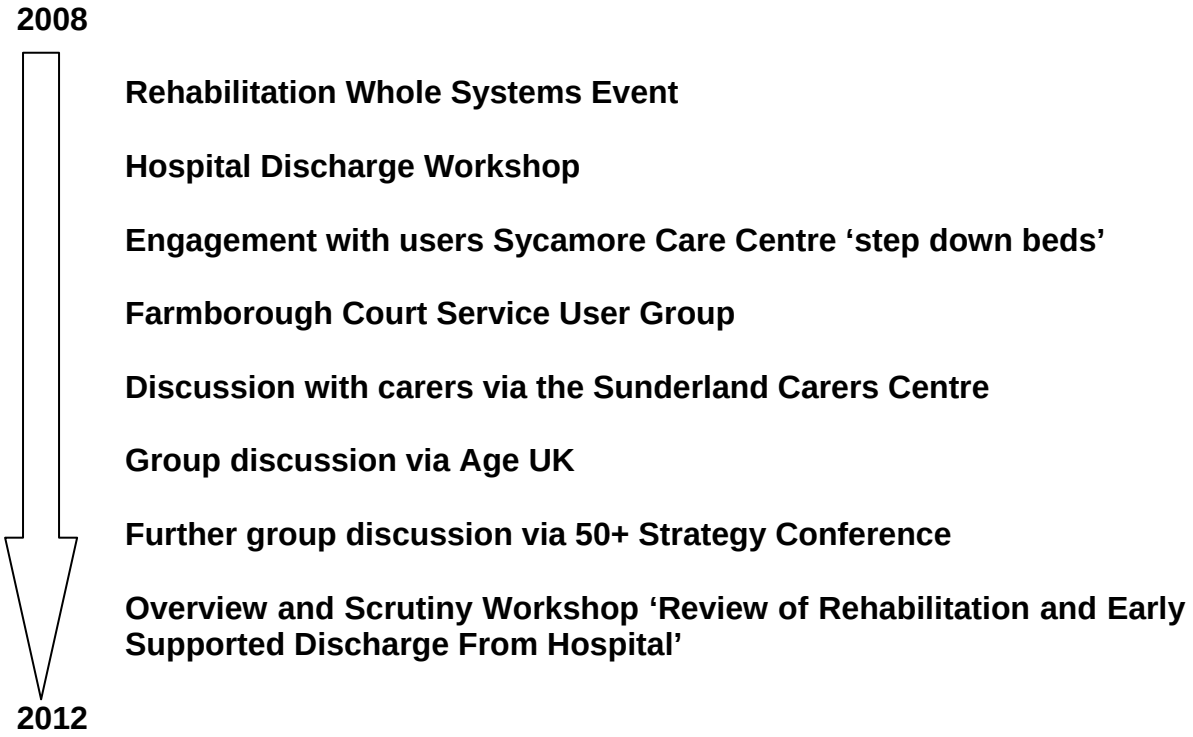
From our engagement with patients, carers and staff who provide services, a set of strategic objectives have been developed to achieve the strategic aims for the people of Sunderland.

- We will provide rehabilitation and reablement approaches appropriate to need
- We will place the individual and their carers at the centre of decision making
- We will facilitate timely access to good information and advice for individuals, carers and staff
- We will coordinate access to intermediate care services, ensuring a rapid response (within 2 hours ) is available where appropriate
- We will increase individual and carers confidence and ability to cope
- We will facilitate increased joint working and streamlined pathways of care
- We will explore appropriate investment in assistive technology
- We will offer a range of bed based options as alternatives to hospital admission
- We will support a timely hospital discharge process by offering a range of intermediate care options
- We will ensure assessment and decision making about peoples long term care needs can only be made after they have had the opportunity for rehabilitation, reablement and recovery
- We will develop an integrated intermediate care workforce to ensure the ethos of rehabilitation and reablement is embedded in practice
- We will measure success by data analysis and seeking the experience of views of patients, carers and staff
- We will set out a clear accountability framework for delivery of the Strategic Direction

**Appendix 1** details a case study example of what the achievement of these objectives will mean for a person in Sunderland

## 4.0 ENGAGEMENT

**4.1** A range of engagement activities with service users, carers, families and members of the public have taken place throughout the development of the Strategic Direction and the early work on rehabilitation.




**4.2** Engagement activities will continue throughout the Strategic Direction implementation plan

## 5.0 ACTIVITIES TO DATE

**5.1** Ongoing shaping and development has taken place throughout the production of the Strategic Direction for Intermediate Care in Sunderland.

Examples include:

**Facilitating Hospital Discharge:**

- Interface team
- Hospital Discharge service (Age UK)
- Discharge Lounge
- Length of stay projects
- Pow Wows (Multi-disciplinary ward meetings)
- Complex Discharge Team
- Central Intermediate Care Hub

## 5.2 Preventing Admission

- Intermediate Care and Assessment Beds at Houghton PCC
- Pilots
  - Farmbrough Court Nursing beds
  - Care Home Time to Think beds
- Evaluation of impact
- Modelling of future demand

## 6.0 MEASURING SUCCESS

6.1 Our approach to measuring success is two-fold:

- A strategic "whole system" perspective on the model, reflecting on the expected outcomes of intermediate care beyond its delivery (e.g. its positive impact on health and social care systems), as well as the outcomes for individuals and carers themselves;

- An operational perspective exploring the management, impact and outcomes of specific parts of the model, particularly within the integrated pathway.

A balanced scorecard has been developed encompassing the following dimensions:

- Patient/Customer & Carer Outcomes
- Service Delivery
- Cost-Effectiveness
- Whole-System Dimension, including Capacity & Standards

## 7.0 ACCOUNTABILITY OF DELIVERY

7.1 Achievement of the strategic objectives and ongoing development of intermediate care services will be overseen by the Sunderland Joint Urgent Care/Intermediate Care Group.

Progress reports will also be provided to the Overview and Scrutiny Committee as part of the updates required for the Review of Rehabilitation and Early Supported Discharge from Hospital.

Updates will also provided as required for the Adult Partnership Board, Sunderland Clinical Commissioning Group and the Shadow Health and Wellbeing Board.

## 8.0 RECOMMENDATIONS

8.1 HWBB are requested to receive the Strategic Direction for Intermediate Care in Sunderland 2012 – 2015.

**Appendix 1**
**Case study – Mrs V**

*Mrs V is 67 years old and was referred to the Reablement at Home team after a hospital stay due to a stroke. She returned home with the support of one member of staff and 4 visits throughout the day.*

*Mrs V also had the Sunderland Stroke Team visiting once/twice a week so both teams worked jointly to provide maximum input for Mrs V and ensure integrated provision across the teams.*

*Mrs V's stroke had left no physical, numbness or weakness but had affected her brain, her memory, communication skills, and difficulties recalling the correct words etc. The Reablement team first started with an assessment around her activities of daily living, and found out quite quickly Mrs V needed lots of prompts, guidance and instructions, but physically could carry out the tasks independently. Mrs V would lose her trail of thought and couldn't recall where items were in her own kitchen. Staff worked each visit alongside her to prepare her meals but only assisted and supported where necessary.*

*Mrs V also had been given a new system to enable her independence with her medication and staff worked each day prompting, and observing Mrs V with the long term goal that she would be able to complete herself. After a couple of weeks staff found Mrs V progressed very well and was managing kitchen activities independently, but had noticed the difficulty she was still having around reading the instructions on a packet or a microwave meal cooking instructions. Staff worked with the Occupational therapist and the Speech Therapist from the Stroke Team to plan how the team could support Ms V. Working with the Stroke team Mrs V was provided with a work booklet to complete and assist with development of independence.*

*The Reablement team suggested to Mrs V that they would help her complete once or maybe twice a day but during that first week Mrs V enjoyed this time so much that 3 out of 4 visits were now around these booklets, it reminded Mrs V about the class room, as she had been a primary teacher during her working days and she found it funny how she was going back to basics herself.*

*By the time the Stroke team visited the following week they were so surprised how far Mrs V had come from not been able to recognise letters to now attempting to spell and sound out small words.*

*Over a couple of more weeks her confidence grew in all areas, she was managing to wash, dress, and manage in kitchen (she still needed support if there was any reading material) and also remembering her own medication it was agreed to reduce visits to an evening call.*

*Once the service reached its 6 weeks it was agreed to extend for 2 more weeks due to her progress.*
*The 8th week came around very quickly Mrs V was now reading small words and recognizing pictures of items, and her communication skills had greatly improved. It was agreed, the stroke team would continue with their visits and Mrs V would continue with the work booklets, but now independently, and the Reablement at Home team would cease their visits.*

Sunderland City Council

Sunderland Clinical Commissioning Group

South of Tyne and Wear

**Sunderland Clinical Commissioning Group**
**Sunderland City Council**
**Sunderland Teaching Primary Care Trust**

# Strategic Direction for Intermediate Care in Sunderland 2012 – 2015

October 2012 – Version 22

# Table of Contents

# Foreword

We are delighted that we have reached the stage of 'launching' our joint Strategic Direction for intermediate care. Sunderland has a long history of partnership across health and social care. The introduction of the new landscape brought about by the Health and Social Care reforms has allowed our partnership working to be enhanced further. Through the Health and Wellbeing Board we are seeing the co-production of the City's Health and Wellbeing Strategy which sets the scene for us to drive integrated working at all levels.

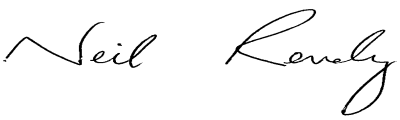
This strategic direction has been developed collaboratively across the whole system and its delivery will ensure people in Sunderland will be able to access high quality, person centred, timely, intermediate care services.

Good intermediate care services ensure faster recovery from illness, prevent unnecessary admissions to hospitals and care homes, and therefore are extremely important to people and their families. This has driven the work in developing the Direction along with our determination to see services which are more personalised and support people's independence.

We are passionate in our ambition for the people of Sunderland and this Strategic Direction supports that ambition to see outcomes for people in Sunderland as good as the best anywhere.

Excellent intermediate care services require a seamless approach and integrated working which this Strategic Direction will deliver. The Strategic Direction describes a journey of continuous improvement and flexibility based on the experience of patients, carers, family members and all the staff involved. This will not only achieve the best possible outcomes for people but will also see the delivery of efficient, cost effective, fit for purpose services.

We, along with our partners, are greatly looking forward to implementing the Strategic Direction and seeing the improvement in the day to day work in our communities for the benefit of citizens across the City.



