EAST & NORTH HERTS AND WEST HERTS PRIMARY CARE TRUSTS

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

FINAL DRAFT FOR PBC GROUPS

No more changes to this document. Build on plans in separate documents and pieces of work

1. Introduction

The purpose of this framework is to translate the strategic vision for intermediate care for Hertfordshire residents into a commissioning framework for the PCTs. This is undertaken in recognition of the current alignment of commissioning plans between the two PCTs in Hertfordshire and Herts County Council, Adult Care Services (ACS) and taking into account the potential for more formal joint commissioning arrangements in the future. The commissioning framework sets out to support the delivery of Local Area Agreement (LAA) targets and to ensure delivery of the intermediate care required as part of the out of hospital shift required in the Acute Services Review.

2. Definition of intermediate care

Intermediate care describes services that meet all of the following criteria;

- are targeted at older people, or other vulnerable people, who would otherwise be inappropriately admitted to acute in patient care, face an unnecessarily prolonged stay in acute in patient care, or be permanently admitted to long term residential or nursing care, or continuing NHS in patient care.
- 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.
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home.
- Involve short term interventions, typically lasting no longer than six weeks and frequently as little as one to two weeks.
- Involve cross professional working, with single assessment framework, single professional records and shared protocols. (DOH, 2001)

The Hertfordshire Intermediate Care Strategic Commissioning Forum acknowledges that this definition is now outdated and also needs to take into account all services which bridge home and acute hospital care. This involves avoiding admission to an acute hospital by providing appropriate alternative services (step up), and earlier discharge from acute services to an environment with enhanced services – this could be the person's own home or a community bed based provision (step down).

3. Vision

The strategic thrust of *Investing in Your Health (IiYH)* was to concentrate acute services for the acutely ill and therefore to concentrate the specialist expertise and high-tech equipment accordingly. IiYH proposed a significant shift of work from acute care to intermediate care either through care to patients at home or in community type hospitals.

Today patients get admitted to hospital for a wide range of reasons that are not always to do with their state of health. These include:

- more appropriate services not being available in the evening or at weekends
- more appropriate services not being available locally
- their principal carer has been taken ill or requires an elective operation
- they are seen by an inexperienced junior doctor at the hospital.

The PCTs believe that admissions such as these should be avoided or minimised. However, services cannot be transferred effectively from acute settings to more locally based non-acute settings without an appropriate range of services available in the community. Following National policy the PCTs proposes a reduction in the number of unplanned admissions to acute hospitals through:

- the expansion of the Community Matron Programme. Community Matrons are already working as part of the community nursing teams helping to keep frail elderly people at home or assisting with admission to a local community hospital or nursing home.
- Increased use of intermediate care services both provided to patients in their homes and increasing the number of beds available within Community Hospitals and Care Homes. Currently many patients who are treated in acute hospitals do not need specialist resources.

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The Acute Services Review - ***"Delivering Quality Healthcare for Hertfordshire"*** sets out the strategic vision for the PCT to 2012/13.This is very much in line with the White Paper "Our Health, Our Care, Our Say" which talks about convenient access to high quality services, making it easier to get the right care at the right time". Key to this is the prevention of admissions for long term conditions and to reduce the excess bed days when patients stay beyond the expected date of discharge. There is a 20% target reduction in admissions for patients with long term conditions such as diabetes, COPD and chronic cardiac failure. For every day beyond the expected discharge date stated in the tariff price the PCT is required to pay additionally for each extra days stay in hospital. Currently the PCTs jointly spend £22million on 110,000 excess bed days.

As part of the Acute Services Review the commissioning requirements are being mapped out. This will forecast the increased Intermediate care capacity both in terms of bed based and community based services that will be required to meet these trajectories.

There are a relatively small number of conditions which account for a significant proportion of unexpectedly long hospital stays and where therefore there may be most benefit in developing alternatives to acute hospital care. The conditions include

- Stroke – where rehabilitation may be provided in a non acute setting
- Kidney or Urinary Infection
- Pneumonia
- Patients awaiting the results of diagnostic tests
- Chronic Respiratory conditions
- Chronic cardiac conditions

Pathways of care are under development for these conditions. For each pathway any intermediate care component will need to be identified. The volume of home based and bed based intermediate care commissioned will need to be revised and updated on an ongoing basis, as further changes in the way care is delivered take place as a result of practice based commissioning. The process for this needs to be set out to ensure that the lead for intermediate care commissioning can be responsive to future demands.

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What is best practice in the delivery of intermediate care? A recent report of Professor Ian Philp, National Director for Older People[1], outlines key principles in the design of high quality care, including

- Effective Partnership working across the NHS, local government and independent sectors
- Shared (or patient held) health and social care records to achieve "more personalised care and better coordination of services "
- Early intervention in dementia care to enhance quality of life and reduce the need for admission to care homes
- Specialist assessment for people with poor mobility, confusion or who suffer falls
- Community rehabilitation to facilitate reductions in length of stay for patients with conditions such as broken hips, joint replacement, pneumonia and stroke
- Provision of intermediate care facilities alongside emergency departments and medical admission units
- Community Hospitals acting as a hub for local health and social care services for older people providing a centre of excellence in integrated care

Philp estimates that the average SHA could save £5m p.a. through investing £2m in falls prevention services.

However not all this resource needs to be provided in inpatient settings. Indeed the National Evaluation of the Cost and Outcomes of Intermediate Care of Older People advocates the development of non residential forms of intermediate care as these are associated with larger short-term gains in both quality of life and functional improvements for patients treated in residential settings". This suggests there will be a need for a mix of bed-based and non bed-based provision.

The *National Evaluation of Costs and Outcomes of IC for Older People*[2] Commissioned by the Department of Health and the Medical Research Council also supports the provision of intermediate care, suggesting it works best where it is well integrated, well resourced, responsive to referrals and efficiently run.

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[1] *A Recipe for Care – Not A Single Ingredient, Clinical case for change: Report by Professor Ian Philp, National Director for Older People* Department of Health, January 2007

[2] A *National Evaluation of the Costs and Outcomes of Intermediate Care for Older P*eople, Universities of Birmingham and Leicester, January 2006

The report found that admission avoidance schemes are more cost effective and offer greater quality of care than supported discharge. In addition home based care can be more cost effective than bed-based care, but that the latter can offer more in terms of quality of life and functional improvement.

Case management of vulnerable people has been shown to be effective in a number of settings, including the Evercare model used in the USA. In November 2006 an evaluation of the Evercare (UK) model of case management using Community Matrons found that while the model was popular with patients and carers there was no overall effect on emergency hospital admissions[3]. However, the researchers accepted that other models of integrated care for older people can reduce admission rates and costs of care[4].

