JOINT INTERMEDIATE CARE AND RE-ABLEMENT STRATEGY 2011 – 2014

CONTENT

1. EXECUTIVE SUMMARY

- This strategy has been developed jointly by NHS Enfield and Enfield Council. It is a joint health and social care strategy which specifies how Enfield intends to commission Intermediate Care and Re-ablement services over the next 3 years (2011 - 2014) in order to improve the quality, effectiveness and efficiency of current service provision.

- Commissioners from Health and Adult Social Care have worked with the local Intermediate Care and re-ablement service to analyse the current picture of service provision and develop strategic objectives and evidence based commissioning intentions. We have been guided by local and national policy and guidance and by the priorities set out in Enfield's Joint Strategic Needs Assessment.

What is Intermediate Care?

- The term 'Intermediate Care' covers a wide array of services which are characterised by the following features:-

    - They are aimed at helping people avoid prolonged hospital stays or inappropriate admission to acute in-patient care, long-term social care or continuing NHS in-patient care.

    - They feature comprehensive assessment and outcome-focused rehabilitation aimed at maximising independence and enabling people to resume normal living.

    - They typically comprise multi-professional, multi-agency working.

    - They are time-limited, usually between 1-6 weeks.

- These services are central to the delivery of a number of key national policies, including the National Service Framework for Older People, management of long-term conditions, and avoiding acute hospital admission.

- Of equal importance, effective Intermediate Care services are very popular with patients, particularly older people who value their independence and ability to remain at home rather than being admitted to hospital.

What is Reablement?

- The term 'Re-ablement' describes the use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long-term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on re-abling people within their homes so they achieve their optimum, stable level of independence with the lowest appropriate level of ongoing support care.

- Evidence shows that timely bursts of social care Re-ablement can either prevent hospital admission or post-hospital transfer to long-term care, or appropriately reduce the level of ongoing home care support required. Re-ablement complements Intermediate Care services and the benefits include:-

- maximised independence;
- minimised whole life cost of care[1].

The Picture in Enfield Today

- Enfield's Intermediate Care service comprises a mix of multi-disciplinary community teams providing home-based care; nurse consultant led community hospital care for acute admission avoidance; and consultant led hospital care purchased from neighbouring Boroughs to facilitate timely discharge from acute care.

- Whilst there is considerable expertise and enthusiasm at managerial and operational level across the range of commissioned services, there is evidence of some duplication of service provision and gaps in the services available.

- Enfield Council operate a Home Care team providing long-term support with a range of personal and domestic tasks to assist people to remain in their homes for as long as it is reasonable to do so.

- The strategic direction for modernising adult social care services means that Home Care teams need to change the way in which they work in order to provide services which promote independence. For Enfield, this means integrating the current in-house Home Care team with the hospital discharge component of the Intermediate Care service and creating a dedicated Re-ablement Service; work on this has already commenced and the new service will become fully operational on 11 April 2011.

- The changes to Enfield Councils home care and Intermediate care services are part of a wider programme of service redesign and the development of a new operating model for social care services. This is in response to the governments personalisation agenda and aims to benefit service users by:

  - Providing a single point of access;
  - providing a more responsive service by ensuring that requests for assistance are processed in a way that is proportionate to the persons circumstances and needs;
  - Embedding of re-ablement within the customer pathway to deliver timely interventions to maximise a persons opportunity to regain skills, confidence and independence; and
  - Increased flexibility delivering choice and control enabling people to self direct the support to achieve the outcomes required to meet their needs.

Finance and Funding

- This strategy has been developed in the context of an extremely challenging financial environment. Councils are being asked to reduce their budgets year on year, and NHS organisations are working hard to improve their financial position and reduce their deficits. One of the key aims of this strategy is to ensure that Intermediate Care and Re-ablement services are commissioned effectively in

[1] CSED website: http://www.dhcarenetworks.org.uk/csed/homeCareReablement/

order to reduce unnecessary use of costly acute hospital beds and delay entry to long-term residential and nursing care.

- Approximately to £6.6 million per annum is currently invested in the range of health and social care commissioned Intermediate Care and Re-ablement services in Enfield.

- A review of services in 2010 indicated that there was spare capacity within the current service to address future need and considerable potential for redesign to increase productivity and to achieve maximum efficiency.

- By decommissioning hospital based Intermediate Care Services provided in neighbouring Boroughs and further investing in the development of services provided in Enfield, it is estimated that, across health and social care, savings of approximately £1.34 million can be made while at the same time provide higher quality, person-centred services.

- In order to achieve these savings, additional funding of £1.24 million over 3 years (2011/12 – 2013/14) will be invested in Intermediate Care and Re-ablement services. This additional funding will be allocated from the NHS Support for Social Care: 2010/11 – 2012/13 allocations set out in the 2011/12 NHS Operating Framework.

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

Strategic Objectives

1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE
Individuals will receive their care in the right place, at the right time. ***We will reduce the cost of acute hospital care and manage increasing projected demand.*** Identify a Single Point of Access (SPA) for Intermediate Care services across Enfield which is readily identifiable and accessible to all referrers and which is promoted widely. Develop an integrated health and social care I.T system. Commission an increased provision of the full range of step down and admission avoidance Intermediate Care beds within Enfield. Decommission out of borough Intermediate Care beds and develop agreements to spot-purchase from alternative hospital and community based providers where demand exceeds local capacity. Increase the capacity of Intermediate Care to provide in-reach to care homes.

Develop clear care pathways

Develop the capacity of the current rapid response component of the Intermediate Care Hospital Avoidance team to provide urgent community based assessment and immediate intervention in people's homes.

Develop the ability of the Intermediate Care service to deliver intravenous therapy at home.

2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY

Assessment and decision making about peoples long term care needs will only be made only after they have had the opportunity for rehabilitation, recuperation and recovery

Ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement.

Implement a unified assessment process, trusted by all with appropriate information shared between partners.

Adjust the time limited criteria currently in place across Intermediate Care, to ensure that individuals with more complex needs have equity of access for assessment and rehabilitation, prior to decisions being made about their longer-term needs.

Determine a clear Re-ablement pathway that links Re-ablement with the self-directed support processes.

3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING

Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community.

Integrate Re-ablement into the customer journey by reconfiguring the provision of in-house Home Care and ensuring an integrated continuum of service provision.

Develop a person centred 'menu based' approach to service provision.

Ensure a dedicated care management service to the Intermediate Care step down and admission avoidance beds to ensure that people are able to move through the whole system in an appropriate and timely manner.

Integrate the health and social care Intermediate Care teams to ensure that the full needs of the client can be met by the service.

Invest in Assistive Technology to support people to remain in their own homes.

Transfer management of people with Chronic Obstructive Pulmonary Disease to Primary Care.

Address the absence of a Community Therapy service, ensuring that this links with

the service redesign programme currently underway in Enfield.

Continue to commission low level Re-ablement Services from the 3rd sector.

4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE

Investing in workforce development will allow the current services to support people with more complex needs thereby reducing hospital admissions, admissions to care homes and home care hours.

Ensure there is ready access to the specialist skills required to enable Intermediate Care to support people with long-term conditions, including those individuals with dementia and mental health needs.

All Intermediate Care staff will receive core training in dementia, and appropriate access to professional support.

5. DELIVER MORE COST EFFECTIVE SERVICES IN ORDER TO MEET CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES

Within the current and future financial and political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.

Ensure cost effective service delivery and monitor outcomes of Intermediate Care and Re-ablement service to ensure that the service meets the desired outcomes of the individual and their carers.

Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget.

Commission a longitudinal study to track the impact of the redesign of Intermediate Care services on;

- admissions to long term care
- hospital readmissions
- home based packages of care
- self care
- user and carer satisfaction
- Cost.

6. ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE

Monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.

Develop and implement a robust performance management framework to ensure that future Intermediate Care provision meets identified needs and achieves desired outcomes.

Ensure that Intermediate Care has a robust governance framework.

2. INTRODUCTION

NHS Enfield and Enfield Council have identified Intermediate Care and Re-ablement services as a key priority within the overarching Personalisation agenda. The development of Intermediate Care, and its integration with social care Re-ablement, is seen as essential to the transformation of health and social care and to maximising people's independence.