Dr Ian Pattison
Chair
Sunderland Clinical Commissioning Group

Neil Revely
Executive Director
Health, Housing and Adult Services
Sunderland City Council

# Endorsements

This strategic direction is endorsed by the following partner organisations:

City Hospitals Sunderland NHS
NHS Foundation Trust

Gateshead Health NHS
NHS Foundation Trust

Northumberland, Tyne and Wear NHS
NHS Foundation Trust

choose
South Tyneside NHS
NHS Foundation Trust

# Executive Summary

This Strategic Direction has been developed jointly by Sunderland's City Council, Teaching Primary Care Trust, Clinical Commissioning Group, Intermediate Care Partnership and other key partners from the Sunderland Intermediate Care Strategy Group. (Membership detailed in Appendix 1).

It is a joint health and social care strategy which details how Sunderland intends to commission and redesign intermediate care, and within that, reablement services, over the next three years (2012-2015) to meet the needs of Sunderland residents. It outlines the principles that will guide development and implementation of the Strategic Direction and also sets out aims and objectives, and plans for delivery.

Commissioners from Health and Adult Services have worked with the key partners involved in the patient /user journey to analyse the current picture of service provision, review current and future needs, and learn from best practice elsewhere, to identify the changes necessary to improve quality, effectiveness and efficiency of future service provision throughout the city.

The Strategic Direction has been guided by local and national policy and by the priorities set out in Sunderland City Council, Health Housing and Adult Services', Delivering our Vision 2025, the 3 Year Delivery Plan, and Sunderland Clinical Commissioning Group's Clear and Credible Plan 2012-15.

Our vision for the future of intermediate care in Sunderland is:

*To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.*

A set of high level aims have been developed that describe what our Intermediate Care Model will deliver for Sunderland. These closely align with the Department of Health guidance 'Intermediate Care - Half Way Home'.

Our aims are to:

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to Long Term Residential Care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

From our engagement with patients, carers and staff who provide services, we have developed a set of objectives and supporting activities, which we believe will help us to achieve the above aims for the people of Sunderland.

We have taken opportunities for engagement of individuals and carers throughout our journey to develop this Strategic Direction. However, it is essential that the Strategy Group establish an ongoing and genuine dialogue going forward. We will draw on current engagement mechanisms across the city such as the Sunderland Carers Centre and local Healthwatch to ensure co-production of the Model of Intermediate Care in the future.

We have incorporated the recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* into the Strategic Direction and implementation plan, and therefore we will report on progress against this plan to the Overview and Scrutiny Committee.

The implementation of this Strategic Direction will become the key work plan for the Sunderland Intermediate Care and Reablement Strategy Group. We will review sub-group structure in light of this, providing opportunities for partner organisations to shape the delivery of key activities and ensuring full integration of the Third, Voluntary and Independent Sector in these arrangements.

We will also review the formal Sunderland Intermediate Care Partnership arrangements to facilitate achievement of the Strategic Direction.

Finally we intend to measure our success over the next three years by developing a suite of metrics and outcome measures, which will include engagement of individuals and their carers regarding their experience and views, which we believe is essential to the delivery and success of this Strategic Direction.

# 1. Introduction

## Purpose

The purpose of this document is to:

- Set out the strategic direction for intermediate care and reablement services in Sunderland
- Outline the principles which will guide development and implementation of the strategic direction
- Share aims and objectives, and plans for delivery

This document has been developed by the Sunderland Intermediate Care Strategy Group, under the direction of Sunderland's Intermediate Care Partnership. *(see Appendix 1 for membership)*

## Development of the Strategic Direction

The Strategy Group, assisted by a number of working groups, *(see Appendix 2 for working groups)* has worked throughout 2011/12 to develop this Strategic Direction for Intermediate Care in Sunderland.

This has been achieved through a series of workshops and time-limited projects to map existing intermediate care and reablement services in Sunderland; gather information on current and future needs, gain experiences of current services and examples of good practice from others areas. These in turn have helped to identify the changes necessary to ensure improved quality, effectiveness and efficiency of future service provision throughout the City, based on the principles described below.

The experiences and views of patients, carers, the public and staff providing health and social care services have helped to shape the Strategic Direction outlined in this document *(see Section 6*). It is essential, however, that the Strategy Group establishes an ongoing and real dialogue with individuals, carers and the staff to enable co-production of the Model of Intermediate Care in the future, and that the Model is able to adapt and change as individual's needs and experiences change.

The Strategy Group has agreed the following principles to guide development and implementation of the Strategic Direction, which states that intermediate care and reablement in Sunderland will be:

- Inclusive and personalised to meet individual needs
- Focused on achieving outcomes for individuals in a way that promotes equality and cultural diversity
- Delivered through a clear integrated pathway, which is flexible with easy access and provided in a range of settings
- Supportive of carers in their caring role, enabling them to continue caring

- Effective and efficient, integrating resources where this improves the customer journey and individual outcomes.
- Measurable by a standard set of performance and outcome metrics with an agreed governance framework that encompasses ongoing evaluation and review.

# 2. National Policy Context

## Intermediate Care

To develop this strategic direction we have drawn on the original intermediate care guidance issued by the Department of Health in 2001[10] and subsequent updated guidance in 2009 'Intermediate Care – Halfway Home'[11], which sets out the national requirements for intermediate care. Whilst the 2009 update provided additional clarification relating to intermediate care the fundamental principles and definitions remained unchanged. The consistencies in the two documents are as follows:

> *"Intermediate care is 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"*

A more detailed definition is also contained in both publications. Intermediate care services can thus be defined as meeting the following criteria:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

The updated guidance also added the following to the 2001 guidance:

- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood
- Renewed emphasis on those at risk of admission to residential care
- Inclusion of people with dementia or mental health needs

[10] Department of Health 2001. Intermediate Care Health service/local authority circular HSC 2001/001 LAC (2001)1 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012680.pdf

[11] Department of Health 2009. Intermediate Care – Halfway Home 2009 Updated Guidance for the NHS and Local Authorities http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@pg/documents/digitalasset/dh_103154.pdf

- Flexibility over the length of the time-limited period
- Integration with mainstream health and social care
- Timely access to specialist support as needed
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement
- Governance of the quality and performance of services

## Supporting Strategies

This Strategic Direction has been developed in response to and influenced by a range of national health and social care policies and strategies, including:

- Our Health Our Care Our Say: A New Direction for Community Services[12]
- The Local Government and Public Involvement Act 2007[13]
- Transforming Community Services: Enabling New Patterns of Provision[14]
- Think Local, Act Personal – Next Steps for transforming Adult Social Care [15]
- National Dementia Strategy[16]
- Valuing people now: a new three year strategy for people with learning disabilities [17]
- Healthcare for All [18]
- Recognised, valued and supported: Next steps for the Carers Strategy[19]
- Caring for our Future : reforming care and support[20]
- Equity and Excellence: Liberating the NHS[21]

'Think Local Act: Personal' provides a framework for partner agencies to develop a co-ordinated approach to the personalisation of services. Using this framework for intermediate care allows for the development of services that are tailored to meet individual needs, rather than provision of a range of targeted specialised services.

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[12] HM Government and Department of Health 2006. Our health, our care, our say: a new direction for community services. Health and Social Care Working in Partnership
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[13] The Local Government and Public Involvement in Health Act 2007
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[14] Department of Health 2009. Transforming Community Services: enabling new patterns of provision
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[15] Department of Health November 2011. Think Local, Act Personal – Next Steps for transforming Adult Social Care
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[17] HM Government and Department of Health 2009. Valuing people now: a new three year strategy for people with learning disabilities
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_093375.pdf

[18] Department of Health July 2008. Health Care for All
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_106126.pdf

[19] Department of Health November 2008. Recognised, valued and supported: Next steps for the Carers Strategy.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_122393.pdf

[20] Department of Health July 2012. Caring for our Future: reforming care and support
http://www.dh.gov.uk/health/files/2012/07/White-Paper-Caring-for-our-future-reforming-care-and-support-PDF-1580K.pdf

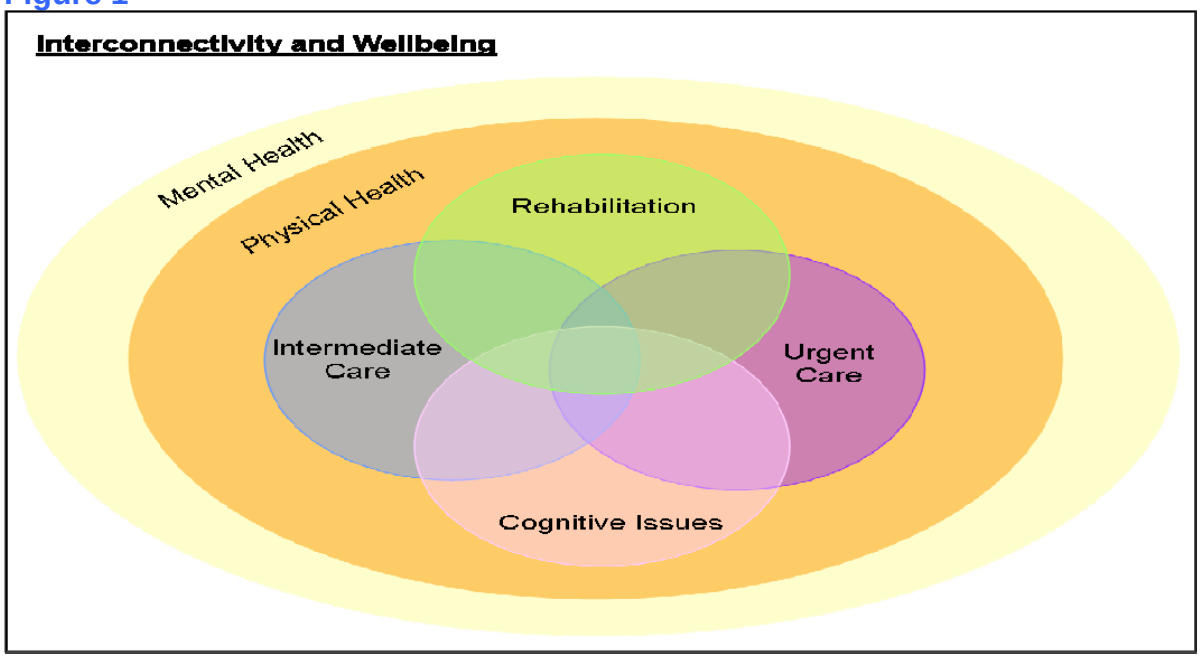
12 Department of Health December 2010. Equity and Excellence: Liberating the NHS
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

*The overall aim is secure a shift to a position where as many people as possible are enabled to stay healthy and actively involved in their communities for longer and delaying or avoiding the need for targeted services. Those who do need help, however, should have maximum control over this, with the information, means (financial and practical) and confidence to make it a reality.*

Adopting a universal approach to intermediate care can be achieved by ensuring that any services make the 'reasonable adjustments' that are needed to ensure accessibility for people identifying themselves under the Home Office six strands of diversity[22] (age, disability, gender, race, religion or belief, sexual orientation) with any particular needs, for example learning disabilities, sensory impairment, as they are to other people. For example support when a visit to hospital is needed; help to communicate; better information, and tighter inspection and regulation will all work to reduce inequalities in access to, and outcomes from, health and social care services.