One alternative to Evercare uses the PARR (Patients at Risk of Re-admission) tool to focus on those patients who are at known as Very High Intensity Users (VHIUs).

A pilot study in Harrow found that autonomous advanced nurse practitioners in primary care managing a defined caseload of high-risk patients could reduce care costs[5] provided that the community matron role was well integrated with other aspects of primary and community care. The Hertfordshire Primary Care Trusts have already implemented some case management programmes and community matron posts. By December 2007 the commissioners will have a robust service specification including identification of the numbers of case managers required per PBC locality. Other studies have also found that prevention of admission is more cost effective than supported discharge[6].

There is also the potential to reduce hospital use through the implementation of the telecare programme which aims to maintain more vulnerable residents at home through the use of wireless technologies[7]. Other studies suggest that intermediate care provided in a community hospital is more cost effective than in an acute hospital setting.[8]

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[3] National Primary Care Research & Development Centre Executive Summary 42. November 2006

[4] Evidence cited in BMJ, 15 November 2006

[5] Health Service Journal, 16 November 2006, pp26-7

[6] A National evaluation of Intermediate Care Birmingham/Leicester (above)

[7] Supporting Self Care: A practical Guide, Department of Health April 2006

[8] Bronagh Walsh et al, British Medical Journal, March 2005

4. Health Needs Analysis

The majority of people using intermediate care services are people aged 65 years and over. Currently, people aged over 65 years old account for 15.4% of the population in Hertfordshire. The common causes of mortality include cancers, coronary heart disease, strokes, pneumonia and a small percentage amount due to accidents. While most of the mortality rates are near or below the national average and generally decreasing since the early 1990s, mortality rates for accidents is higher than the national average (especially for females) and slowly increasing. The mortality rates following fractured neck of femur are also above the national average, especially in females, with the highest rates in west Hertfordshire. Cancers, coronary heart disease, and strokes also contribute significantly to the morbidity and hence to the need for intermediate care services. Accidents and falls and early dementia also make up a significant number of patients receiving intermediate care services.

Table 1 indicates that the population of those aged 65 years old and over will increase by about 3% from the projected 2008 baseline by 2010. The increase in the over 85 year old will increase by 6% by 2010. By 2020 these populations are forecasted to grow by 23% and 40% over and above the 2008 baseline. The forecasted 61% increase in the population over 85 year old in Hertfordshire by 2025 is greater than the national average of 36%. It is in the over 85 year olds that there is a significant increase in the prevalence of diseases such dementia and in the incidence of falls and the resulting fractures.

Table 1 Population projections for both males and females in Hertfordshire

	2008	2010	Percentage increase from 2008 baseline	2020	Percentage increase from 2008 baseline	2025	Percentage increase from 2008 baseline
> 65 years old	164,700	169,800	3.1%	202,200	23%	219,400	37%
> 85 years old	22,900	24,300	6.1%	32,100	40%	36,900	61%

Source: POPP

Table 2 indicates the increase in common conditions for which people received intermediate care, such as rehabilitation post-strokes and falls. Currently older people (aged 65+) occupy 60% plus of hospital beds and of these 40% may have dementia or will develop a mental disorder during the acute admission stay (depression, anxiety) There are likely to be increases in need of 3-4% over and above the 2008 baseline by 2010. The prevalence of these conditions is likely to increase by 23%- 26% by 2020. It is therefore important that future planning of service provision takes account of these increases in need.

Table 2 Projections of specific diseases/ conditions for both males and females in Hertfordshire

	2008	2010	Percentage increase from 2008 baseline	2020	Percentage increase from 2008 baseline	2025	Percentage increase from 2008 baseline
Self reported limiting long-term illnesses	70,088	72,284	3.1%	86,101	23%	94,844	26%
Myocardial infarction	11,514	11,884	3.2%	14,188	23%	15,481	34%
Strokes	4,326	4,473	3.4%	5,348	24%	6,015	39%
Falls (hospital admissions)	3,612	3,714	2.8%	4,402	22%	4,993	38%
Dementia	12,708	13,189	3.8%	16,068	26%	18,112	42%
Severe depression	4,941- 8,235	5,094- 8,490	3.1%	6,066 – 10,110	23%	6,552 – 10,970	33%

Source: POPPI

Despite the ageing population, it is important to note prevention strategies targeted at those currently aged 45 years and over will be necessary to contain and perhaps reduce the need for intermediate care services through a reduction in the prevalence of common diseases such as cardiovascular disease, cancers and strokes. Current initiatives include smoking cessation, encouraging increased exercise and healthy diet. These initiatives are likely to make rehabilitation following myocardial infarction, strokes and falls more effective and help prevent recurrences. In addition, for falls it is important to roll out good examples of falls prevention based on current NICE guidance, with integrated pathways for maintaining good bone health and preventing and managing osteoporosis. The PCTs are in the process of reviewing best practice for falls prevention in order to commission effective falls prevention and management services.

In addition to prevention programmes, it is important build on local good examples of early intervention and assessment, effective management of long-term conditions and early supported discharge from hospital (see later sections for further details).

5. National policy

- Consultation on 'Commissioning for health and Wellbeing (march 2007)
- Our health, Our Care, Our say: a new direction for community services (dates)
- A recipe for care-Not a Single ingredient, Clinical case for change Report by Professor Ian Philip National Director for older People DOH (Jan 07)
- National evaluation of the costs and outcomes of Intermediate Care for Older People, Jan 2006
- NSF for Older People
- NSF for Long term Conditions
- Full commissioning of PCT provider services
- Contestability and development of the market (private, voluntary and NHS provision)

6. Whole systems strategies and reconfigurations

- Hertfordshire Local Area Agreement, Healthy Communities and Older People Block (2006-2009)
- Investing In your health and delivering the required outcome from the Acute Service Review (2007)

7. Workforce capacity constraints and opportunities

Redesign of intermediate care services offers staff real opportunities for career development and improved working environments within which to deliver care.

Staff employment patterns will depend on future geographical service patterns, the volume of bed and home based care as well as other issues related to productivity and skill mix. As part of the Investing in your health consultation workforce profiles were identified to supporter delivery of new pathways of care. These profiles identify skills and competencies required and the extent of role design that will be necessary to deliver more effective local health services.

Workforce development priorities related to intermediate care are;

- Adapting and developing roles to support new models of care
- Re-aligning roles between organisations to reflects shifts of care and support the delivery of clinical pathway
- Increasing case management capacity

The PCTs will explore the potential for a range of providers of intermediate care and associated services. This may include service provision by the PCTs provider arm, NHS Trusts, through Adult Care Services, private providers and third sector development. This optimises the opportunities for increasing workforce capacity. When new services are tendered it will be vital to ensure that providers can recruit the required workforce, with the necessary skills and abilities to meet the service specification.