NHS Enfield and Enfield Council are committed to investing in a unified Intermediate Care framework across Enfield and have agreed to commission jointly a service for the population of Enfield that:-

- Promotes faster recovery from illness;
- Prevents unnecessary acute hospital admission;
- Prevents premature admission to long-term residential care;
- Supports timely discharge from hospital;
- Maximises independent living;
- Facilitates timely hospital transfer;
- Ensures re-admissions to hospital are avoided as appropriate;
- Is 'joined up' across health and social care with clear and easy to recognise access points and care pathways;
- Increases access to those with complex needs including those with dementia;
- Ensures the focus is on achieving outcomes for individuals;
- Makes optimum use of Telecare and Telehealth;
- Is of a high quality and based on best practice and research;
- Has a robust performance management framework;
- Works within an agreed governance framework.

This strategy describes how each of these elements will be achieved and progress monitored over the next three years.

3. NATIONAL AND LOCAL GUIDANCE AND RESEARCH

National Guidance and Policy Context

There is a national drive towards enabling patient choice and developing services that are responsive to individual needs (or 'personalised'). This agenda is outlined in the Department of Health White Paper "*Our Health, Our Care, Our Say"* (2006) which sets out a fundamental change in the way in which services are delivered. Of relevance to the development of Intermediate Care and Re-ablement services are the objectives of shifting resources into preventative services; providing care closer to home; further development of joint commissioning; and encouraging innovation through direct payments and individual budgets.

Following on from this, the Department of Health published *"Putting People First"* (2008), which outlined a radical reform of the way that health and social care services are delivered. The requirements set out in this document build on *"Our Health, Our Care, Our Say*" (2006) and describe a vision for transforming the adult health and social care system from one which intervenes at the point of crisis to one which helps people to remain healthy and independent and maximises individual choice and control.

The Department of Health published its original Intermediate Care guidance in 2001[2] which was incorporated within the *"National Service Framework (NSF) for Older People"* 2001[3] . Since 2001, there have been numerous policy developments and considerable investment in the whole health and social care economy and in July 2009 the updated guidance, "Intermediate Care – Halfway Home"[4] was published.

The *"Intermediate Care – Halfway Home"*, July 2009 guidance informs local health and social care economies to ensure that:-

- Intermediate Care is widely available to support a diverse range of service users to promote their independence in the community.
- Lean thinking methodology is used to develop pathways which ensure timely transfers from acute settings.
- There is an effective alternative to avoidable hospital admissions.
- There is the widest access to Intermediate Care, underpinned by a collaborative approach
- Assessment and decision making of an individual's longer term care needs is undertaken outside of an acute setting, in a rehabilitative and re-enabling environment.
- The number of individuals requiring readmission to hospital is minimised.
- There is a reduction in the number of service users requiring formalised care.
- That assessment for, and delivery of Assistive Technology, is an integral part of Intermediate Care provision.

The *"Personal Care at Home Act"* (2010)[5] which amends the 2003 Act and introduces the provision of free personal care at home is also relevant to this strategy. The Act includes a new provision that gives local authorities the power to make a person's eligibility for free personal care conditional on the person undergoing a process designed to maximise the person's ability to live independently. This could include a short period of intensive and focused Re-ablement to maximise the person's independent living skills.

In May 2010, the Secretary of State indicated that Health and Social Care economies must be influenced by the following emerging priorities:

- Patients must be at the heart of everything, not just as beneficiaries of care, but as participants, in shared decision-making. As patients, there should be no decision about them, without them.
- The focus for Health and Social Care should be to seek to achieve continuously improving outcomes. Not simply measuring inputs or constant changes to

[2] Department of Health *Intermediate Care* 2001 Health Service / Local Authority Circular HSC 2001/001

[3] Department of Health *National Service Framework for Older People* 2001

[4] Department of Health *Intermediate Care – Halfway Home* 2009

[5] Department of Health *Personal Care at Home Act - 2010*

structures, but a consistent, rigorous focus on outcomes which achieve results for patients.
- Professionals are empowered to deliver. This is the only way we can secure the quality, innovation, productivity and safe care, all of which are essential to achieving those outcomes.
- As a society, focus should concentrate on improving the health and well-being and of preventing ill-health more effectively, of families and communities. This will result more in the overall health outcomes being sought, not just good health services but good population-wide health outcomes, and reduce the inequalities in health, which so blight our society.
- Health and social care should be more integrated. Whether provided by their families, by carers, by support workers or by health professionals, all are part of a spectrum of care for those in need. There is a need to reform social care alongside healthcare, so that we can support and empower people – not least as individuals – to be more safe and secure and, themselves, to be able to exercise greater control over their care.

In November 2010, the Care Services Minister Paul Burstow launched "A vision for adult social care: Capable communities and active citizens ". The Vision sets out how the Government wishes to see services delivered for people; a new direction for adult social care, putting personalised services and outcomes centre stage.

Alongside the launch of the new vision for social care, the Government is supporting an expansion of re-ablement across the NHS and social care, with £70m in new resources in 2010/11 and up to £300m a year earmarked for re-ablement in the next Spending Review period. In addition to this, the 2011/12 NHS Operating Framework provides details of separate PCT allocations for social care, totalling £648m in 2011/12 and £622m in 2012/13.

The Health and Social Care Bill 2011

The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients, led by health professionals and focused on delivering world-class healthcare outcomes.

The Bill takes forward the areas of Equity and Excellence: Liberating the NHS (July 2010) and the subsequent Government response Liberating the NHS: legislative framework and next steps (December 2010), which require primary legislation. It also includes provision to strengthen public health services and reform the Department's arm's length bodies.

Of relevance to the successful implementation of this strategy, is the development of GP consortia who will become responsible for the commissioning of health services.

Definition of Intermediate Care

The original guidance described Intermediate Care as a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, prevent premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

The definition included services that met 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 developing care plans that are person-centred and reflect the individual's outcomes. The timescales for reviews are incorporated into these.
- They involve cross-professional working, with a single assessment.
- 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 other mental health needs.
- Flexibility over the length of the time-limited period.
- Integration with mainstream health and social care services.
- Timely access to specialist support as needed.
- Joint commissioning of a wide range of integrated services to fulfill the intermediate care function, including social care re-ablement.
- Governance of the quality and performance of services.
- Clarity on where decision-making falls.

Providers of Intermediate Care

"Halfway Home" states that the services that might contribute to the Intermediate Care function include:-

- Rapid response teams to prevent avoidable admission to hospital for patients referred from Primary Care, Accident and Emergency or other sources, with short-term care and support in their own home;
- Acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics;
- Residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks;
- Supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing;
- Day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

Arrangements for providing local authority home care, day care and residential care free to the user, where they are an integral part of an Intermediate Care package, remain unchanged from the guidance issued in 2001.

The core service should generally be provided in community-based settings or in the person's own home, but a range of services is likely to be needed, including beds in residential settings, some with nursing care. It may include a rapid response team to provide assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. It could also include more intensive support and treatment in the person's home to avoid admission or to facilitate discharge, sometimes described as 'hospital at home'. Part of the service should be available on a 24-hour, seven days a week basis, with access to assessment.