Figure 1 below shows the inter-relationships between these supporting strategies, intermediate care and the wider prevention and well-being agenda.

**Figure 1**




Of particular importance to this Strategic Direction is the relationship between physical health and mental health and the need to ensure an inclusive strategy that addresses the needs of individuals holistically.

A range of mental health needs, including anxiety and depression, are likely to be identified through development of intermediate care and reablement services. It is understood that physical health needs predispose service users to development of mental health issues, and that those with mental health needs are more likely to develop physical health needs. Those with co-morbidities are more likely to be admitted to hospital and the care home population has particularly high levels of

[22] Equality Act 2010 | Home Office

physical and mental health co-morbidity. Addressing mental health needs such as anxiety and depression as part of intermediate care and reablement will reap dividends in terms of effectiveness and efficiency as well as improving service users quality of life.

In addition, through ensuring that all intermediate care and reablement services become accessible for those with dementia and their families, the potential for identifying mental health needs and providing interventions at all stages of the journey will be realised. The predicted demographic change for Sunderland over the next 20 years makes current practices for care of people with dementia, (which are acknowledged to be wanting), quite unaffordable. Thus identifying and intervening at an early stage in the journey of dementia, and promoting independence and wellbeing, keeping people in lower levels of care for longer, should allow for more effective and affordable services.

A key aspect of the national and local carers strategies are to ensure that the immense contribution made by carers every day is recognised and valued by society and that they are respected as an expert partner in the provision of support to the person they care for. They should have access to integrated and personalised services that support them in their caring role. Supporting carers to effectively care should be a key element of a successful intermediate care service, and the potential for providing services to carers needs to be fully explored.

# 3. Local Policy Context

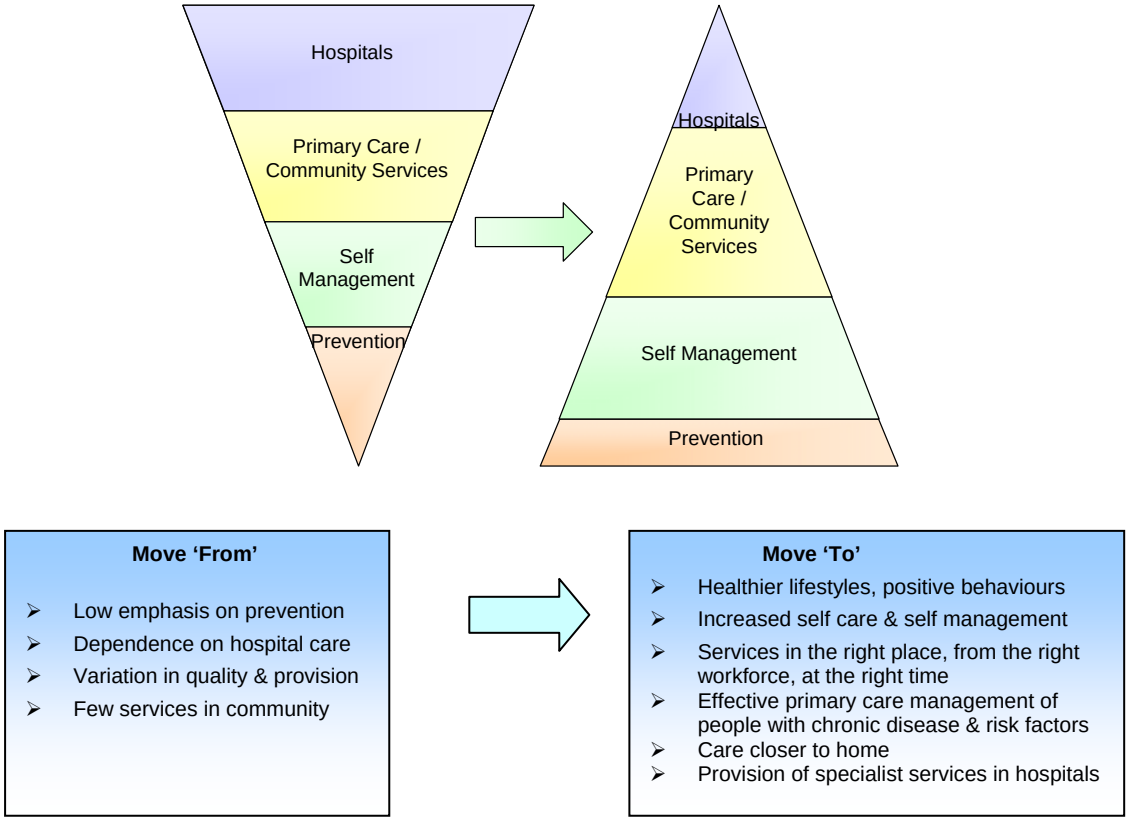
The national policy drivers outlined in Section 2 provide a framework for the further development of health and social care in Sunderland and the implementation of a coordinated approach to the personalisation of services across health, social care and partner agencies.

We aim to change the shape of health and social care services in the future to focus on:

- Prevention and promotion of health and wellbeing and away from an emphasis on ill health.
- Active identification of individuals at risk of developing illness, deterioration or crisis providing early intervention such as reablement and case management to support individuals to remain at home and avoid hospital admission.
- When people do need care and support, ensuring this is high quality and provided in the right setting at the right time, as close to home as possible
- Providing services that are personalised to meet needs so that individuals have choice, flexibility and control over the care and support they receive.

Figure 2 highlights the strategic shift in services and resources that we aim to achieve through implementation of our wider health and social care strategies.

**Figure 2**




# 4. What do we know about the needs of Sunderland's residents ?

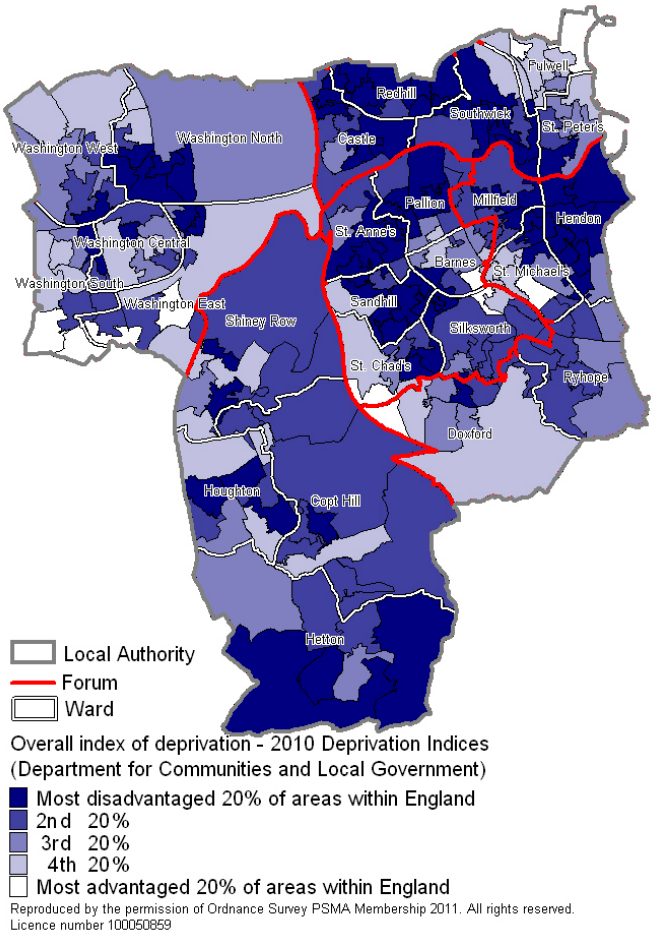
Sunderland is one of the largest cities in the North East with a population of around 283,000. There are approximately 46,800 people over 65 in Sunderland, representing around 16.7% of the population (POPPI)[23].

| Population ('000s)[1] | | | | | |
|---|---|---|---|---|---|
| | Now | In the future | | | |
| Age(years) | 2010 | 2020 | | 2030 | |
| All ages | 284 | 285 | ↑ | 289 | ↑ |
| 0-14 | 46 | 47 | ↑ | 45 | ↓ |
| 65+ | 47 | 56 | ↑ | 68 | ↑ |

[23] Projecting Older People Population Information
www.poppi.org.uk

The map overleaf shows levels of deprivation across the 5 neighbourhood localities in Sunderland and super output areas, with 37% of the population of Sunderland living in areas that are among the 20% most disadvantaged across England[24]. 7% of the population of Sunderland are from BME groups, which whilst lower than the national average remains significant in terms of local needs to be addressed.

| Population by ethnic group ('000s) [2] | | | |
|---|---|---|---|
| | White British | BME | % BME |
| **Sunderland** | 262 | 19 | 7 |
| **England** | 42,900 | 8,900 | 17 |
| BME = Black & minority ethnic groups | | | |





Sunderland continues to have worse health outcomes than the England position in terms of life expectancy, mortality rates and the prevalence of specific conditions. This relatively poor health profile of the population leads to a higher level of need for those with resulting daily living problems and increased risks of admissions to hospital and long term care.

Early death from all cancers per 100,000 of the population in Sunderland is significantly worse than in England and continues to show a rising trend. The percentage of people diagnosed with heart disease / stroke and respiratory illness is also significantly worse than England. The percentage of people diagnosed with diabetes and the percentage of people who smoke is also increasing.

Currently 68,000 people or 24% of the population of Sunderland have a limiting long-term illness which is higher than that of the region or national average. National

[24] http://www.communities.gov.uk/documents/statistics/pdf/1871208.pdf

research shows that the majority of people aged 65 and over have two or more long term conditions (LTC), the majority over 75 have three.