8. Current service provision

Within Hertfordshire a wide variety of bed and home based schemes have been developed. As elsewhere in the country (ref A National Evaluation of Intermediate Care for Older People, Universities of Birmingham and Leicester, January 2006) there are historical differences in approach, definition, availability of service, funding streams, caseload and quality of management information. There is substantial scope to develop an increased range of intermediate care provision across Herts.

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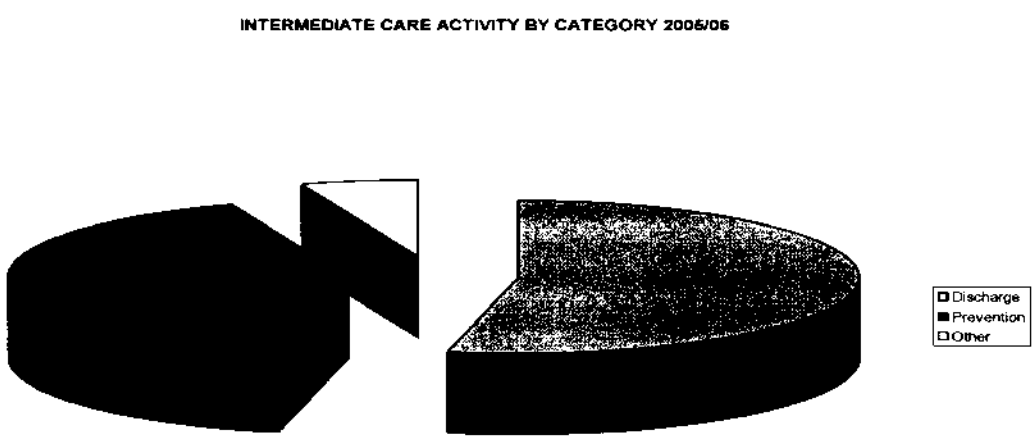
PCT provider services are not exempt from efforts to secure best value for money. If alternative providers represent better value for money, with equal or improved clinical outcomes, they should be commissioned instead. The creation of the two PCTS in Herts from 8 allows the rolling out of best practice and a critical review of services which may not be functioning as well as others.

National evidence suggests that Intermediate Care teams should be integrated with other services. Locally there is evidence of good practice in terms of working with ACS, including the commissioning of service from Westgate house in Ware and the creation of 8 ACS funded intermediate care beds at Bulwer Lytton residential home in Knebworth.

Health and Social Care coordinators, managed by ACS, specialise in the avoidance of inappropriate admission. The full potential of these posts may not have been reached as some of the posts are vacant. Appendix One shows current staffing establishment.

Figure 1 below shows the breakdown of intermediate care activity in East and North Hertfordshire by type of activity. The picture in West Herts is comparable.

Figure 1



8.1 Bed based care schemes

In West Hertfordshire, bed based intermediate care is provided at the following locations

- Chiltern Ward, Gossom's End, Berkhamsted
- Windmill House Bushey
- Langley House Garston
- Holywell ward St Albans
- Sopwell and Langton Wards, Runcie Wing, St Albans
- Potter's Bar Community Hospital

In East and North Hertfordshire, bed based intermediate care is provided in the following locations:

- Herts and Essex County Hospital, Bishop's Stortford
- Hitchin Hospital
- Royston Hospital
- Queen Victoria Memorial Hospital(including Castle Ward), Old Welwyn and Danesbury Home on the same site
- Bulwer Lytton Residential Home, Knebworth; and
- Westgate House, Ware

For historical reasons a number of the community hospitals tend to be outside the main centres of population. Some are modern such as Potters Bar, but some are old and the fabric is relatively poor (e.g. Hitchin Hospital). The layout of older units may not be conducive to modern clinical practice and may require more staff as a result, which can result in diseconomies of scale. Some are also isolated from other healthcare facilities, whilst others are primarily linked to acute hospital providers outside Herts (Barnet & Chase Farm, Princess Alexandra Harlow and Addenbrookes Cambridge).

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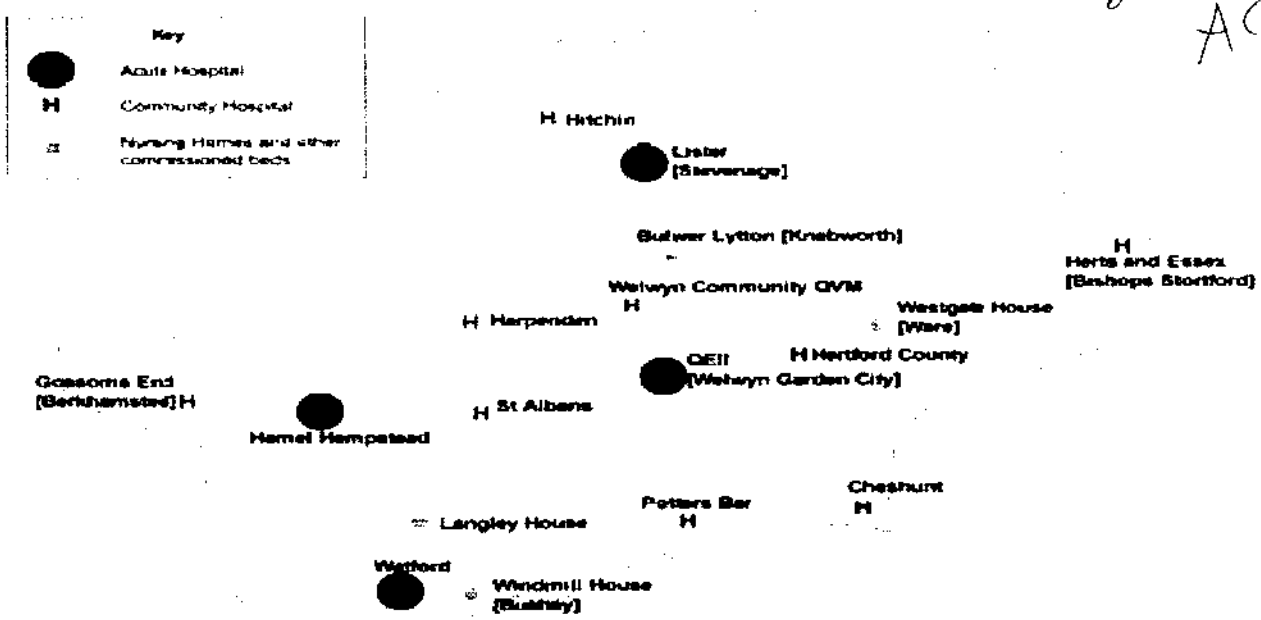
PCT looking @ mapping of where beds are with ACS could commission less intensive beds through ACS



Current location of acute hospitals, community hospitals and other commissioned intermediate care beds.