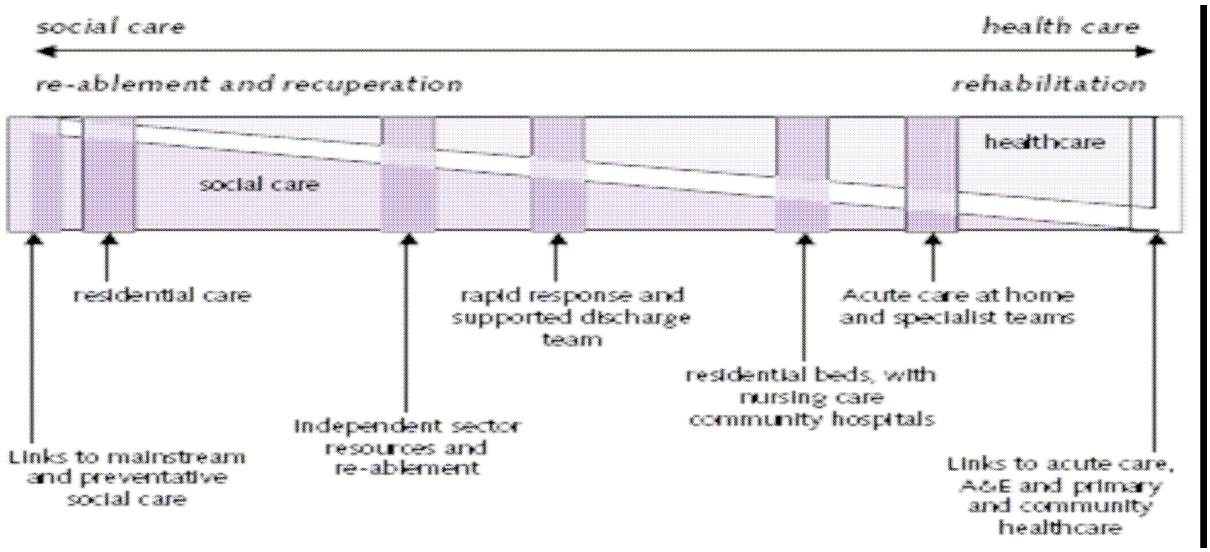
Some services make greater use of residential beds, while others provide more care at home or in day care settings or resource centres, with therapies available. In some areas, the service might be able to manage with fewer beds if it employed more 24-hour community-based staff. Some beds may be provided in care homes, possibly linked to long-term placements, but the Intermediate Care function should be distinct and be related to short-term goals.

Sheltered or extra care housing can be part of Intermediate Care, providing a range of options with input from the core team. Rapid care and repair services can also enable people to move back home who might otherwise have remained in hospital or a residential setting. Technology such as Telecare can also enable people to remain at home safely and independently who might otherwise have needed either residential care or more intensive home care.

Types of Intermediate Care provision

Intermediate Care is a function rather than a discreet service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, as illustrated below, spanning acute and long-term care, linking with social care re-ablement.

Figure 1: The continuum of Intermediate Care (adapted from Brophy 2008)



Since the components of the Intermediate Care service vary, depending on the context of other local services, it should provide the function of linking and filling gaps in the local network. For example, a crisis response service for older people who fall, resulting in minor injury, might be provided by the Intermediate Care service in some areas, but in others it might be provided by primary care or by the Ambulance Service. What is important is that the service is available and all agencies know about it.

Intermediate Care should also encompass a wider preventative role, aiming to promote confidence building and social inclusion, thus avoiding the need for institutional care or intensive home care at a later date. It should link closely with social care Re-ablement, acute or urgent healthcare (including out of hours primary care services), Accident and Emergency, community health services and management of long-term conditions, primary health care, domiciliary social care, day care and residential or nursing care homes.

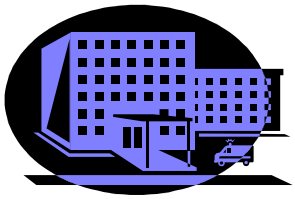
Effective links are necessary so that potential users are referred into the service from any of these services as soon as the need arises. It can be useful to have some staff located close to Accident and Emergency. General Practitioners in particular need to be well informed about the service, as well as acute trusts.

The Intermediate Care function should be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management. This might be best achieved with a single manager, although it may consist of a number of multi-agency teams and facilities.

The following diagram (Figure 2) details the journey of a person through Intermediate Care from the identification of their need to access services to the maximisation of their skills and independence.

Figure 2: Step Up / Down Care Pathways





Individual becomes unwell. Primary / DN / ECP / SW / A&E attendance. Contact Single Point of Access. Assessment < 2 hours. Intervention as required: • Nursing • Therapy • Support Worker Timely diagnosis by: • GP Specialist input by: • Community Geriatrician • Community diagnostics • Rapid access Clinic	If too unwell to be cared for at home, step up to community facility. History / Examination/ Diagnostics. GP or Nurse Consultant review within 24 hours. MDT input with principle of care delivery at home when appropriate.	If too unwell to be cared for in a community facility, admit to acute hospital for comprehensive assessment. Transfer to community facility or home when medically stable and fit for transfer.

Level of acute need



Timely comprehensive assessment by: • Clinician • Therapist • Social Worker • Nurse Rehabilitative need identified. Referral to Intermediate Care Single Point of Access. Individual is medically stable and fit for transfer. Individual transferred to the appropriate setting: • Own home • Community based step-down facility	If the individual requires more care than can be delivered at home, step down from acute hospital to community facility. Regular MDT and GP / Nurse Consultant review with principle of step down to care at home to continue rehabilitation when appropriate.	Majority of users of intermediate care to receive their episode of care at home. MDT driven Re-ablement to optimise recovery and promote independence.

Level of need during recovery

The Department of Health published *"Living Well with Dementia: A National Dementia Strategy"* in 2009.[6] The Strategy identifies 17 key objectives which, when implemented, largely at a local level, should result in significant improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. The following objectives are relevant to Intermediate Care:

- **Improved community personal support services**

An appropriate range of services to support people with dementia and their carers, living at home. Access to flexible and reliable services, ranging from early intervention to specialist home care services, responsive to the personal needs and preferences of each individual taking into account their broader family circumstances. These services should be accessible to people living alone or with carers, and people who pay for their care privately, through personal budgets or through local authority-arranged services.

- **Improved Intermediate Care for people with dementia**

Intermediate Care which is accessible to people with dementia and which meets their needs.

- **Considering the potential for housing support, housing-related services and Telecare to support people with dementia and their carers**

The needs of people with dementia and their carers should be included in the development of housing options, Assistive Technology and Telecare. As evidence emerges, commissioners should consider the provision of options to prolong independent living and delay reliance on more intensive services.

- **Effective national and regional support for implementation of the Strategy**

The appropriate national and regional support to be available to advise and assist local implementation of the Strategy. Good-quality information to be available on the development of dementia services, including information from evaluations and demonstrator sites.

Improved Intermediate Care for people with dementia is part of the vision of jointly commissioned services along a defined care pathway to enable people to live well with dementia.

The National Stroke Strategy (2007)[7] must also be considered in relation to the further development of Intermediate Care services. It identifies the importance of the provision of high quality rehabilitative support. It documents that intensive rehabilitation immediately after stroke, operating across a seven day week, can limit disability and improve recovery. Specialised rehabilitation needs to continue across the transition to home or care home ensuring that health, social care and voluntary services together provide the long-term support people need.

[6] Department of Health, *Living Well with Dementia: A National Dementia Strategy - 2009*

[7] Department of health – *The National Stroke Strategy - 2007*

Homecare Re-ablement

Evidence shows that timely bursts of social care Re-ablement can either prevent hospital admission or post hospital transfer to long term care, or appropriately reduce the level of ongoing home care support required. Re-ablement complements intermediate care services and the benefits include:

- maximised independence;
- minimised whole life cost of care[8].

The Department of Health's definition of Re-ablement is:

'The use of timely and focused intensive therapy and care in a person's home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on re-abling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care'.

The philosophy behind a Re-ablement Service is that people want to be independent and that means being able to do things themselves rather than having people do things for them. Often when people have had a crisis, such as a fall or illness, or they just get to the stage where they feel that they can't manage anymore without help, they need someone to work with them to regain lost skills or, perhaps even more importantly, to regain confidence in their own abilities.

A Re-ablement Service offers support that is designed specifically for the client, taking into account all the elements that are important to independence, such as making sure they have the right equipment, that they have any modern aids and gadgets that might assist with improving their independence. In addition it takes into consideration, carers and their role, providing help so that they can practice daily living skills in a positive and supportive way. There is a growing body of evidence that an effective Re-ablement Service results in a reduction of the need for ongoing traditional home care type services.

Local Guidance and Policy Context

In April 2008, Enfield published *Getting Personal*[9] a joint social care and health document which set out the commissioning intentions for older people's services (2008 – 2011). This document included a commitment to the development of Intermediate Care Services in the Borough.