Within the City's older person population there is also approximately 3,114 individuals with dementia, including 2043 aged 80 and over. The expected number of older people with dementia will increase by 40% (to 4,200) by 2025.

| | Sunderland | | England | |
|---|---|---|---|---|
| Male life expectancy[7] | 76 | ↑ | 78 | ↑ |
| Female life expectancy[7] | 81 | ↑ | 82 | ↑ |
| Early mortality rate, heart disease/stroke[8] | 82 | ↓ | 71 | ↓ |
| % and number diagnosed with heart disease[9] | 5.2% 14,900 | ↓ | 3.4% | ↓ |
| Early mortality rate all cancers[10] | 144 | ↑ | 112 | ↓ |
| % and number diagnosed with diabetes[9] | 5.6% 12,800 | ↑ | 5.4% | ↑ |
| % and number diagnosed with COPD[9] | 2.9% 8,200 | – | 1.6% | ↑ |
| % and number diagnosed with dementia[9] | 0.5% 1,500 | ↑ | 0.5% | ↑ |
| % of adults that smoke[11] | 30% 39% | ↑ | 21% | ↓ |

Locally it is estimated that 37% of people aged 65 and over have problems with aspects of daily living, and this will rise by more than 25% to over 22,400 in the next 15 years, simply because there will be more, older people in the City, living for longer. In particular the number of people aged 85 and over, often those that tend to be the most vulnerable group of older people requiring the most support, is set to rise substantially in the next 20 years-from 5,200 to 12,800.

National research suggests that older people with 2 or more types of significant problems in daily living are particularly at risk of admission to hospital or care.

Informal 'carer fatigue' in supporting people in daily living as a result of long standing and life limited conditions is significant for public sector care and support particularly for those individuals with more significant dependencies. Without this informal care in place there is an increased risk of admission to hospital.

Sunderland has around 33,000 people reporting themselves to be a carer. However it is important to remember that many people do not consider themselves to be a carer, they are just looking after their mother, son, or best friend, just getting on with it and doing what anyone else would in the same situation. Many carers provide over 50 hours a week of unpaid care to the person they look after.

Approximately 17,550 people in Sunderland have a moderate physical disability, with a further 4,916 people having a serious physical disability. The total number of those with a physical disability is set to increase by 7.4% in 2025. This will be highly influenced by the number of people aged 50-64 years in the City. In particular, those people with "severe functional dependencies" are most at risk of admission to hospital because of the nature of their conditions.

It is estimated that around 2.4% of the overall population have learning disabilities. Children and adults with more significant learning disabilities, currently making up 0.43% of the population, are living longer that they once would have done, particularly into adulthood. It is expected that this number will increase to 1,500 people by 2021.

Sunderland has the highest prevalence of depression compared to the rest of the North East and is twice over the expected level. Depression occurs alongside anxiety in between 25% - 50% of people presenting with a common mental health problem.

In 2010/11 there were 33,613 emergency admissions to Sunderland hospital of which 14,531 (43%) were readmitted within 30 days. In March 2012 a joint audit of readmissions to the acute medical unit was undertaken which found that in 43% of cases the readmissions were thought to be avoidable. Moreover 22.92% of older people discharged from hospital in 2010/2011, and 13.65% in 2011/12 were no longer at home 3 months after discharge. This clearly highlights the need for greater focus on preventing avoidable hospital admissions by improving the support available to patients within the 30 days following discharge.

# 5. Intermediate Care and the links to Rehabilitation and Reablement

Different interpretations have emerged and evolved nationally and locally regarding the definition of 'intermediate care' and its links to 'rehabilitation' and 'reablement . In Sunderland, partners have worked together in order to review national guidance and agree a clear set of definitions for intermediate care, rehabilitation and reablement. These are as follows:

**Rehabilitation Definition**

'*The primary objective of rehabilitation involves restoration to the maximum degree possible, either of function (physical or mental) or role (within the family, social network or workforce)*

*Rehabilitation usually requires a mixture of clinical , therapeutic and social interventions that also address issues relevant to a person's physical and social environment*

*And*

*Effective rehabilitation needs to be responsive to a user's needs and wishes, to be purposeful , involve a number of agencies and disciplines and be available when required.'*

Audit Commission 2000. The Way to go Home – Rehabilitation and Remedial Services for Older People

**Intermediate Care Definition**

*"Intermediate care is 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"*

Department of Health 2009. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities

**Reablement Definition**

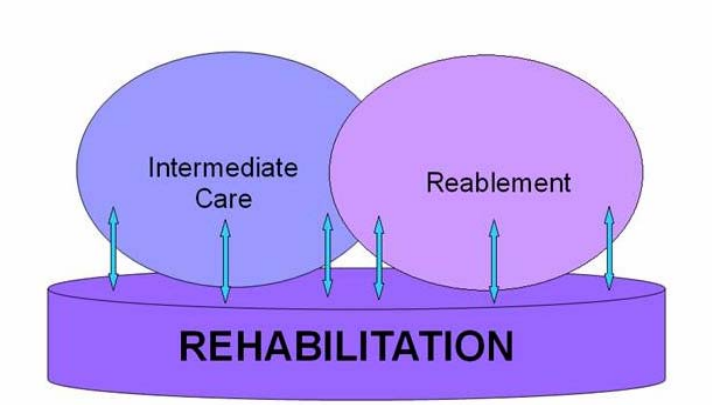
*Reablement is an 'approach' or 'philosophy', which aims to help people 'to do things for themselves' rather than 'having things done for them'.*

*It is the use of timely, and time limited, focused support to improve choice and quality of life, so that people maximise their independence by regaining skills and confidence.*

Developed by the Reablement and Accommodation Group on behalf of the Sunderland Intermediate Care Strategy Group, 2011

Therefore it is clear that many of the of the principles and functions of intermediate care fall within the spectrum of rehabilitation services, as stated in the local Rehabilitation Strategy (Transforming Rehabilitation – Achieving Synergy in South of Tyne and Wear 2011) which complements the development of a new intermediate care model for Sunderland. The Rehabilitation Strategy reiterates the clear connectivity between intermediate care and rehabilitation, with reablement being used to support individuals in order to encourage independence – see Figure 3 below. It is important to note that reablement is not limited to intermediate care and may be found in other areas such as mental health or long term conditions.

**Figure 3**



# 6. What does Intermediate Care look like now in Sunderland?

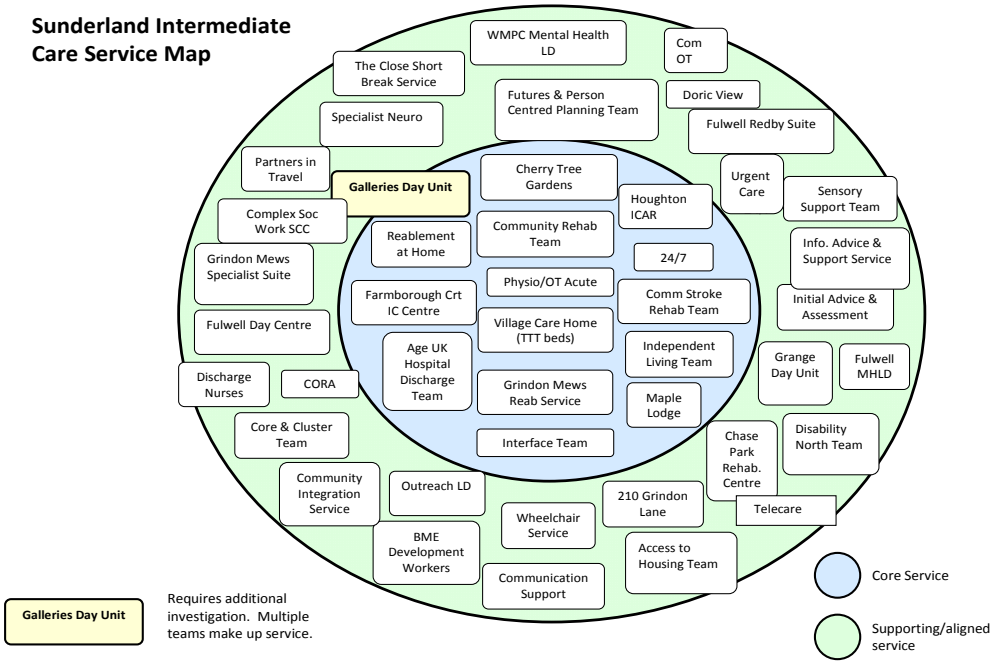
## Sunderland Intermediate Care Service Partnership

Sunderland's Intermediate Care Service Partnership was established on 25 February 2005 and exists as a formal agreement between Sunderland City Council, Sunderland Teaching Primary Care Trust, City Hospitals Sunderland NHS Foundation Trust and Northumberland, Tyne and Wear NHS Trust. The Partnership has overseen the development of intermediate care services and managed the pooled budget for intermediate care, which currently is £2.2 million. It is acknowledged that significant new initiatives and service developments have recently emerged to support the population of Sunderland and new partners are also involved in this work such as South Tyneside NHS Foundation Trust and Gateshead Health NHS Foundation Trust. Given the changing landscape and also a lack of clarity regarding definitions of intermediate care, rehabilitation and reablement, it was agreed that a review of the overall intermediate care picture would be helpful, alongside a stock take of the budget for core intermediate care services both within and out with the pooled budget.