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Table Three shows total bed capacity, the number of open beds by site, and access to diagnostics for each of these.

Unit	Physical Capacity (beds)	Current Usage (beds)	Designated continuing care beds*	Potential Capacity (beds)	Access to X ray and ultrasound	Access to theatres
Hitchin Hospital	39	20		+19	No	No
Herts & Essex Hospital – Oxford Ward	24	20		+4	Yes	No
Herts & Essex Hospital – Cambridge Ward	20	16		+4	Yes	No
QVM Hospital, Danesbury Unit	30	18	2 (excludes historical respite provision)	+12	No	No
Queen Victoria Memorial Hospital, Castle Ward	40	27		+13	No	No
Royston Hospital	24	18		+6	X Ray only	No
Bulwer Lytton	8	8		Nil	No	No
Westgate House	20	20	17 (4 bed for life HPT)	Nil	No	No
Potters Bar Community Hospital	29	29	4	Nil	Yes	Yes
St Albans City Hospital, Sopwell Ward	19	19	2	Nil	Yes	Yes
St Albans City Hospital, Langton Ward	20	20	2	Nil	Yes	Yes
St Albans City Hospital, Holywell Unit	6	6	counted neurological beds incl.	Nil	Yes complex early stroke	Yes
Gossom's End, Berkhamstead	24	24		Nil	No	No
Windmill House, Watford	43	43	10	Nil	No	No
Langley House	48	32		+16		

East

West

designated stroke beds in each locality but not included in Nat Prog

Data source: Provider Services - August 2007 *Continuing care beds are designated and are included in the total number of beds under current usage.

8.2 Non-Bed Based Care

There are intermediate care teams in all localities in Hertfordshire though there are significant differences from locality to locality in terms of

- The mix of professions delivering care (including nursing and therapies)
- Grade mix
- Hours of access
- Bases
- Balance of work between prevention of admission and supported discharge
- Links with other services, especially social services, primary care and District Nursing
- Specialist services

Health not only commissioners of home based services need to work ε ACS have asked to connect into work of PBC gps

The teams take referrals mainly from GPs, A&E, Medical Assessment Units, social workers and other healthcare professionals. They provide services to prevent unnecessary hospital admission (step-up), speed up discharge from hospital (step-down) and ensure community rehabilitation for patients with long term conditions.

The services are available to adults of any age, but primarily accessed by older adults, generally provided across a range of settings, including the patient's home and/or Residential/Nursing Home.

Patients are accepted by the community based intermediate care team for active rehabilitation with a view to being discharged within 6 weeks. The teams will occasionally take "social referrals" - the aim being to provide appropriate recovery and rehabilitation support, helping older people to regain their independence when they come out of hospital, and just as importantly to prevent them going unnecessarily into hospital.

Want IC team approach has best clinical outcomes 7/7 integ & co-located 8-9 am pm

Watford sDa cannot deliver this need to move to evidence based model

8.3 Management of Very High Intensity Users

With community teams and General Practices, Community Matrons provide "case management" for people who have particularly complex health needs. At present, the Community Matron establishment across Hertfordshire is 24 (Source: LDPR Q1 data).

According to an analysis of the Very High Intensity Users per Practice Based Locality, this has identified the current need for 22 Community Matrons, with each having a caseload of sixty five in accordance with the EoE SHA guidelines. However, with each Community Matron having a caseload of fifty patients, the number of Community Matrons required is 28.5. (Table Four)

In order to provide an equitable service, then each locality should have a number of Community Matrons that roughly matches their population size. The "Proposed Establishment" does this (Table Four) and shows the need for 25 Community Matrons across Herts. Half posts have been included, so that the rates are roughly equal across all localities, which may mean a shared-post across 2 localities or part time workers. It would thus seem reasonable to use this plan now and as the status quo thereafter, as in theory it should generate a similar workload per Community Matron.

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Proposed Community Matron Establishment - Table Four

Locality	VHUI's 40-100% re-admission probability	C.M Caseload (50)	C.M Caseload (65)	Current Establishment	Population	Proposed Population per matron as per LDP	Proposed Establishment	New Posts/ changes	Population per Matron c30,000* Proposed Establishment	New Posts / changes
Watcom PBC Ltd	197	3.94	3.03	**2 (1 Vac.)**	**187,454**	**46,864**	**4**	**2**	**6**	**4**
DacCom PBC Ltd	189	3.78	2.91	**2**	**153,776**	**51,259**	**3**	**1**	**5**	**3**
St Albans Harpenden	157	3.14	2.42	**3**	**129,691**	**43,230**	**3**		**4**	**1**
Hertsmere LMG	170	3.4	2.61	**3 (1 Vac.)**	**96,421**	**48,211**	**2**	**-1**	**3**	
North Herts	89	1.78	1.37	**3**	**114,085**	**45,634**	**2.5**	**-0.5**	**4**	**1**
Welwyn/ Hatfield	102	2.04	1.57	**2**	**111,790**	**44,716**	**2.5**	**0.5**	**4**	**2**
Stevenage	85	1.7	1.3	**3**	**93,455**	**46,728**	**2**	**-1**	**3**	
South Locality	126	2.52	1.94	**3**	**72,924**	**40,513**	**1.8**		**4**	**1**
East Locality	125	2.5	1.92		**49,447**	**41,206**	**1.2**			
North Locality	87	1.74	1.34	**3**	**35,337**	**44,171**	**0.8**		**4**	**1**
West&Central Locality	98	1.96	1.51		**93,133**	**42,333**	**2.2**			
Total	**1425**	**28.5**	**21.92**	**24 (2Vacs)**	**1,137,513**	**45,501**	**25**	**1**	**37**	**13**

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The Community Matron Service will require continual performance monitoring and evaluation in order to meet the needs of the population service. The Key Performance Indicators are outlined in Table Five:-