This strategy builds on the intentions outlined in *Getting Personal* and aims to ensure that our strategic objectives and commissioning intentions are underpinned by robust evidence based approach and informed by the priorities identified in the Joint Strategic Needs Assessment and Local Area Agreement. The priorities identified in these documents include:

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[8] CSED website: http://www.dhcarenetworks.org.uk/csed/homeCareReablement/

[9] London Borough of Enfield – *Getting Personal - 2008*

- Reducing health inequalities;
- Early intervention and prevention for people with long term conditions;
- Improving outcomes for people with dementia;
- Focusing on healthy lifestyles and improved cardiovascular health;
- Improving access to health and wellbeing information;
- Giving people increased choice and control;
- Maximising independence and enabling people to remain in their own homes for as long as possible;
- Strengthening the Voluntary and Community Sector and developing their capacity to deliver services.

Enfield Council and NHS Enfield are also developing a number of other joint health and social care commissioning strategies that will sit alongside the Intermediate Care and Re-ablement Strategy and will contribute to achieving the strategic objectives outlined in Section 6 of this document. They include:

- Prevention and Early Intervention
- End of Life Care
- Dementia
- Stroke
- Carers
- Learning Disability
- Mental Health
- Accommodation

All of the strategies are being developed as part of a wider local work programme to develop personalised services and take forward the recommendations outlined in *Putting People First (*2007)[10]. This is an ambitious work programme that aims to transform local services and will make a significant contribution to achieving the strategic objectives for Intermediate Care and Re-ablement that are set out in this strategy. It includes a commitment to:

- Local Authority leadership accompanied by authentic partnership working with NHS Enfield, other statutory agencies, third and private sector providers, users and carers and the wider local community to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.

- Agreed and shared outcomes which should ensure people, irrespective of illness or disability, are supported to:
    - live independently;
    - stay healthy and recover quickly from illness;
    - exercise maximum control over their own life and, where appropriate, the lives of their family members;
    - sustain a family unit which avoids children being required to take on inappropriate caring roles;
    - participate as active and equal citizens, both economically and socially;
    - have the best possible quality of life, irrespective of illness or disability;

[10] Department of Health – *Putting People First - 2007*

- retain maximum dignity and respect.

- System-wide transformation, developed and owned by local partners covering the following objectives:
  - Commissioning which incentivises and stimulates quality provision offering high standards of care, dignity and maximum choice and control for service users.
  - Universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding.
  - A common assessment process of individual social care needs with a greater emphasis on self-assessment. Social workers spending less time on assessment and more on support, brokerage and advocacy.
  - Person-centred planning and self directed support to become mainstream and define individually tailored support packages. Telecare to be viewed as integral not marginal.
  - Personal budgets for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision.
  - Direct payments utilised by increasing numbers of people, as defined by our Local Area Agreement targets.
  - Family members and carers to be treated as experts and care partners other than in circumstances where their views and aspirations are at odds with the person using the service or they are seeking to deny a family member the chance to experience maximum choice and control over their own life. Programmes to be supported which enable carers to develop their skills and confidence.
  - Systems which act on and minimise the risk of abuse and neglect of vulnerable adults, supported by a network of "champions", including volunteers and professionals, promoting dignity in local care services.
  - Local workforce development strategies focussed on raising skill levels and providing career development opportunities across all sectors.

Implementing Personalisation in Enfield

Enfield Council is undertaking a programme of work to implement the government's agenda to achieve a shift in resources from the point of crisis to early intervention and prevention. This will be achieved by developing an effective Re-ablement Service within existing resources available (existing homecare and Re-ablement Services) as well as developing our preventative approach to customers, including the mixture of service delivery models across the market (voluntary sector and private provision). Consideration will be given as to the placement of preventative and Re-ablement Services within the customer pathway for the future.

The strategic approach to the development of preventative services will be set out in a Prevention and Early intervention strategy that is currently under development. The development of Re-ablement Services and their integration with Intermediate Care is set out in this strategy and the local approach is described below.

The Re-ablement Service is intended to maximise independence and promote well-being by helping people to gain or regain the skills and confidence they need to live at home. The service is often needed following hospital discharge, bereavement or a crisis in the community or a general deterioration in ability to live safely at home.

National information indicates that a Re-ablement Service should provide a home based intensive period of close working with people (typically up to six weeks but in assessed circumstances up to twelve). Typical tasks could include, teaching a person to use a microwave, enabling them to prepare a meal for themselves or helping them to relearn the skills required to wash, get dressed, make their own bed, do the laundry, use transport or organise shopping. However, a Re-ablement Service is very different from a home care service in that it aims to work alongside clients to help them to do as much as they can for themselves working towards goals agreed at the start of the service.

The philosophy behind a Re-ablement Service is that people want to be independent and that means being able to do things themselves rather than having people do things for them. Often when people have had a crisis (such as a fall or illness) or they feel that they can't manage without help, they may benefit from someone working with them to regain skills or to build confidence in their own abilities.

A Re-ablement Service offers support that is designed specifically for the client. This takes into account all the elements that are important for independent living such as making sure they have the right equipment (including Telecare). As well as assisting with improving their independence it is important to take into consideration carers and their crucial role. This may involve providing support to the client so that they can practice their daily living skills in an un-pressurised and supportive way. There is evidence that an effective Re-ablement Service is likely to lead to a reduction in the need for ongoing traditional home care services.

Continual assessment of a client's needs and progress will take place throughout the provision of Re-ablement. This will identify the potential for ongoing improvement in function and ability. However, there may be for some people a need for longer-term help with personal care type tasks. The core principals of Re-ablement should then continue within any further package of support.

Enfield Council is in the process of developing an effective in-house Re-ablement Service by transforming the existing in-house homecare provision and other Re-ablement Services. It is important to recognise that evidence from national pilots confirm that Re-ablement Services are most effective when delivered jointly by health and social care working closely together with a mixture of skills available (e.g. Social Work, Occupational Therapy, Physiotherapy, Nursing and Care Support Workers) and therefore consideration will be given to the skill mix required within the service to maximise effectiveness for people in Enfield.

Research

Intermediate Care

Intermediate Care is now considered a mainstream activity and many different models have developed across the country. Whilst the evidence base to support the effectiveness of Intermediate Care is mixed, it has been shown to reduce acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life. A comprehensive review of the available research findings is summarised in Intermediate Care – Halfway Home, the Department of Health's updated guidance on Intermediate Care.

Home-care Re-ablement

Building on evidence contained within an earlier discussion document[11], a retrospective longitudinal study was commissioned by Care Services Efficiency Delivery[12] with the Social Policy Research Unit, at the University of York.

Examining the experiences of four councils and schemes, three of which were highlighted in the original Care Services Efficiency Delivery discussion document, the retrospective longitudinal study shows that in three of the four schemes:

- 53% to 68% left Re-ablement requiring no immediate homecare package;
- 36% to 48% continued to require no homecare package two years after Re-ablement;
- In the fourth service, which operated on a selective basis, the results were significantly higher.

Of those that required a homecare package within the two years after Re-ablement:

- 34% to 54% had maintained or reduced their homecare package two years after Re-ablement;
- In the fourth service, which operated on a selective basis, the results were higher.

Of those aged over 65 years that required a homecare package within two years after Re-ablement:

- In three of the four schemes the number that had reduced their package was higher after 24 months than after three months;
- This was even more noticeable in two of the schemes for those aged over 85 years.

National pilot studies evidence a reduction in the life costs of care (table below). However, the anticipated growth in numbers will require further investment in preventative and Re-ablement Services in the longer term.