## Current Services – Self Assessment

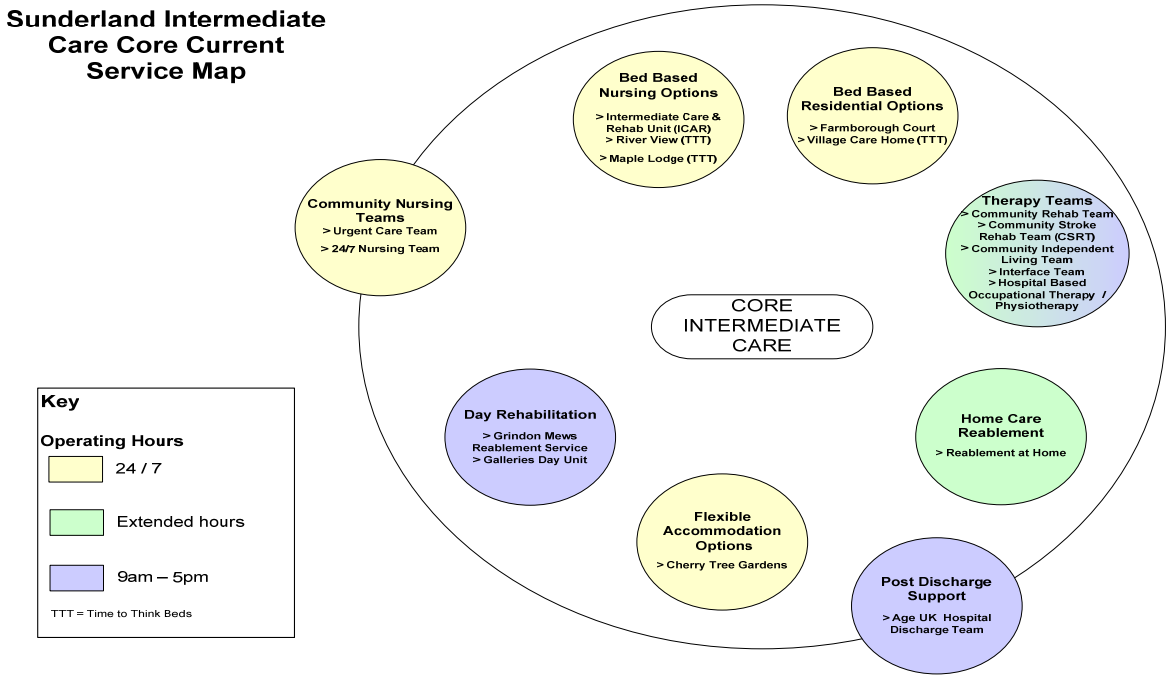
A self assessment exercise was initiated in Sunderland, with services believed to be providing intermediate care options in order to provide clarity and identify any gaps in provision. The outcome of the review resulted in the development of Figure 4 below, which depicts the feedback from the self assessment exercise in terms of a set of 'core' intermediate care options, with surrounding 'supporting services', reflecting the current picture in Sunderland. These services are delivered by a range of providers, within health, local authority and the third sector.

**Figure 4**



For the purposes of clarifying the functions of the teams and services identified in the core intermediate care service following the self assessment exercise, these have been grouped in Figure 5 as follows with an indication of their hours of service. It is important to note that whilst these services have been identified as core following the self assessment exercise of the current state, the emerging future model of intermediate care may need to incorporate other existing or new services as it develops therefore Figures 4 and 5 must be viewed collectively in order to understand the complexity and range of services in Sunderland.

## Figure 5




The core services within the current state comprises of skilled staff from a variety of disciplines including:

- Physiotherapists
- Occupational Therapists
- Nurses
- Social Workers
- Support Workers

The review identified that the 'core' intermediate care services employ similar staff groups, whilst staff identified 'their team' as being their direct colleagues, they were less able to visualise the links between services and how their work could be complemented with the intervention of others. It was recognised that there had been little opportunity for planned shared learning and development.

As a result of their organic development over ten years, services are delivered at a variety of facilities or by various teams, and at times this can prove difficult to

navigate. It was noted that there are some duplications in function which is not conducive to a streamlined pathway. Services are working hard to deliver and support the intermediate care agenda, despite the mosaic of providers and teams and have developed strong links where possible, but few can describe the whole system or articulate how this is accessed.

This is emphasised for those responding to crisis situations, for example GPs identifying an individual in crisis in the community, faced with unclear pathways for care. In this environment and requirement for an immediate action, it is understandable that a hospital referral and admission is often the default option as opposed to the intermediate care services.

### Current Services – Financial Stock Take

The current pooled budget for intermediate care is £2.2 million, however, via the self assessment exercise, a wide range of services were identified as providing a 'core' intermediate care function, which amounts to a total budget of £12.2 million. This is £10 million in excess of the formal pooled budget arrangements and demonstrates firstly the significant new investment that has been made in services for Sunderland, but also highlights the potential vulnerability of these services with funding sitting outwith the formal agreement. This is possibly a result of the lack of clarity that has already been described regarding definitions of what is or is not core intermediate care.

The development of clear definitions identifying core intermediate care services provides an ideal opportunity to review the formal pooled budget arrangements to ensure they are reflective of core intermediate care services which will enable a sustainable future model to be further developed.

### Ideas for Change – A service provider and commissioner perspective

The self assessment undertaken by stakeholders has generated new and significant ideas for change. These include:

- To develop a central point for all referrals into intermediate care services
- To facilitate access to intermediate care services 24/7.
- Integrated working across a range of teams and services delivering intermediate care.
- Shared assessment frameworks.
- Workforce development strategies that promote shared learning and skills development across health and social care teams.
- To develop mechanisms to ensure services are shaped through user and carer engagement.
- To ensure services address the mental health as well as the physical needs of individuals.
- Increased support for carers within intermediate care services.
- To establish pathways that keep people at home safely when they are unwell and prevent hospital admission and readmission.

- To better understand and harness assistive technology in the individual's journey in order to support independence.
- To review the pooled budget arrangements to ensure they are reflective of core intermediate care services in the agreed future model.

These ideas combined with the views and ideas of the public, service users and carers have helped inform the development of objectives for this Strategic Direction.

## Ideas for change – the views of public, service users and carers

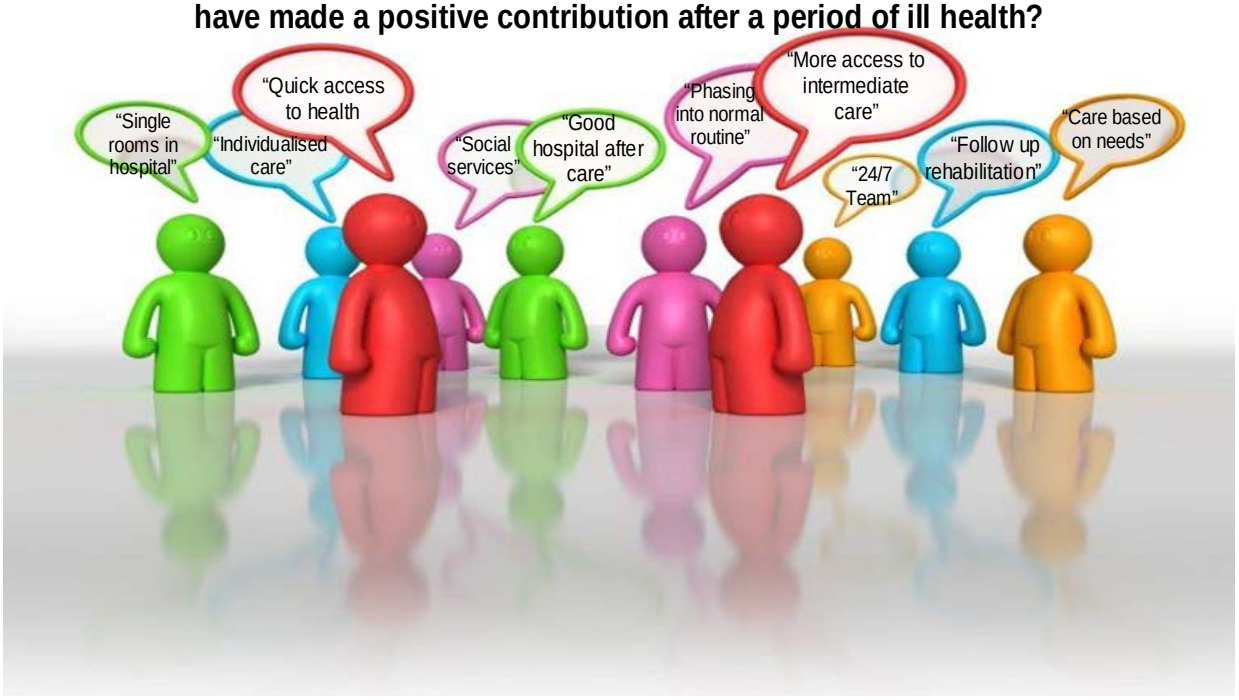
During 2009/10, a number of focus groups and 1-1 interviews on the topic of intermediate are took place with the public and carers, working with Age Concern (now Age UK), Sunderland Carers Centre, Farmborough Court Intermediate Care Centre, Sycamore Care Centre and City Hospitals Sunderland.

In addition in September 2010, a 'Positive Ageing' conference was held by Sunderland Teaching Primary Care Trust, in conjunction with Sunderland Council and Age UK. During the conference, more than 60 members of the public, users and carers participated in workshops on 'Staying Healthy for the Future', which included discussion around experiences and views on what works well and what could be better in relation to *'care and support available after a period of ill-health'*.

Due to the breadth of services that come under the heading of intermediate care, and its links with hospital discharge and wider community health and social care services, this led to a very varied content of discussion in the engagement work described above and subsequently very diverse comments and views. Key themes emerging have been summarised in the table below:

- *The need for person-centred care, focused on individual needs and promoting choice and control*
- *A social disability model which promotes independence and enablement not compensation*
- *Carers as partners in care, whose views, needs and expertise should be recognised and acted upon*
- *Care at home if possible, but availability of alternatives to hospital if recuperation and rehabilitation is required*
- *Need for quick access to health and social care services whether in the community or after a hospital stay such as: immediate post-op care, 24/7 Team, social services, equipment, follow up rehabilitation, respite*
- *Longer hospital stay to recover or more access to intermediate care i.e. Farmborough Court*
- *The need for good discharge planning and coordinated transfer of care*
- *GP to contact patients post discharge or periods of ill health*
- *Need for better information in the community and hospital*
- *Opportunities required for ongoing support so that the benefits of intermediate care are not lost once the services stop*

**What have been your good experiences? Any ideas/thoughts on what else would have made a positive contribution after a period of ill health?**




In February 2011, the Sunderland Health and Well-being Scrutiny Committee held a stakeholder engagement workshop as part of their *Review of Rehabilitation and Early Supported Discharge from Hospital*. The following is a summary of the key themes that emerged from the table-top discussions that relate to intermediate care:

***Preventing admission to hospital***

- *Lack of confidence in services available in the community – need to raise awareness of what is available – would result in possible reduction in admissions i.e. Break culture of 'when in doubt go to hospital'*
- *More education\information is required to encourage earlier contact with health services with better use/more awareness of screening services. This could help prevent admissions for chronic illness.*
- *More support to cares/families could result in fewer admissions*
- *Improve health education – People being made more aware of how to manage their health in the long term*
- *Much better understanding of services available to keep people out of hospital – people have no idea of what services/support is out there – Huge lack of knowledge of availability of support services.*
- *There is a need to tailor services for the individual. Need to be person-centred.*
- *After 5pm and on weekends access to services is reduced – need to plan in advance.*