Acute Prevention of Admission	When a single visit, activity of liaison prevents a patient's admission to hospital. Examples might include: • Liaison with GP to titrate diuretics for someone in acute phase of heart failure • Commencing therapy for an acute exacerbation of COPD or instigating ICT involvement.
Long Term Prevention of Admission	When a number of activities over a longer space of time has prevented the admission of a patient. Examples might include: • Daily visits to monitor effect of drug therapy and liaison with medical staff to titrate / alter drug therapy. • Organisation of respite to prevent the home situation breaking down.
Averted GP Visit	A visit or liaison, which prevents the need for a GP appointment or home visit, or an Outpatient appointment. Examples might include: • Diagnostic physical examination of the patient. • Nurse prescribing of antibiotics or other drug therapy.
Averted Health Professional Visit	A visit or appointment becomes unnecessary due to Case Manager involvement. Examples might include: • Cancellation of consultant outpatient appointments with patient agreement due to extra support now being given. • Community nursing visit not required as specific intervention carried out by CM.
Improved Outcome	An improved health or social outcome as a result of Case Manager intervention. Examples might include: • Improvements in blood chemistry such as HbA1c. • Reduction in exacerbations due to medicine management or teaching active cycle of breathing in COPD patients. • Referral for housing modifications such as stair lifts to aid independence.
Medicine Management	Review or monitoring of medications, which leads to increased compliance, prevention of drug stock piling or removal of items from repeat list.
Key Patient / Carer Support	An intervention, which has led to an improvement in the physical, social or emotional situation of the patient or carer. *Examples might include:-* • Referral for pulmonary rehab. • Bereavement counselling. • Smoking cessation classes. • Benefits or money advice. • Counselling. • Support groups. • Carer assessments.

Evaluation of the pilot scheme in North Herts & Stevenage suggested that the employment of community matrons has been beneficial – resulting in the prevention of unnecessary admissions to hospital and unnecessary A&E attendances[9]. In addition the pilot scheme reduced the number of GP home visits required each week[10]. Hertfordshire PCTs have taken account of published evidence in relation to community matrons and are adopting a PARR[11] approach targeting high risk patients.

Work is currently underway to produce a strategic implementation plan for improving the management of long-term conditions, incorporating targets to be delivered, success measures, a risk management strategy and workforce plan, with a clear financial framework (costs, value for money and potential freed-up resources).

8.4 Prevention of Admission

Within Hertfordshire 41% of new referrals to intermediate care teams are for admission prevention. These referrals are received from many different sources including; GPs (43%), A&E (17%), ACS (10%), District Nurses (9%) and a range of other professionals (21%).

A review of the new step up and step down beds showed that step up patients had an average length of stay of 27 days compared with 37 days for step down[12].

Higher success rates of prevention of admission have been associated with

- a higher proportion of qualified nurses to respond to referrals
- close relationships with GPs and District Nurses
- Availability of specialist clinics/nursing services for e.g. Deep vein thrombosis[13]

[9] Based on full costs per matron at £38,800 assuming 6 matrons covering a weighted populations of c 30,000 = total costs of £232,800

[10] The E&N Herts budget for Community matrons in 2005/06 was £150k in Welhat plus £111k in SE Herts..

[11] Patients at Risk of Readmission

[12] Based on 76 step up admissions and 72 step down admissions January 2006-January 2007.

[13] Based on a review of IC teams in East & North Herts where POA rates varied from 28%-50%

8.5 Speeding Discharge

Speeding or supporting discharge has traditionally been the focus of referrals to intermediate care. Although there is now increasing emphasis on prevention of admission, supporting discharge or "step down" is still an important function of Intermediate Care and still accounts for over half of all referrals. Patients often stay in acute beds for reasons other than their primary admission, for instance because they are awaiting diagnostic tests, awaiting a consultant opinion, awaiting a care package (or a family preference). Various intermediate care services can help reduce this problem.

Discharge referrals to intermediate care teams come from a range of sources, though Orthopaedics and General Medicine account for half of all referrals.

8.6 Falls Prevention

Locally there has been a steady rise in accidents and specifically falls in older people which is similar to national trends. Combined with the often devastating impact that falls can have on older people, it has been agreed that falls prevention work should be a local priority. There are plans to set up a multi-disciplinary group looking at falls prevention to ensure that good practice in terms of NICE and other National Guidance is disseminated across the county. The group will look at all relevant sections from home through to intermediate care and hospital settings. As part of this remit, increasingly the PCT will be working more closely with County Council and Social Services in both the intermediate care and older people's strategy. As part of this remit the group will look at the increasing contribution that new technology such as Telecare can make to falls prevention in older people's homes and their care setting.

8.7 Nutrition

The beneficial effect of good nutrition on recovery from illness has been known for some time. However, research of the last 10 years on the relationship between nutritional status, periods of illness requiring hospital stays and recovery times has provided proof of the matter. At the same time, these and other studies and reports (ACHEW, 1997; Allison, 1999) have shown how difficult it is to achieve good nutritional status whilst ill. In addition the Department of Health Standards for Better Health under the domain for Patient Focus sets that where food is provided, health care organisations have systems in place to ensure that: individual nutritional, personal and clinical dietary requirements are met .The Government has now launched the first ever nutrition action plan which outlines a range of actions to ensure the nutritional needs of older people are better met, which will form part of the future Hertfordshire Intermediate Care Strategic Commissioning Forum agenda.

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8.9Accommodation for frail older people in each District within Herts

Need to describe what each of these models provide

Table Six below shows the number of units, location of scheme, number of bed spaces or units at each scheme, together with the management/owner of the scheme.

changing to this ? what level of support

Area	Care Homes Bed spaces	PCT Community Beds	PCT Continuing Care Block Contracts	Sheltered Housing Units	Extra Care Housing Units	Estimated Additional Accommodation Units Required upto 2010	ACS planning to fund extra care housing places
Broxbourne Borough	**206** (includes 112 Quantum Care Ltd)	**0**	**0**	**830** (*554)	**111** (*60)	**87**	**15**
Dacorum Borough	**692** (includes 137 Quantum Care & Runwood Homes)	**24**	**10**	**1992** (*1908)	**172** (*14)	**99**	**100**
East Herts District	**591** (includes 206 Quantum Care & Runwood Homes)	**88**	**59**	**1281** (*1122)	**53** (*24)	**122**	**110**
Hertsmere Borough	**728** (includes 183 Quantum Care)	**72**	**0**	**1342** (*867)	**142** (*45)	**11**	**10**
North Herts District	**894** (includes 242 Quantum Care)	**71**	**0**	**1615** (*1104)	(*17)	**30**	**95**
(*socially rented schemes managed by registered social landlords)							

very successful

peripatetic care teams support IC beds

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

Area	Care Homes Bedspaces	PCT Community Beds	PCT Continuing Care Block Contracts	Sheltered Housing Units	Extra Care Housing Units	Estimated Additional Accommodation Units Required upto 2010	ACS planning to fund extra care housing places
St Albans City & District	**784** (includes 236 Quantum Care)	**65**	**0**	**1007** (*478)	**0**	**60**	**75**
Stevenage Borough	**166** (includes 85 Quantum Care & Runwood Homes)	**0**	**6**	**1254** (*1170)	(*45)	**71**	**55**
Three Rivers District	**447** (includes 207 Quantum Care)	**0**	**0**	**950** (*746)	**244**	**43**	**60**
Watford Borough	**511** (includes 120 Quantum Care & Runwood Homes)	**48**	**20**	**1148** (*751)	(*32)	**13**	**55**
Welwyn Hatfield District	**423** (includes 106 quantum Care)	**70**	**27**	**2778** (*2550)	(*27)	**83**	**75**
(*socially rented schemes managed by registered social landlords)							