Homecare Package at First Review *			
Care package req'd post 1st review (6 wks)	Matched service users (control group)	Re-ablement Pilot (selective)	Re-ablement Roll-out (intake)
Discontinued	5%	62%	58%
Decreased	13%	26%	17%
Maintained	71%	10%	17%
Increased	11%	2%	8%
Total	100%	100%	100%

Leicestershire De Montfort Study 2000

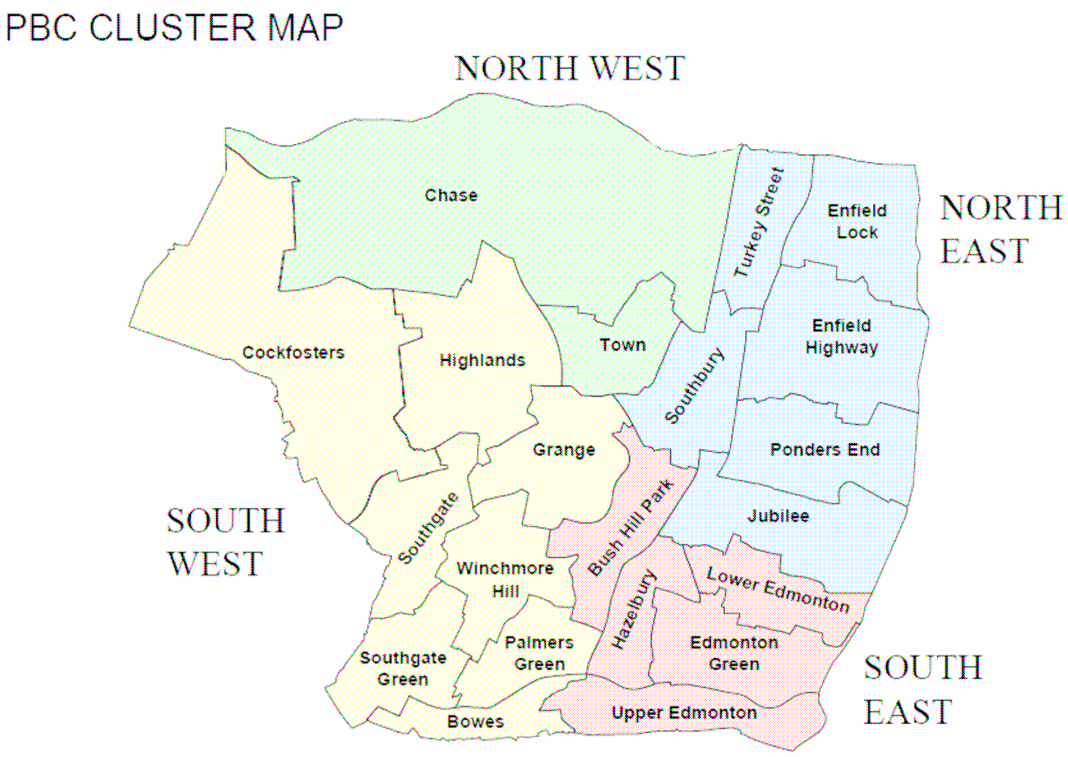
[11] Care Services Efficiency Delivery Homecare Re-ablement Discussion Document January 2007

[12] Care Services Efficiency Delivery is a part of the Department of Health that helps councils to identify and develop more efficient ways of delivering adult social care.

4. CURRENT AND FUTURE DEMAND

The map below demonstrates the distribution of wards within the London Borough of Enfield. It also demonstrates the four cluster areas as supported by NHS Enfield.

Map of Enfield at the Ward Level



Estimating the current and future demand for Intermediate Care Services is a complex exercise as it very much depends on how you define Intermediate Care and what services are included. It also requires mapping of the needs of those individuals who are not currently accessing health and social care services, as well as those who are already known to service providers. In addition, Intermediate Care services are accessed by people with a wide range of different conditions, at different levels of need, and across all ages.

For the purpose of this strategy, current and future demand for Intermediate Care services has been estimated by undertaking an assessment of the needs of the Enfield population. The assessment of need is based on a balance of national and local data and consists of demography, incidence and prevalence, risk factor data and local and service user data.

This section highlights key facts that have informed the development of this strategy[13].

- 287,000 people live in the Borough of Enfield and of these, 220,900 are over the age of 18 years.
- The current number of people aged 65 years and over living in Enfield are 38,000. This is projected to increase to 40,800 in 5 years and 53,500 in 20 years.
- The current number of people aged 85 years and over living in Enfield is 5,200. This is projected to increase to 5,700 in 5 years and 8,500 in 20 years.
- Enfield has the 8th highest percentage of people aged 65 years and over in London.
- In 2001, 8.5% of people in Enfield were from Black and Minority Ethnic groups. This is projected to increase to 24% by 2021.
- There are currently 1096 people 65 years and over living in residential care. This is projected to increase to 1,145 by 2013 and 1,240 by 2020.
- In 2009/10 there were 202 new admissions to long-term nursing and residential care. Of these, 126 people (62%) where admitted to long-term care directly from hospital (55 to nursing care and 71 to residential care). The number of new long term care placements has decreased from 2008/09 when 238 new placements were made, however the number being admitted directly from hospital has remained constant.
- Of the 202 new admissions to long-term residential or nursing care in 2009/10, 138 had a community based support package prior to admission and 66% of these had packages valued at £300 or less per week.
- Compared to London, the population of Enfield has relatively poor health. Enfield has the:
    - 8th highest prevalence rate for stroke or Transient Ischemic Attack
    - 5th highest number of people on the obesity register
    - 7th highest number of smokers
    - 5th highest prevalence rate for hypertension

There is a high level of inequality in health status in the borough and reducing this is one of the key priorities identified in the *Joint Strategic Needs Assessment* (2009)[14]. Inequality in health outcomes mirrors the patterns of deprivation seen within the borough. The differences are so significant that it is judged essential to have this as a priority – albeit one that is reflected across all other areas. Life expectancy at birth in Enfield over the past 15 years has been higher than London or national averages for both males and females. However there is a significant life expectancy gap between deprived and more affluent wards within the borough, and there is evidence that this gap is widening for both men and women.

The highest life expectancies for both men and women are reported in the South West Wards. The main causes of death within Enfield, identified as contributing to existing inequalities are circulatory disease, cancer and respiratory disease, and in particular stroke occurring in women. Diabetes is also known to contribute by increasing the risk of developing co-morbidity for long-term conditions.

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[13] Data sourced from: Enfield Joint Strategic Needs Assessment (2009); POPPI & PANSI (2009); and LBE social care performance data.

[14] Department of Health – *Joint Strategic Needs Assessment - 2007*

In the North East Cluster, Ponders End has one of the lowest female life expectancy rates in Enfield. In the *Joint Strategic Needs Assessment*, models for the early identification of long-term conditions indicate that a large number of patients remain undiagnosed for chronic conditions where early identification and treatment is critical to health and the reduction of emergency admissions and mortality rates. The North West Cluster has the second lowest life expectancy for the Borough especially in the Chase Ward.

Enfield's population of older people are more heavily concentrated in the Western half of the Borough, particularly in Cockfosters, Southgate and Winchmore Hill, however, some of the fastest increases for 2006-11 are projected in some Eastern wards.

In summary, Enfield has a growing population of older people and a population with relatively poor health status. There are significant inequalities in health status across the Borough which mirrors the pattern of deprivation. Older people and people with poor health are more likely to develop long-term conditions which lead them to require health and social care services. People with long term conditions account for a significant and growing amount of health and social care resources. We need to plan to manage this increased demand and put in place services that enable people to maximise their independence and decrease their reliance on costly acute and social care services.

In planning Intermediate Care and Re-ablement Services, it is important to be mindful of the differing health status and age profile of people living in the Borough and aim to locate services in areas where need is greatest.

Almost two thirds of admissions to long term residential care in 2009 to 2010 were made directly from hospital. This would suggest that there may be scope for services to further develop their capacity to meet the needs of this group of people with the aim of reducing the number of admissions to long term care. Good practice dictates that no one should be admitted directly into long-term care from hospital (unless there are exceptional circumstances) without first being offered a period of Intermediate Care and/or Re-ablement.

5. MARKET ANALYSIS

Map of Services: Intermediate Care

Intermediate Care in Enfield currently consists of the following components.

The Magnolia Unit

The Magnolia Unit is managed by NHS Enfield Community Services, and provides Intermediate Care admission avoidance beds on the St Michael's Care Centre site within Enfield. This is a Nurse Consultant led unit. The multidisciplinary team provides specialist nursing care, occupational therapy, physiotherapy and social work. It also has the facility to receive ad-hoc input from other clinicians. Medical cover at evenings and weekends is provided by Barndoc[15] with week day morning GP medical cover.

[15] After hours GP service

The unit currently provides a admission avoidance beds offering short-term care (approximately 2 weeks).

The building is able to support the use of 28 beds, however, currently 18 are used for Intermediate Care and two additional beds are used for continuing care patients. Staffing levels are in place to support 20 beds. If diagnostics are required, patients are transferred to the Acute Trust.