***My stay in hospital***

- *Holistic approach to admissions needed – physical and mental health.*
- *Patients feel that the doctors are not listening when they are trying to tell them about any underlying or existing health problems – Not enough joined up thinking between departments, doctors etc.*
- *Treat patients with dignity courtesy and respect. Listen more to carers and respect patient's wishes*
- *Better awareness and ongoing promotion of what services are available through Community Health Services and Social Care and what their remit is. There needs to be a central contact / single point of entry that can provide this information for both patients and health professionals.*
- *The levels and services delivered by Community Health Services should be the same across the city. Numbers need to be increased to account for the increasing needs of an ageing population.*
- *Use of housing providers as a resource to promote health-related services, including preventative measures.*
- *Communication methods can be a barrier – internet and 0845 numbers are not accessible for all.*
- *Need for multi-agency planning and coordination.*
- *Training, support and inclusion of Carers. Give them information on patients' illness, treatment and care etc. and empower carers and help them and the patient make informed decisions etc*
- *Involvement of patients and carers in decision-making about their treatment and care*
- *Communication needs to be pitched at a level that everyone understands.*
- *Hospital staff need to make sure that they have an understanding of all health problems the patient is suffering from and not just the one they are presenting with.*
- *Need to give people more information on their treatment and care and listen to families too*

***Hospital discharge process***

- *Discharge process should be initiated when patient is admitted, with involvement of carers and Social Services if required from the beginning.*
- *Multi-agency discharge planning and links to follow up services*
- *Care plans shared across agencies – for everyone – needs to include whole process from admission to discharge.*
- *Delay in getting test results and medications so discharge can be delayed.*
- *Identifying a care coordinator for a patient to take responsibility for a patient's welfare / aftercare to ensure that the right level of care is being provided.*
- *Discharge navigator – communicator / coordinator – acts as a Lead / Mentor through the whole process.*
- *Delays in sending discharge information to GP can affect time in which practice are able to follow up with patient.*
- *Management of medications following discharge needs to be included as part of the package of care.*
- *Stronger links with housing providers – inform housing if people discharged so they can put in support if needed.*
- *Services need to be proactive and contact must be made with patients after discharge to find out how they are getting on. Regular reviews and follow ups are needed as a patient's need may change*
- *Evaluation after discharge - unclear who, if anyone, reviews the care plan after discharge – initially the patient may not need lots of support when discharged but circumstances could change re availability of carer/family member but this is not being taken into account but would be captured if regular reviews were undertaken.*

# 7. What does the future look like for the people of Sunderland ?

Our vision for the future of intermediate care in Sunderland is:

*To develop a locality focused collaborative model, which maximises independence and quality of life for people of all ages, whilst ensuring cost effective use of resources. We will* ensure the individual and their carers/family are at the heart of their care and support, ensuring they have access to information, advice and support to promote real choice and control, increase self care and self management, and enabling individuals and their carers to remain as independent as possible, for as long as possible.

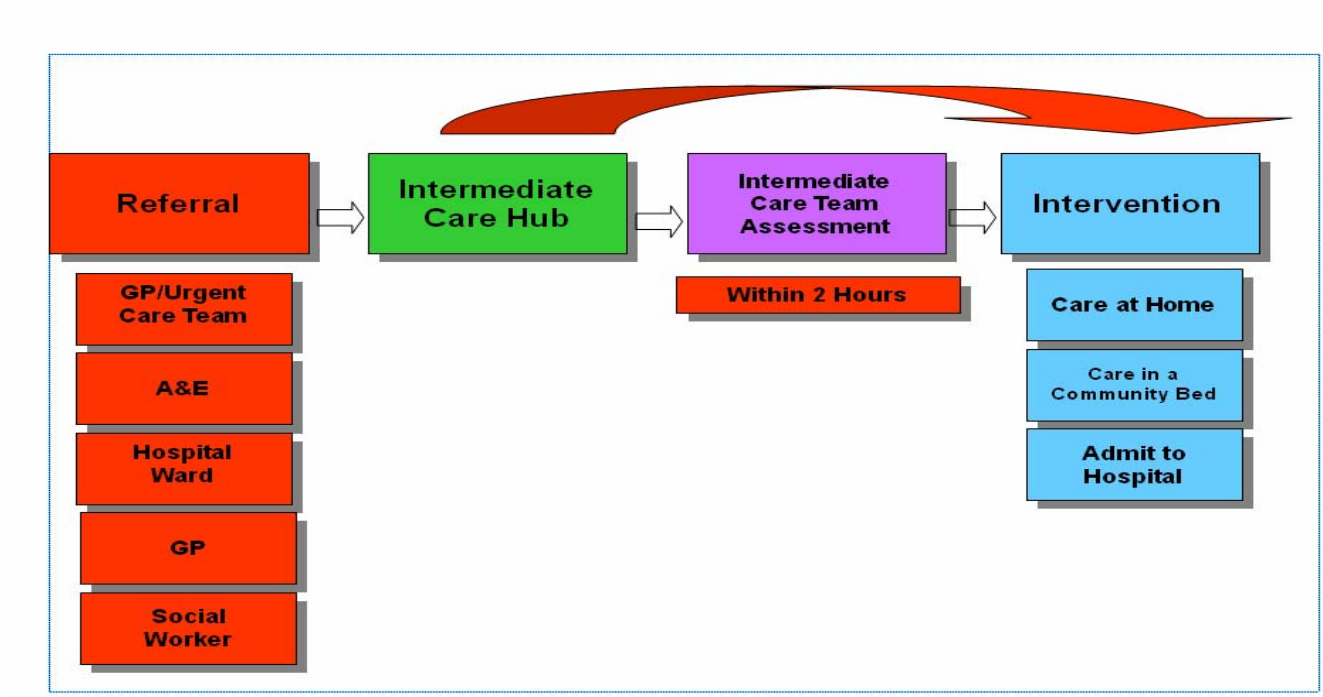
The overarching Model for Intermediate Care Services will be one where the emphasis is on delivering care closer to home as illustrated in the diagram below Figure 6.

**Figure 6 – Future model for Intermediate Care in Sunderland**


Reproduced with kind permission of Sheffield City Council/NHS Sheffield

Figure 7 shows the flow through the intermediate care services via the Intermediate Care Hub where multi-agency assessment takes place ensuring the person receives the right intervention in a timely manner.

**Figure 7 – Flow through the Intermediate Care Services**




A set of high level aims have been developed that describe what our Intermediate Care Model will deliver for Sunderland. These closely align with the Department of Health guidance 'Intermediate Care Half Way Home'.

## Aims

- Maximise independent living
- Promote faster recovery from illness
- Minimise admissions to long term residential care
- Facilitate a timely discharge from hospital
- Provide effective alternatives to hospital admissions
- Ensure a skilled intermediate care workforce
- Measure success from the view point of all

From our engagement with patients, carers and staff who provide services, we have developed a set of objectives which we believe will help us to achieve the above aims for the people of Sunderland.

## Objectives

| **We will provide rehabilitation and reablement approaches appropriate to need** |
|---|
| ***Key activities***<br>• Transition to an in-reach model of rehabilitation and reablement wherever the person is (eg. own home, care home, extra care, hospital)<br>• Ensure needs are identified through therapy led assessment<br>• Strengthen working relationship with specialist pathways and services (eg, stroke, falls, continence)<br>• Greater integration and coordination with the spectrum of rehabilitation services in line with the new Rehabilitation Strategy<br>• Ensure that individuals with complex needs (e.g. dementia, mental health, learning disabilities, long term conditions) have equity of access to the Intermediate Care Model which is sensitive and flexible to their specific needs<br>• Explore linkages to the End of Life Strategy |

| **We will place the individual and their carers at the centre of decision making** |
|---|
| ***Key activities***<br>• The model of decision making will embrace the personalisation agenda with individuals and carers<br>• Develop a person centred 'menu based' approach to service provision to offer choice and control to individuals |

| **We will facilitate timely access to good information and advice for individuals, carers and staff** |
|---|
| ***Key activities***<br>• Customer Service Centres will have access to a directory of services for staff and the public<br>• Links with Healthwatch will continue to be maintained as it evolves<br>• Individuals will have access to full and fair information, advice and support in order for them to make informed decisions |

**We will coordinate access to intermediate care services, ensuring a rapid response (within 2 hours ) is available where appropriate**

***Key activities***

- Development of an 'Intermediate Care Hub' to provide a single point of access and streamlined referral to intermediate care services
- Develop clear referral pathways into the Intermediate Care Hub with standard documentation, for hospital, community and primary care
- Review and further develop the rapid response component (within 2 hours) of the Intermediate Care Model to provide urgent community based assessment and intervention in peoples homes
- Develop a standard process for GP admissions, ensuring alternative pathways are readily available for individuals via the Intermediate Care Hub if a hospital admission can be prevented
- Analysis of the demand for intermediate care services over a 24 hour period to enable demand to be matched to capacity/availability

**We will increase individual and carers confidence and ability to cope**

***Key activities***

- People will be supported and empowered to manage their anxieties
- Carers will be actively identified by intermediate care services and signposted to appropriate support services
- Ensure robust support system for carers and explore opportunities for Reablement for carers
- The Intermediate Care Model will take into account the current Carers Strategy Review
- We will review the opportunities to support individuals to manage their medication

**We will facilitate increased joint working and streamlined pathways of care**

***Key activities***

- Establish joint working protocols and unified assessment documentation, trusted by all with appropriate information shared amongst partners
- Ensure documentation clearly indicates the individual's 'normal' level of functioning so that changes can be identified and appropriate goals set
- Re-model care management service in response to the Intermediate Care Model
- We will strengthen links with medical staff
- Reposition and strengthen prevention strategies within the model, this would include increased engagement with the third and voluntary sector
- Ensure that the model embraces the Memory Protection Service

**We will explore appropriate investment in assistive technology**

***Key activities***

- Invest and embed usage of assistive technology
- Ensure staff have access to appropriate training to maximise development opportunities in this area
- Develop 24 / 7 response to support people in any setting (eg. own home, care home, extra care, hospital)

**We will offer a range of bed based options as alternatives to hospital admission**

***Key activities***

- Drawing on current intelligence, jointly commission appropriate numbers and types of bed based provision to meet future need
- Ensure local commissioning arrangements are flexible to cope with surges in demand during episodes of peak activity

**We will support a timely hospital discharge process by offering a range of intermediate care options**

***Key activities***

- Ensure individuals have had the opportunity to access rehabilitation to meet their needs during their hospital stay to maximise recovery opportunities and independence
- Review the effectiveness of ward based multidisciplinary team discussions ('pow wows') to optimise effective communication and assessment of needs
- Ensure accurate and appropriate information regarding an individual's ongoing needs is shared with agreed services in a timely way, prior to hospital discharge
- Explore opportunities for access to rehabilitation and reablement for all those who could benefit post hospital discharge
- Review third and voluntary sector role in hospital discharge process