8.9 Available and Planned Bed Spaces

In Hertfordshire there are a total of 5442 bedspaces provided in Care Homes who have accepted Herts County Council contract terms and conditions. There are a total of 438 PCT Community beds; plus 122 Continuing Care block beds. There are a total of 14,197 sheltered housing units and 843 extra care housing units. Hertfordshire County Council have estimated that 619 additional units of accommodation for older people will be required in the period upto 2010. This provision will be met through extending and re-modelling existing services. ACS are planning to fund the revenue costs of a further 650 extra care housing places as an alternative to residential care. This analysis does not include the demand for private extra care, private retirement housing or private residential care (Ref: 'Accommodation for Fail Older People : county Wide Strategy, July 2007).

9. Activity and costs of current service delivery

The average cost per bed in East and North is £269.61 and in the West is £222.42. These are inclusive of direct and indirect costs but come with major cautions and caveats. Preliminary work estimates the cost per bed day on a local general hospital site at £175 and this figure has been used in the financial calculations below.

The average cost of a home based intermediate care service is £740 per referral. This is based on the cost per annum of the Intermediate Care Teams in East and North Hertfordshire and in Hertsmere.

10. Comparative use of services to national average and trends

Nationally there is little available comparison and trends analysis information for intermediate care. As with current service delivery in Hertfordshire it should be acknowledged that intermediate care services vary in their delivery and therefore the limited data that is available for the East of England does not measure 'like for like' services.

11. Resource prospects

11.1 Sizing of capacity required for Step Down Intermediate Care

Table Seven - Data and modelling for step down care:

Excess Bed Days Over the Trim Point in Acute Beds, 06/07 Data, 7 Key				
Trust		**Bed Days**	**Spells**	**Long Stay Top Up Cost £'000**
E&NHT	elective	2,804	205	1,016
	emergency	13,273	972	2,394
WHHT	elective	3,200	312	584
	emergency	14,587	1,420	1,376
B&CFHT	elective	898	61	315
	emergency	4,250	292	743
PAH	elective	489	46	170
	emergency	2,313	215	400
CUHFT	elective	95	11	34
Emergency		447	52	80
Total		**42,355**	**3,586**	**7,111**

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

Other providers outside the County have been excluded as it may not be possible to develop the Intermediate Care pathways with them required to remove the excess bed days. The volume (and associated costs) in these Trusts is relatively small.

The data has been developed using local information about available alternative provision for patients, to produce excess bed days. This supposes:

10% returned to their home without requiring additional services (i.e. no additional investment required in the community, to be achieved through more effective and efficient discharge processes and efficiencies in the pathway).

30% to Intermediate Care home based services.

60% to Intermediate Care bed based services.

From the Acute Services Review the proposed shift from acute hospital bed days will be phased over three years. This shift is now phased to start in 2008/2009, and the assessment of the capacity required is

08/09 25% 09/10 25% 2010/11 remaining 50%

Extrapolated from Table Seven data

Intervention	**No of Spells (people)**	**Excess Bed days saved**	**Financial saving**
Returned home (10%)	358	4233	£713k
Intermediate Care home based (30%)	1614	19061	£3199k
Intermediate Care Bed Based (60%)	1614	19061	£3199k
Cost to re-provide these services needs to be deducted from savings			

11.2 Sizing of capacity required for step up intermediate care

Table Eight describes step up beds that may be required to meet the additional prevention of admission work from the 20% reduction in LTCs, based on average 3 days and 5 days length of stay.

		Elective Spells	Non Elective Spells	20% Non Elective Spells to be Reduced	Assuming 3 days LOS	Assuming 5 days LOS
Asthma	Barnet and Chase Farm Hospitals NHS Trust	1	109	22	65	109
	Cambridge University Hospitals NHS Foundation Trust	1	37	7	22	37
	East and North Hertfordshire NHS Trust	7	391	78	235	391
	Essex Rivers Healthcare NHS Trust		3	1	2	3
	Hertfordshire Partnership NHS Trust		62	12	37	62
	Luton and Dunstable Hospital NHS Foundation Trust		11	2	7	11
	St Albans and Harpenden PCT		1	0	1	1
	The Princess Alexandra Hospital NHS Trust		54	11	32	54
	West Hertfordshire Hospitals NHS Trust		305	61	183	305
Asthma Total		**9**	**973**	**195**	**584**	**973**
Congestive heart failure	Barnet and Chase Farm Hospitals NHS Trust		65	13	39	65
	Cambridge University Hospitals NHS Foundation Trust		11	2	7	11
	Luton and Dunstable Hospital NHS Foundation Trust		7	1	4	7
	East and North Hertfordshire NHS Trust – Estimate based on WHHT as no specific coding data available		200	40	120	200
	St Albans and Harpenden PCT	4	2	0	1	2
	The Princess Alexandra Hospital NHS Trust		31	6	19	31
	West Essex PCT		1	0	1	1
	West Hertfordshire Hospitals NHS Trust	4	195	39	117	196
Congestive heart failure		**8**	**512**	**102**	**307**	**512**
COPD	Barnet and Chase Farm Hospitals NHS Trust	2	271	54	163	271
	Cambridge University Hospitals NHS Foundation Trust		29	6	17	29
	East and North Hertfordshire NHS Trust	8	650	130	390	650
	Luton and Dunstable Hospital NHS Foundation Trust		17	3	10	17
	Royston, Buntingford and Bishop's Stortford PCT		1	0	1	1
	St Albans and Harpenden PCT		1	0	1	1
	The Princess Alexandra Hospital NHS Trust		104	21	62	104
	Watford and Three Rivers PCT	1		0	0	0
	West Hertfordshire Hospitals NHS Trust	6	618	124	371	618
COPD Total		**17**	**1691**	**338**	**1015**	**1691**