Referrals are made into the unit from Primary Care, Accident and Emergency and the Ambulance Service. In order to be eligible, patients must:-

- Be registered with an Enfield GP.
- Have a medical condition that has the potential to improve following a short-term period of rehabilitation with clearly defined goals.
- A medical condition that is stable and can be safely managed within the unit.
- Patients requiring diagnostics should have these completed prior to admission.

Currently, 18 admission avoidance beds (and 2 additional beds used for continuing care), are commissioned within the Magnolia Unit by NHS Enfield, the number of beds commissioned, having reduced by of total of 8 beds during the previous two years.

Figures collected during 2008/09 demonstrated average bed occupancy of 75.5%. The numbers of bed days available were 5597, of which 4084 were used. However, the bed occupancy for 2009/10 reduced. The numbers of bed days available were 6178, of which 3270 were used. It should be acknowledged that during this period Intermediate Care saw its budget reduced accordingly as the 8 beds were removed. There is potential to increase the provision to 28 beds and to increase the bed occupancy rate.

See Appendix 1 and 2 for details of Bed Occupancy and Establishment.

Intermediate Care Team - Hospital Avoidance Service
This NHS Enfield service provides a nursing, therapy and support role to individuals as an alternative to inappropriate hospital admission. The service is divided into three geographical areas across Enfield. It provides seven day a week assessment and appropriate intervention to assist individuals to rehabilitate at home. The service operates between 08.30 to 22.00 hours. There is no cover provided outside of these hours.

Criteria for the patient to use the service:
- The patient is a resident of Enfield or is registered with an Enfield GP.
- The patient has been diagnosed with an acute short-term medical condition requiring nursing, or therapy intervention in order to prevent a hospital admission.
- The GP must agree to provide medical cover as needed.
- The team can safely manage the patient's medical condition.
- Expected duration of input should be 1 to 2 weeks in most cases and should not exceed 6 weeks.
- Patients and main carers must agree to admission to the service, and the patient must have the potential to improve from their current condition.

- Home circumstances are suitable and have adequate facilities to maintain the patient at home in a safe environment.
- There are no known risk factors for staff to provide care in the patient's own home.
- The Intermediate Care Team has the capacity and resources to admit the patient.

Referrals are received from primary care, Accident and Emergency and the Ambulance Service.

Map of Services: Re-ablement

Reablement Team (Previously called the Hospital Discharge Team).
This service is provided by Enfield Council to facilitate a safe and successful discharge from hospital and to prevent admission or re-admission. The service provides short-term reablement support and the recovery of independence to individuals. Provision is normally for between two to three weeks and provided to a maximum of six weeks. The operating hours are from 8am to 10pm, seven days a week.

Care Support workers, co-ordinated by a Manager and Assistant Managers work in close partnership with the social care and health professionals within the wider Intermediate Care service. People access this service by referral from the hospital social work team. The eligibility criteria are as follows:-

- the person has the potential for full recovery within a maximum period of 6 weeks (with some room for flexibility); and
- the person does not have an existing care package in place.

People are also able to access the service if they have been discharged from hospital with no support services and within 14 days from discharge it is clear that they require support to avoid a re-admission.

Additionally, where a primary carer has been admitted to hospital, the team will provide support to the cared for person.

See Appendix 2 for details of the establishment.

Out of Borough Intermediate Care Provision

Greentrees Unit
This out of Borough Unit operated by NHS Haringey provides step down beds for up to 32 patients who reside in Haringey and Enfield. This is a consultant led unit and has nursing, therapy and social work input. Predominantly, patients admitted to the North Middlesex Hospital for their acute care, requiring step down Intermediate Care services will be referred to the unit. The average length of stay is approximately 35 days. The average cost per occupied bed day for 2009/10 was £323.55.and the number of occupied bed days were 2653. (This includes the bed days used for 22 stroke patients).The proportion of the service used for Enfield patients is funded by NHS Enfield.

Finchley Memorial
This service is operated by NHS Barnet and is situated out of borough at Finchley Memorial Hospital. It is a 56 bedded unit which is consultant led and has nursing,

therapy and social work input. Patients requiring step down Intermediate Care from Barnet and Chase Farm Hospital Trust are referred into the service in the absence of step down beds in Enfield. The average length of stay is approximately 35 days. The average cost per occupied bed day for 2009/10 was £239.56, the number of occupied bed days were 3645. This figure excludes the stoke rehabilitation function. The proportion of the service used for Enfield patients is funded by NHS Enfield.

In addition, Enfield patients requiring Stroke Rehabilitation are able to access specialist in-patient services at Finchley Memorial Hospital. The cost per day in 2009/10 was £258.97 and a total of 820 bed days were recharged to NHS Enfield.

Service Performance and Contractual Arrangements

A scoping exercise was undertaken between February and April 2010. It should be noted that a significant amount of work has already been undertaken to develop Intermediate Care, particularly with regards to the development of the re-ablement agenda, and the Intermediate Care and Reablement strategy will complement this important and high profile development.

There is significant Intermediate Care investment annually across the partner organisations, which provides considerable opportunities for innovative re-design.

There is considerable expertise and enthusiasm at managerial and operational level to refresh the current services in line with guidance.

There are a broad range of Intermediate Care services, with a knowledgeable workforce in place across Enfield, but there is some evidence of a lack of joined up thinking regarding how these services interact. In addition, there is evidence of differing time-limiting criteria across the three components of Intermediate Care in Enfield, as referred to previously.

There is evidence of some duplication of service provision and consequently evidence of gaps in the services available, which gives potential for service users with more complex long-term needs to be excluded.

There are a relatively high number of admissions to long term residential / nursing care directly from the acute hospital setting. In the financial year 2009/10, 62% of new residential admissions came directly from hospital. There is no current facility for these individuals to have the assessment and decision making of their longer term care needs carried out within an Intermediate Care facility. This is particularly the case if the person has an identified element of dementia.

Intensive community support, providing specialist support over 6-12 weeks to older people with mental health problems who were considered to be at risk of admission to hospital or institutional care was cited as an example of good practice in Bradford

in the updated Intermediate Care guidance[16]. The evaluation indicated that 26% of the service users were prevented from being admitted to a care home, 13% had a hospital admission prevented or delayed and the home care hours needed were reduced by 26%. The net savings were estimated at more than £0.5m per year.

The health components of Intermediate Care in Enfield (the Hospital Avoidance Service and the Magnolia Unit beds) are predominantly dedicated to support individuals from the community, rather than timely hospital transfer. The recent one-day audit across the services identified a degree of spare capacity, but also, significant numbers of patients whose needs could be met in less supported environments.

NHS Enfield has a cost and volume contract for Intermediate Care step-down beds with NHS Haringey. This is provided at Greentrees on the St Anne's Hospital site. The contract is based on the previous year's activity and multiplied up by the bed day price. Identified Enfield patients access the facility following their acute care at North Middlesex Hospital.

NHS Enfield also has a cost per case contractual arrangement with NHS Barnet. This relates to the provision of general and orthopaedic rehabilitation within the 56 beds at Finchley Memorial Hospital and to a much lesser extent, 37 beds at Edgware Hospital. NHS Enfield also has a separate contractual arrangement with NHS Barnet to provide Stroke rehabilitation

Intermediate Care in Enfield is used to supplement the absence of some other mainstream services, i.e. the lack of a Community Occupational Therapy service, the absence of a Phlebotomy service, the supplementation of District Nursing and long-term conditions management. This severely affects the ability of the health components of Intermediate Care in Enfield to function proactively as is encouraged by the updated Intermediate Care guidance.

There is an Avoidance of Admission service which operates out of the Accident and Emergency Department of the North Middlesex Hospital. This service has good liaison links with the Intermediate Care health based services in Enfield. There is no equivalent service operating from within Chase Farm Hospital. That has reflected in the number of referrals to Intermediate Care as an alternative to admission. Hence, individuals who attend Accident and Emergency at Chase Farm or North Middlesex Hospital do not have comparable access to Intermediate Care as an alternative to hospital admission.

[16] Intermediate Care – Halfway Home, Update Guidance for the NHS and Local Authorities (DH, 2009)

Previous evidence from figures available from 2008 to 2009 show that 79 patients were referred from the Accident and Emergency department at the North Middlesex hospital to Intermediate Care, compared to only 10 patients referred from the Accident and Emergency at Chase Farm during the same period.