**We will ensure assessment and decision making about peoples long term care needs can only be made after they have had the opportunity for rehabilitation, reablement and recovery**

***Key activities***

- A period of rehabilitation and reablement will be part of the core offer to all individuals prior to decision making about their long term care needs, this includes individuals receiving care at home or in a care home
- We will agree a multi disciplinary approach to identifying and meetings individuals' long term care needs

**We will develop an integrated intermediate care workforce to ensure the ethos of rehabilitation and reablement is embedded in practice**

***Key activities***

- Develop virtual teams across health and social care to deliver the intermediate care model
- Ensure linkages with all teams for high / low risk patients
- Integration of therapy teams to reflect the intermediate care model
- Explore opportunities to secure dedicated medical support and input into intermediate care services
- Dedicated work to integrate the third and voluntary sector provision which contributes to intermediate care
- Align health and social care therapy workforce to the intermediate care model
- Develop social care Community Occupational Therapy work force to support reablement / rehabilitation journeys in addition to the statutory functions of the Council
- Profiling the workforce and ensuring they are equipped with the appropriate skills and knowledge
- All intermediate care workforce will receive core training in dementia
- Ensure the workforce is skilled to support individuals to manage anxiety or make behavioural changes

**We will measure success by data analysis and seeking the experience of views of patients, carers and staff**

***Key activities***

- Develop a suite of metrics and outcome measures that enable us to meet the desired outcomes of individual and their carers
- Establish mechanisms for capturing experience and views
- Commission a longitudinal study / evaluation

**We will set out a clear accountability framework for delivery of the Strategic Direction**

***Key activities***

- Review the Intermediate Care Partnership Agreement and pooled budget for Sunderland to incorporate all the elements of the new model and ensure ongoing governance across partners
- Develop a robust financial monitoring framework to deliver a cost effective service delivery
- Data collection for the key contracts relating to the intermediate care model will be aligned to produce a single data set
- Continually demonstrate accountability by establishing a process for continuous development of the model in response to metrics and experiential feedback

## Outcomes for individuals

The following case studies provide some examples of what the achievement of these objectives will mean for the people of Sunderland.

### Case study 1 – Mrs H

*Mrs H is 94, a widow and living with her son and daughter-in-law.*
*She had a number of urinary infections and was constantly getting up in the night.*
*One night she fell and fractured her pelvis, ending up in Sunderland Royal Hospital.*
*Whilst in hospital Mrs H lost all her confidence, became depressed about her situation and began to feel that life wasn't worth living – her son became concerned that she would not be able to get back home.*
*Following treatment for her pelvis, the discharge team contacted the 'Intermediate Care Hub' a single point of access to all community services, who arranged for Mrs H to transfer to an Intermediate Care Assessment and Rehabilitation (ICAR) bed at the Houghton Primary Care Centre.*
*During her stay there, the team resolved the issues around her urinary infections and she had daily visits from the Occupational Therapist and Physiotherapist from the Community Rehabilitation Team to get her back on her feet. The team also worked with the Telecare service to install an alarm in her home to provide an alert to her family if she got up in the night and to prevent future falls.*
*After a short 2 week stay in ICAR, Mrs H went home feeling confident and well, and received a few weeks of additional support from the Reablement at Home team.*
*A few weeks later Mrs H was at the Stadium of Light cheering her favourite team, Sunderland Football Club, at their last match of the season.*

### Case study 2 – Mrs V

*Mrs V is 67 years old and was referred to the Reablement at Home team after a hospital stay due to a stroke. She returned home with the support of one member of staff and 4 visits throughout the day.*
*Mrs V also had the Sunderland Stroke Team visiting once/twice a week so both teams worked jointly to provide maximum input for Mrs V and ensure integrated provision across the teams.*
*Mrs V's stroke had left no physical, numbness or weakness but had affected her brain, her memory, communication skills, and difficulties recalling the correct words etc. The Reablement team first started with an assessment around her activities of daily living, and found out quite quickly Mrs V needed lots of prompts, guidance and instructions, but physically could carry out the tasks independently. Mrs V would lose her trail of thought and couldn't recall where items were in her own kitchen. Staff worked each visit alongside her to prepare her meals but only assisted and supported where necessary.*
*Mrs V also had been given a new system to enable her independence with her medication and staff worked each day prompting, and observing Mrs V with the long term goal that she would be able to complete herself. After a couple of weeks staff found Mrs V progressed very well and was managing kitchen activities independently, but had noticed the difficulty she was still having around reading the instructions on a packet or a microwave meal cooking instructions. Staff worked with the Occupational therapist and the Speech Therapist from the Stroke Team to plan how the team could support Ms V.*
*Working with the Stroke team Mrs V was provided with a work booklet to complete and assist with development of independence.*
*The Reablement team suggested to Mrs V that they would help her complete once or maybe twice a day but during that first week Mrs V enjoyed this time so much that 3 out of 4 visits were now around these booklets, it reminded Mrs V about the class room, as she had been a primary teacher during her working days and she found it funny how she was going back to basics herself.*
*By the time the Stroke team visited the following week they were so surprised how far Mrs V had come from not been able to recognise letters to now attempting to spell and sound out small words.*

*Over a couple of more weeks her confidence grew in all areas, she was managing to wash, dress, and manage in kitchen (she still needed support if there was any reading material) and also remembering her own medication it was agreed to reduce visits to an evening call.*
*Once the service reached its 6 weeks it was agreed to extend for 2 more weeks due to her progress.*
*The 8th week came around very quickly Mrs V was now reading small words and recognizing pictures of items, and her communication skills had greatly improved. It was agreed, the stroke team would continue with their visits and Mrs V would continue with the work booklets, but now independently, and the Reablement at Home team would cease their visits.*

## Case study 3 – Mrs M

*Mrs M is 70 years old and lives at home with her husband. She is in remission from bowel cancer and has other co morbidities including chronic obstructive pulmonary disease and diabetes. Mrs M was recently discharged from hospital after an extended stay post surgery. Recovery had been slow in hospital, complicated by immobility and a grade 4 sacral sore. She is now living downstairs with hoist for all transfers, other equipment and home care support services were in place for discharge. Her GP Visits 4 weeks post discharge after a call from patient's husband in crisis.*

*Mrs M's GP identifies Early Warning Score of 0 and feels patient may benefit from an Intermediate Care Assessment and Rehabilitation (ICAR) bed at the Houghton Primary Care Centre, however she wishes to remain at home. GP discusses needs with Intermediate Care Hub, who arrange same day assessment from Rapid Response Therapy and 24 7 Community Nursing Team.*

*A comprehensive multidisciplinary assessment and intensive rehabilitation/treatment takes place over the next six weeks. Mrs H made significant progress, her mood improved, she is now mobile with the aid of a walking frame, and supervision from husband/carers, her catheter has been removed, and her sacral sore is much improved.*

*Mrs M's future goals are to assess her ability to manage stairs.*

*Hospital admission/admission to Intermediate Care Bed was avoided.*

# 8. Measuring our Success

This section sets out we intend to measure achievement of the aims and objectives of the Strategic Direction for Intermediate Care Model.

Our approach is two-fold:

- A strategic "whole system" perspective on the model, reflecting on the expected outcomes of intermediate care beyond its delivery (e.g. its positive impact on health and social care systems), as well as the outcomes for individuals and carers themselves;

- An operational perspective exploring the management, impact and outcomes of specific parts of the model, particularly within the integrated pathway. Clearly, some of the measures identified in the operational perspective will be reported upon (or aggregated across the pathway) for the 'whole systems' perspective.

For the purposes of this document we have outlined how the 'whole systems' perspective on the model will be measured.

## Whole systems perspective

We have developed a Balanced Scorecard with four different dimensions:

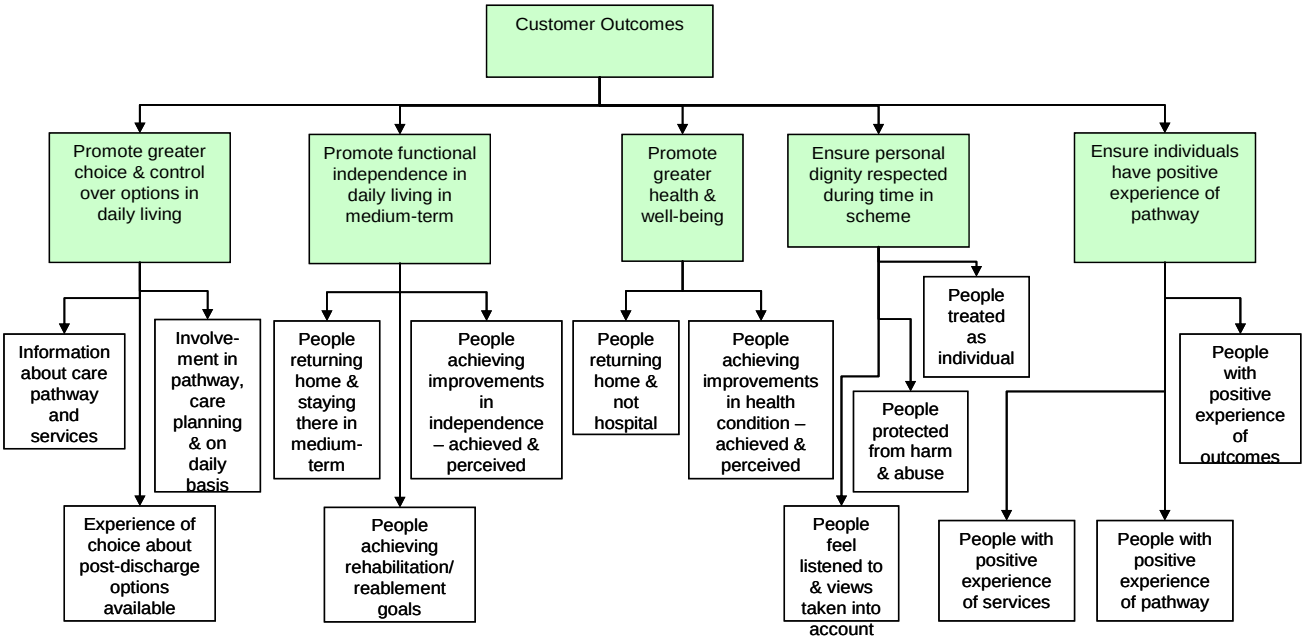
- Patient/Customer & Carer Outcomes
- Service Delivery
- Cost-Effectiveness
- Whole-System Dimension, including capacity & standards

### *Patient/Customer & Carer Outcomes*

This first dimension seeks to determine whether the outcomes relating to individual customer/patients and carers are achieved – from a variety of different perspectives, but including those of individuals themselves and those of professionals in terms of improvements in the individual's condition or independence or their ability to better manage either.