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

Diabetes	Barnet and Chase Farm Hospitals NHS Trust	2	59	12	35	59
	Cambridge University Hospitals NHS Foundation Trust	3	17	3	10	17
	East and North Hertfordshire NHS Trust	20	245	49	147	245
	Hertfordshire Partnership NHS Trust		14	3	8	14
	Luton and Dunstable Hospital NHS Foundation Trust		9	2	5	9
	Royston, Buntingford and Bishop's Stortford PCT	3		0	0	0
	St Albans and Harpenden PCT	1	2	0	1	2
	The Princess Alexandra Hospital NHS Trust	6	45	9	27	45
	Watford and Three Rivers PCT	3		0	0	0
	West Hertfordshire Hospitals NHS Trust	12	266	53	160	266
Diabetes Total		**50**	**657**	**131**	**394**	**657**
Hypertension	Barnet and Chase Farm Hospitals NHS Trust	1	8	2	5	8
	Cambridge University Hospitals NHS Foundation Trust	1	3	1	2	3
	East and North Hertfordshire NHS Trust	10	46	9	28	46
	Hertfordshire Partnership NHS Trust		2	0	1	2
	Luton and Dunstable Hospital NHS Foundation Trust		1	0	1	1
	St Albans and Harpenden PCT		1	0	1	1
	The Princess Alexandra Hospital NHS Trust		11	2	7	11
	West Hertfordshire Hospitals NHS Trust	5	34	7	20	34
Hypertension Total		**17**	**106**	**21**	**64**	**106**
Total number of spells to be prevented				**788**	**2363**	**3939**

For 3 day length of stay if all 2363 bed days are required at 85% occupancy = 7.62 means 8 additional beds
For 5 day length of stay if all 2363 beds are required at 85% occupancy = 12.70 means 13 additional beds

These are relatively short length of stays in intermediate care beds as they assume that the patients do not require high medical input for nursing and access to diagnostics.

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

Stepdown

PCT funded more beds potentially work = WHHT as commissioners that they commission as in tariff Subacute move off Watford site (in tariff) ? + commission with them on same model

Table Nine : Summary of capacity requirements and costs of additional provision

	East and North				West			
	Beds	Beds	Intermediate Home Care	Intermediate Home Care	Beds	Beds	Intermediate Home Care	Intermediate Home Care
		£'000	Episode	£'000		£'000	Episode	£'000
2008/09	9	517	209	154	16	862	=people 195	144
2009/10	9	517	209	154	3	230	195	144
2010/11	17	977	417	308	5	287	390	288

TL going to open 16 beds @ Hemel 1/7/08

Following looking

Will need to open extra 16 beds this year

? Additional beds for winter period → Elderly Assmt Unit

Need to comfortable that when AAU opens no gap

11.3 Assumptions

The following assumptions have been in the sizing of capacity for intermediate care;

- The excess bed days can be removed from the Acute sector by achieving 10% efficiency, 30% care to Intermediate Care at home and 60% care to community bed based services. The data can be remodelled if localities wish to pursue a different split.
- The excess bed days in the Acute sector translate to capacity required within Intermediate Care. There may be a potential for more efficiencies to be made on top of 10%.
- A constant bed occupancy of 95% has been adopted. This does not allow for peaks and troughs of demand throughout the year or in particular areas of the County.
- There is no allowance for 'length of stay' in the Intermediate Care home based service.
- The excess bed day data is taken from seven specialties only. These are Cardiology, Gastroenterology, General Medicine, General Surgery, Geriatric Medicine, Nephrology and Trauma & Orthopaedics.
- The calculation of capacity does not include taking patients from acute care before trim point or splitting the tariff.

11.4 NHS Continuing Healthcare and NHS-funded Nursing Care

From October 1st, 2007 new directions, which outline the PCTs responsibilities, come into force. The combined effect of these direction on NHS provider services will be to increase the volume of assessments to screen patients for eligibility for NHS Continuing Healthcare, prior to referral to Social Services, prior to discharge from hospital. This may not necessarily result in a higher demand for continuing care in the short term; however there may be an impact on the acute hospital length of stay whilst these patients are undergoing assessment. Evidence suggests that older people and those with complex problems take longer to recover following illness/operation and that earlier continuing care assessments may result in allocation of continuing care funds, and premature placement which may not be in the best long term interest of the patient. A short period of step down rehabilitation in an intermediate care service prior to full continuing care assessment may benefit some patients. Currently intermediate care services do not provide this capacity although the principle is being piloted on a very small scale in Westgate House. Further work is taking place to identify if additional intermediate care capacity for this group of patients is required, in addition to the capacity arising from the ASR.

12. Options for meeting future needs

12.1 Future provision on intermediate care services

The future provision of intermediate care needs to be responsive to the following challenges;

- Category One

Meeting the capacity for step down intermediate care, responding to the reduction of excess bed days and shifts arising as part of the Acute Services review and modernisation of services. This care has been defined as category one and may suitably be provided in patients own homes and in bed based provision.

- Category Two

Responding to increased demand for step up intermediate care, particularly in the management of patients who are known or Potentially very high intensity users of acute services such as those with asthma, congestive heart failure, chronic obstructive airways disease and diabetes and for older people. These patients require rapid access to diagnostic services, and services which may be available currently within the acute hospital setting. Between 2008/2009 and through to 2010/2011 it is envisaged that these patients will usually require admission to a bed based intermediate care service in facilities on the same site as diagnostic services. As the range and location of diagnostic services increases, and with technological advances, there will be opportunities to increase the provision of category two care in patients own homes and in sites which are not in geographical proximity to the diagnostic units.

The future provision of intermediate care may be through a range of providers and in different settings. All intermediate care services must be provided by integrated multi-disciplinary teams with rapid access to Consultant medical input when required. Providers will need to be explicit about the category of intermediate care they are able to provide and for those electing to provide category two care there must be clear pathways of care to enable the rapid and easy access to diagnostics that this patient group require.

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

As part of the implementation of the Acute Services Review, and in order to support the reduction of excess bed days and inappropriate admissions the PCTs will need to commission daytime assessment unit and or emergency clinics at Hemel Hempstead General Hospital and the local general hospital in East and North Herts. These units will need to be led by Consultants in the Care of the Elderly and those managing Long term Conditions, treating older people less likely to require admission, through either GP or other healthcare professional referral (i.e. Community Matrons, Nurse Practitioners). If admission was deemed necessary the patient would be transferred to intermediate care services or to one of the acute hospitals. Overall this would remove the need for anything other than local travel and lessen the demand on the acute hospital site diagnostic services. If admitted to an acute hospital the patient should be transferred back to a local step down intermediate care facility (home or bed based) once the acute episode is under control.

In conjunction with the PCTs local Practice based commissioning groups will need to make the following considerations when developing their business cases, and developing criteria to procure intermediate care services;

- The additional capacity requirements as set out in Table Nine are met
- There is clear definition from providers of the category of intermediate care they wish to provide, and delivery to the agreed care pathways is demonstrated
- Services demonstrate a robust integrated governance framework which can assure clinical quality and cost effectiveness. This includes ensuring an optimum clinical environment. As a result of this there may be implications on where and how current services are delivered, with a requirement to review the effectiveness of smaller 'stand alone' units which are in fairly close proximity to the local general hospitals. For example commissioners and providers will need to review the estate, clinical and cost effectiveness of sites such as the Queen Victoria Memorial Hospital in Welwyn and Gossom's End in Berkhamsted, as well as exploring the opportunities presented by non NHS providers for delivery of intermediate care within new build homes such as those under development in Hatfield and Hemel Hempstead.
- All commissioners agree on what is to be purchased, select from the best possible alternatives and consider the impact any changes may have on existing services.