There appears to be limited links between Intermediate Care and the discharge planning arrangements within the two acute hospitals in Enfield, predominantly, because of the admission avoidance function of the current health services and the limited access to step-down beds, except during periods of acute bed pressure.

There are limited links between Intermediate Care in Enfield and the Ambulance Service to signpost appropriate individuals to any services other than an acute Accident and Emergency episode.

There is no single point of access to Intermediate Care across Enfield and thence referrers could be unclear of the pathway and therefore not adhere to it.

There is limited access to Intermediate Care, particularly the health component of home based care, out of hours, and at week-ends. This limits its potential to function at its optimised capacity.

There is some evidence to suggest that Intermediate Care in Enfield is service driven rather than person-centred, in that, individuals who are likely to have more complex needs and, therefore, need a longer period of Intermediate Care, are less likely to be considered for inclusion.

There is limited use of a unified assessment, some evidence of duplication of assessment and a lack of trust in the assessment of referrers to the service, all of which contribute to a potential for delay and the unnecessary usage of resources.

There is an inconsistent approach to goal setting and outcome measurement, as demonstrated in the Hospital Avoidance service where individuals have the potential to receive an ongoing maintenance service rather than one which is time limited and outcome based. It is acknowledged that this is mainly due to the lack of ongoing provision in Enfield.

There is limited understanding of the potential for the use of Telecare and Telehealth as part of assessment and the management of risk within Intermediate Care.

There is a lack of Interim Care provision for those individuals whose longer term needs are unlikely to be met in an Intermediate Care environment and who currently are likely to be delayed in hospital inappropriately.

Home from Hospital Service

Age Concern provides a home based Re-ablement Service for people discharged from hospital with low to medium care needs. It provides short-term practical support to facilitate rehabilitation after a hospital stay for a period of up to 6 weeks, for example, help with shopping, paying bills and housework.

This service received £46,920 per annum from the Enfield Council. In 2008 to 2009, 84 people accessed the service, giving a unit price of £559 per person.

In-House Home Care Team

The purpose of the In-House Home Care Team is:

- To provide long-term support with a range of personal and domestic tasks to assist people to remain in their homes for as long as it is reasonable to do so. The service is primarily provided to older people with dementia but also service users with learning difficulties, physical disabilities and mental health support needs.
- To provide an Out-of-Hours service during evenings and weekends to respond to the need for emergency home care in the community and to support home carers working at these.

Help is provided with the following:

- Washing
- Dressing
- Toileting needs
- Eating and drinking
- Assistance with medication
- Assistance with housework, shopping, laundry and with everyday financial matters may be provided to people who are already receiving help with personal care, either provided by the Council or by family or friends.

The strategic direction for modernising adult social care services means that home care teams need to change the way in which they work in order to provide services which promote independence. For Enfield, this means integrating the current in-house home care team with the intermediate care service and creating a dedicated Re-ablement Service.

All people requiring social care services will be offered a period of Re-ablement during which time comprehensive assessment of their potential for independence can be assessed by therapists and home carers. Occupational Therapists and Home Care services are experienced in supporting people in their own home and their skills can be used to good effect when they focus on enabling people to be self-caring. This dispenses with the need for the traditional ‘doing for’ model of care.

The use of Assistive Technology (Telecare) and other equipment aids, together with a Re-ablement programme if required, allows many people to achieve full

independence. For those who people who need ongoing support following assessment and the development of an agreed support plan, they will be offered an individual budget from which to purchase any required support.

It has been demonstrated by a number of other authorities who have already fully introduced Re-ablement Services, that this form of provision is more effective and efficient than traditional in-house home care services and that it is valued by Service Users.

Health and Adult Social Care: New Customer Pathway

The new Re-ablement service will be operational from 11 April 2011 as part of the redesigned Social Care customer pathway.

The key features of the new structure are described below:

- A 'single point of access' for all enquiries about health and adult social care;
- A re-ablement service to deliver timely interventions to maximise a persons opportunity to regain skills, confidence and independence;
- Non-complex cases being assessed and support planned following a period of re-ablement for cases where ongoing needs have been identified;
- A complex service dedicated to those where the identified needs are high and more in-depth assessment and support planning is required as well as dealing with complex safeguarding cases;
- A brokerage team responsible for arranging the services identified within the support plan.

The new re-ablement service will provide short-term interventions to maximise someone's ability to live independently in the community. The re-ablement service will make an assessment of need and identify the types, levels and expected timeline of interventions required to improve the person's independence. This may also include the provision of equipment.
Once an individual has reached their goals and prior to the point of the intervention ceasing, the re-ablement team will to take the person through the Resource Allocation System to identify their personal budget.

Assistance with support planning will also take place but only for those that are straight forward and non-complex in nature. Professionals within the team will be called upon to support the process as required. Those with complex needs will be directed on to the Complex Service for assessment and support planning.

The Re-ablement Service has three parts:

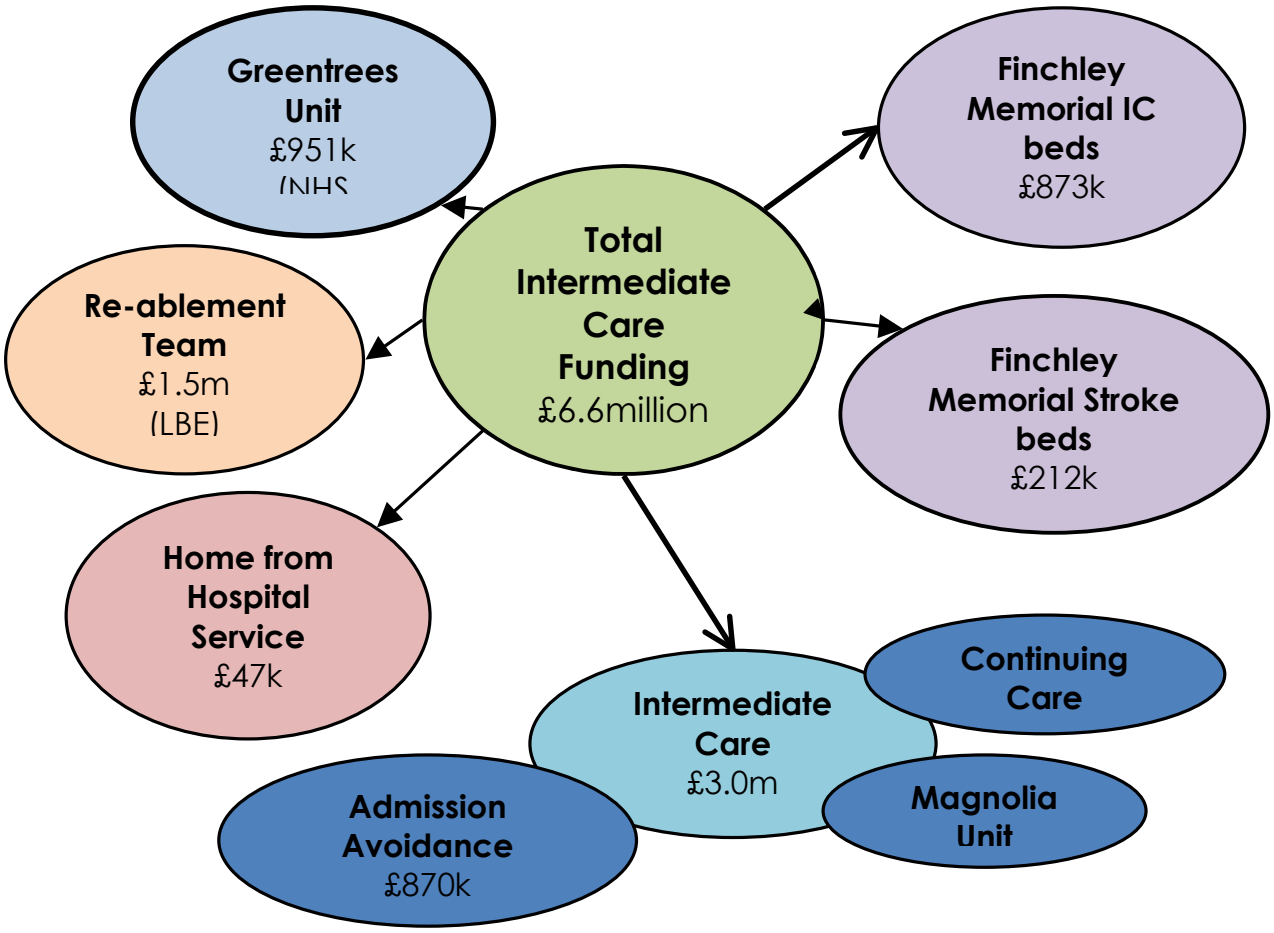
- Hospital Social Work team will complete 4-6 week reviews where placements are made directly.
- Re-ablement team, which will include re-ablement care workers, occupational therapy assistants, homecare officers / managers, social workers, occupational therapists and physiotherapists.
- Health Intermediate Care, which is a Health service to support hospital avoidance (Magnolia Unit). Social Care professionals within the Re-ablement Service will

support the unit particularly in relation to those being discharged and returning back into the community.