The framework described in Figure 5 below shows the range of expected outcomes that will be measured. Intelligence will be gathered through a range of methods such as focus groups, research and audit, quantitative professional outcome measures (e.g. longitudinal studies – "before" and "after") and case studies. This intelligence is then combined to provide a coherent narrative about whether the stated outcomes are being achieved.

**Figure 5**




## *Service Delivery*

This second dimension relates to outputs of delivery such as the number of clients accessing intermediate care and the logistics of this delivery, e.g. length of access etc. A range of quantitative performance metrics have been developed across the Intermediate Care Model to monitor this dimension. Clearly, these measures can also apply to individual elements of the Model in the operational Scorecard discussed above.

## *Cost-Effectiveness*

This third dimension relates to outputs of cost-effectiveness on two levels:

- *Direct efficiency of delivery* of the intermediate care service, including monitoring where different partners' resources have been combined across the customer journey – which could be benchmarked against others' models of delivery;
- *Cost-Benefit analysis:* Understanding the (positive) impact the Intermediate Care Model would have on wider health and social care systems, translated into financial terms, but being careful to differentiate between "cashable" savings and "non-cashable" savings (i.e. savings would not be real; but if the Intermediate Care Model was not in place, there would be a greater spend on other parts of the system).

### *Whole-System Dimension, including Capacity & Standards*

This fourth dimension relates to:

- *Partner Capacity & Standards:* This relates to the organisational capacity to deliver and improve an ongoing service, including "future proofing" delivery of services. As a partnership, this would include ongoing monitoring of training and development of staff and its positive impact in the service, quality assurance mechanisms such as case file audit and inspection and monitoring against standards and the management of safeguarding or risk issues;
- *Whole-System Impact:* Understanding the (positive) impact the Intermediate Care Model would have on wider health and social care systems, e.g. reducing emergency re-admission rates to hospital for certain conditions; or reductions in residential or nursing care. It will be important to understand the level of attribution between the Model's outcomes and the measures in this section, e.g. the Intermediate Care Model might be highly effective in reducing subsequent hospital re-admission rates for those patients it admits, but nonetheless, emergency re-admission rates in the city might continue to increase overall.

### Governance

The scorecard is comprehensive and populated by a range of performance and outcome measures. However, we aim to reduce the burden on partners by using readily available information and monitoring of the separate dimensions of the Scorecard, which can then be aggregated up as required. e.g. partners would be expected to use their own monitoring tools and reporting arrangement in relation to Capacity & Standards rather than developing a common bespoke approach across partners for the Intermediate Care Model. Furthermore, some of the Customer Outcomes methods (e.g. case studies) could be collected over the period of a year to gradually build a holistic picture of progress in this area.

A short performance summary with recommendations for consideration using the above framework will be updated and prepared for the Intermediate Care Strategy Group (and for wider partners) on a quarterly basis, whilst a more in-depth evaluation with recommendations (together with progress against any quarterly recommendations made during the year) using the same framework will be presented to the Strategy Group annually.

# 9. Taking the Strategic Direction forward

## Seeking Agreement

The next step for the Sunderland Intermediate Care and Reablement Strategy Group is to seek agreement and sign up to this strategic direction from all statutory partners via the appropriate internal mechanisms.

We have taken opportunities for engagement of individuals and carers through out our journey to develop this Strategic Direction however, it is essential that the Strategy Group establish an ongoing and genuine dialogue going forward. We will draw on current engagement mechanisms across the city such as the Sunderland Carers Centre and local Healthwatch to ensure co-production of the Model of Intermediate Care in the future.

We have incorporated the recommendations from the Health and Well-being Overview and Scrutiny Committee review of *Rehabilitation and Early Supported Discharge from Hospital* into the strategic direction and implementation plan, and therefore we will report on progress against this plan to the Overview and Scrutiny Committee.

The links between the Strategy Group and the development of the Sunderland Health and Wellbeing Strategy overseen by the Health and Wellbeing Board is also critical to its success ensuring democratic legitimacy from elected members, and therefore we will seek to ensure that this Strategic Direction document is acknowledged in the developing strategy.

## Implementation

The implementation of this Strategic Direction will become the key work plan for the Sunderland Intermediate Care and Reablement Strategy Group. We will review sub-group structure in light of this, providing opportunities for partner organisations to shape the delivery of key activities and ensuring full integration of the third, voluntary and independent sector in these arrangements.

We will review the formal Sunderland Intermediate Care Partnership arrangements to facilitate achievement of the Strategic Direction.

As described above, continuous engagement of individuals and their carers is essential to delivery of this Strategic Direction.

# Appendices

## Appendix 1: Sunderland Intermediate Care Strategy Group Membership

**Joint Chair:**
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform Team, NHS SOTW
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council

**Members:**
Dr Iain Gilmour, Board Member, Sunderland Clinical Commissioning Group
Philip Foster, Head of Service Care & Support, Health, Housing & Adult Services, Sunderland City Council
Philippa Corner, Head of Personalisation, Health, Housing & Adult Services, Sunderland City Council
Alan Caddick, Head of Service, Housing, Health Housing & Adult Services, Sunderland City Council
Graham King, Head of Service, Commissioning, Health Housing & Adult Services, Sunderland City Council
Mark Smith, Chief Operating Officer, City Hospitals Sunderland NHS FT
Bev Atkinson, Executive Director of Nursing and Patient Safety, South Tyneside NHS FT
Tim Docking, Group Director, Planned Care Group, Northumberland, Tyne and Wear NHS FT
Yvonne Ormston, Executive Director, Gateshead Health NHS FT
Wendy Kaiser, Strategic Lead, Mental Health Model of Care, Business Delivery Team, NHS SOTW
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council

## Appendix 2: Working Groups reporting to Sunderland Intermediate Care Strategy Group

### Discharge Working Group

**Chair:**
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform Team, NHS SOTW
**Vice Chair:**
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council

**Members:**
Philip Foster, Head of Service, Care & Support, Health, Housing & Adult Services, Sunderland City Council
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Anna Hargrave, Divisional General Manager, City Hospitals Sunderland NHS FT
Susan Martin, Divisional Discharge Co-ordinator, City Hospitals Sunderland NHS FT
Angus McLellan, Business Manager, South Tyneside NHS FT
Jill Graham, Occupational Therapy Manager, City Hospitals Sunderland NHS FT
John Padget, Service Manger, LD Inpatient Service, Urgent Care, Northumberland, Tyne and Wear NHS Foundation Trust
Norman Wilson, Team Manager, Health Housing and Adult Services, Sunderland City Council
Phil Hounsell, Service Development Manager, Personalisation Service, Health, Housing and Adult Services, Sunderland City Council
Gill Lawson, Service Development Manager, (Prevention Services) Care & Support, Health, Housing and Adult Services, Sunderland City Council
Pauline Forster, Commissioning Specialist, Commissioning Team, Health, Housing and Adult Services, Sunderland City Council
Anne De Cruz, Team Manager, Intermediate Care and Reablement at Home, Care and Support, Health, Housing and Adult Services, Sunderland City Council
Paul Allen, Intelligence Hub Lead Officer, Strategy, Policy & Performance Management, Office of the Chief Executive, Sunderland City Council
Rachael Forbister, Service Pathway Development Officer, Telehealth, Health, Housing and Adult

Services, Sunderland City Council
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council

## Reablement & Accommodation Working Group

**Chair:**
Philip Foster, Head of Service Care & Support, Health, Housing and Adult Services, Sunderland City Council
**Vice Chair:**
Emma Anderson, Service Development Manager Reablement, Health, Housing and Adult Services, Sunderland City Council

**Members:**
Jean Carter, Deputy Executive Director, Health Housing & Adult Services, Sunderland City Council
Ailsa Nokes, Strategic Lead for Long Term Conditions, QIPP Reform, NHS SOTW
Helen Turnbull, Operational Reform Officer, QIPP Reform, NHS SOTW
Penny Davison, Senior Business and Contract Manager, NHS SOTW
Sharon Lowes, Lead Commissioner, Health, Housing and Adult Services, Sunderland City Council
Anne Prentice, Strategic Development Lead, Housing, Health, Housing and Adult Services, Sunderland City Council
Jim Usher, Service Transformation and Professional Lead Manager, Health, Housing and Adult Services, Sunderland City Council
Norman Wilson, Senior Team Leader, Hospital Social Work, Health, Housing and Adult Services, Sunderland City Council
Jill Graham, Occupational Therapy Manager, City Hospitals Sunderland NHS FT
Angus McLellan, Business Manager, South Tyneside NHS FT
Kerry Barclay, Team Lead Intermediate Care, South Tyneside NHS FT
Phil Hounsell, Service Development Manager, Personalisation Service, Health Housing & Adult Services, Sunderland City Council
Lynden Langman, Service Development Manager, Personalisation Service, Health Housing & Adult Services, Sunderland City Council
Rachael Forbister, Service Pathway Development Officer, Telehealth, Health, Housing and Adult Services, Sunderland City Council
Karen Wright, Rehabilitation Service Manager, Farmborough Court Intermediate Care Centre, Health, Housing and Adult Services, Sunderland City Council
Louisa Thompson, Community Support Manager, Social & Health Care Services, Health, Housing and Adult Services, Sunderland City Council
Sandra Begbie, Community Support Manager, Care & Support, Health Housing and Adult Services, Sunderland City Council
Anne De Cruz, Team Manager, Intermediate Care and Reablement at Home, Care and Support, Health, Housing and Adult Services, Sunderland City Council
Lesley Bainbridge, Business Manager, South Tyneside NHS FT
Anna Hargrave, Divisional General Manager, City Hospitals Sunderland NHS FT
Susan Martin, Divisional Discharge Co-ordinator, City Hospitals Sunderland NHS FT
Ron Todd, Directorate Manager, City Hospitals Sunderland NHS FT
Suzanne Miller, Service Manager, South Of Tyne Stepped Care Services, Planned Care Group, Northumberland, Tyne and Wear NHS FT
Angela Richardson, Network Development Officer, Tyne & Wear Care Alliance
Janette Oliver, Sunderland Intermediate Care & Reablement Co-ordinator, Health, Housing and Adult Services, Sunderland City Council