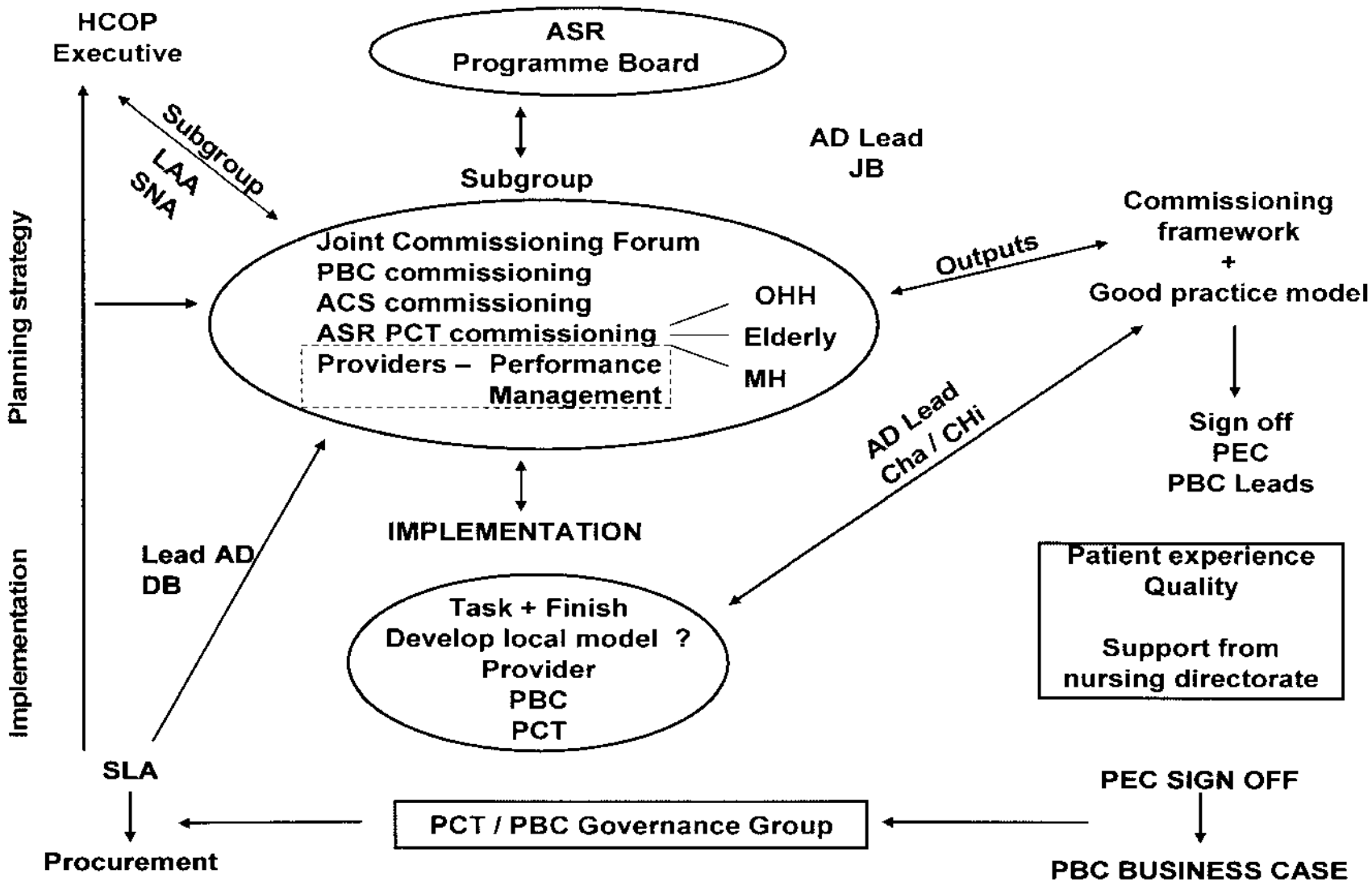
12.2 Intermediate care commissioning cycle

The intermediate care commissioning cycle is a complex one, by virtue of the range of organisations involved. The following key stages have been proposed and work is taking place to confirm the process required;

- Overall strategic direction set within the Intermediate Care Joint Commissioning Forum (PCTs/PBC and ACS), in response to the Acute Services review and PCTs strategy
- Strategic commissioning framework and good practice models developed
- Approval of strategic commissioning framework and good practice model by the Professional Executive Committee (PEC) and PBC leads.
- Implementation of service redesign process and local care pathways in locality 'task and finish' groups. This will need to include a description of the various models of care and pathways, service specifications and the resources required to support them, joint assessment processes and the expected outcomes .
- Approval from PEC for service redesign and care pathways.
- PBC to develop business case for commissioning of services
- Business case approved at PBC governance committee
- Procurement commences
- Service level agreement established and subsequently performance managed as part of the Joint Commissioning forum.

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

INTERMEDIATE CARE COMMISSIONING



13. Process to achieve desired change

The implementation plan for the commissioning of intermediate care beds will be incorporated in the timetable for the Acute Services Review and will be specified within the ASR programme. Components will include the following;

- Project management
- Stakeholder involvement and public engagement/communication
- Risk assessment
- Service redesign, pathway development and Service Specifications
- Business case development
- Procurement

INTERMEDIATE CARE COMMISSIONING FRAMEWORK

APPENDIX ONE

Appendix one shows the current establishment of Health & Social Care Co-ordinators across Herts

Health and Social Co-ordinators in Hertfordshire

Locality	Establishment	In Post
Watford Dacorum Three Rivers	**3 WTE**	1.8 WTE, 2.6 WTE Social Workers working with & co-located in Intermediate Care deployed from area and hospital establishment
St Albans and Hertsmere	**2 WTE**	2.9 WTE, 0.5 post funded by PCT. 1WTE Community Care Officer
North Herts/Stevenage/ Welwyn and Hatfield	**3 WTE**	Converted HSCC posts to 1WTE Senior Practitioner, 2 WTE Community Care Officers
South East Herts	**2 WTE**	1 WTE temporarily designated Intermediate Care Social Worker. 1 WTE Community Care Officer
SMHTOP	**1 WTE**	1 WTE

Data Source: Adult Care Services: September 2007