Finance and Funding

The figure below shows the current elements of the Intermediate Care and re-ablement service in Enfield and also the annual spend by the Enfield Council and NHS Enfield on these services.

Figure 2: Intermediate Care Financial Model



Please note the organisations detailed above are the providers of each service. The commissioners of each service are detailed in Table 1 below along with details of the specific funding arrangements.

Table 1: Providers of Intermediate Care

Intermediate Care Service	Provider	Commissioner	Annual Budget
Magnolia Unit- Residential Rehabilitation	NHS Enfield	NHS Enfield	£2.186 million (Continuing Care component is £0.729m)
Hospital Avoidance Service	NHS Enfield	NHS Enfield	£870,183
Greentrees Unit Step-down beds.	NHS Haringey	NHS Enfield	£951,241 (agreed estimated cost for 2010-11. Includes provision of Stroke

			Rehabilitation)
Finchley Memorial Hospital Step-down beds.	NHS Barnet	NHS Enfield	£873,000 (spot purchased)
Finchley Memorial Stroke Rehabilitation beds.	NHS Barnet	NHS Enfield	£212,354 (cost per case provision)
Total NHS Enfield:			**£5,092,778**
Re-ablement Service	LBE	LBE	£1.5 million
Home from Hospital Service	Age Concern	LBE	£46,920
Total LBE:			**£1,546,920**
TOTAL:			**£6,639,698**

Bed based provision analysis

It can be demonstrated, based on the recent one day audit of Patients / Service Users receiving Intermediate Care in Enfield, which the auditors were informed was a typical representation of usage, that there is spare capacity within the current service to address future need and considerable potential for redesign to increase the throughput and to achieve maximum re-configuration.

Table 2: Bed based provision analysis

Service Provider	Type of Provision	Type of Contract	Capacity	Available Bed Days (annual)	Occupied Bed Days (annual)	Average Length of Stay (days)	Cost per Day	Occupancy (people)
NHS Enfield Magnolia Unit	Admission avoidance beds	Cost and volume	20 beds (18 Intermediate Care + 2 CHC)	5,992	3,688	12.89	£295	168
NHS Barnet Finchley Memorial Hospital	Step down beds	Cost per case	56 beds (not all available to Enfield patients)	3,645 – General Orth 820 – Stroke	3,645 – General Orth 820 – Stroke	35	£239.36	86
NHS Haringey Greentrees Unit	Step down beds	Cost and volume	32 beds (12 stroke)	2,653 – Gen & stroke	2,653 – Gen & stroke	35.35	£369.23	72 (estimated)
TOTAL				**12,290 (excl. Stroke)**	**9,986**			326

Current capacity and usage
The current and future demand and capacity for the beds has been calculated as shown below.

- Demand per year for Intermediate Care beds by Enfield residents (including stroke) for 2009 / 2010 = 326 patients

- Available bed days to Enfield in 2009 / 2010 (from all providers) = 12,290

- Occupied bed days for Enfield patients in 2009 / 2010 (at all sites) = 9,986

- Unoccupied bed days in 2009 / 2010 = 2,304

- In 2010 – 2011 Magnolia Unit is able to provide (based on 20 beds) = 7,280

- Capacity available based on 2009 2010 usage = 7,280 – 3,688 (bed days used) = 3,592 days spare capacity

Therefore, even if the beds were no longer commissioned at Finchley Memorial Hospital and at Greentrees Unit there would be capacity in the system. Previously there has been no single point of access to Intermediate Care in Enfield and it relied on referrers to signpost to the most appropriate type of Intermediate Care provision for their patient. Hence it can be argued that there are patients in the system referred to the bed based facility, when a home based package of care might have been more appropriate.

Similarly, in the absence of step-down access for patients requiring a more complex assessment and rehabilitation programme of care, patients were automatically referred out of Borough.

Even at its maximum reported beds days used in 2009 -2010 capacity was only at 79% in Magnolia Unit and demonstrated spare capacity within the Hospital Avoidance Service. Using the rationale demonstrated in Figure 2 (page 14). Therefore there is at least 20% spare capacity based on the current configuration. Additional capacity can also be found where inappropriate usage is prevented.

Future capacity and usage
Magnolia Unit has the potential to increase the amount of beds available for Intermediate Care by 8 beds to a total of 28 beds. This would give additional capacity within Enfield of 2,920 bed days and making a total of **10,200** available bed days. The estimated cost for the provision of those extra days would be £531.440. (Forecast provided by NHS Enfield - Community Services).

By shifting the focus of Magnolia Unit to provide step down as well as step up Intermediate Care provision and by altering the contracts with NHS Haringey and NHS Barnet to a cost per case contract, it is possible to demonstrate enough capacity in the system and to make a gross cost reduction of approximately £1.5 million per annum.

The Market
It is considered that the Intermediate Care services currently provided are specialist in nature and as such are most appropriately commissioned from expert providers.

Current providers of step down residential care for NHS Enfield include Finchley Memorial Hospital, North Middlesex Hospital (Greentrees Unit), and St Michaels Care Centre site, (Magnolia Unit). Any of these providers, as well as other acute trusts, could potentially provide residential step down services for Enfield. In addition, we have a number of nursing care home providers from whom we could consider commissioning step down residential care with support provided from the Intermediate Care team.

The current development of an Over 65's Admission Avoidance Programme will have the effect of reducing Accident and Emergency and unplanned hospital admissions through the proactive identification, assessment and support of high risk patients over 65 years. This programme is being piloted initially in the Enfield Town area and will be delivered through Community Matrons, GP's and Social Workers who will be closely aligned to work collaboratively with identified individuals. If successful the programme will be mainstreamed throughout all areas of Enfield within three years. Intermediate Care will be a key partner in the delivery of short-term support for these individuals using clearly defined pathways.

Enfield is working closely with the London Ambulance Service (LAS) to strengthen the falls pathway and to ensure timely and appropriate access to Intermediate Care and other falls services over a 24 hour period. This takes effect from October 2010.

The hospital discharge/social care Re-ablement component of the Intermediate Care service is currently provided by the Enfield Council. This ensures good links with social care and health services and access to specialist expertise. It is conceivable however that this service could be commissioned from the voluntary or independent sector, however there may be a risk that links with the Hospital Avoidance Service would weaken and access to specialist expertise could become problematic.

Similarly, the Hospital Avoidance component of the Intermediate Care service is provided by NHS Enfield. However, there may be potential to consider looking to the voluntary or independent sector to provide this service.

Further to this, it is considered that in the short-term, we are not sufficiently confident that the voluntary or independent sector have the expertise and capacity to deliver a localised, integrated Intermediate Care service and that the risks inherent in going to the market to commission this service are too high at present. However, the market can be explored and capacity built over time. For example, this could involve capacity building within the third sector, the private sector or other health and social care providers.

The market for providers of home care is relatively competitive, with a large number of providers who are able to provide domiciliary support. Consequently, there is more choice for Service Users and commissioners, as well as increased cost effectiveness. Enfield Council has recently run a tender for the provision of home care services and has entered into contracts with four independent service providers. Service Users are now offered a choice of providers and are able to use individual budgets to purchase this support. There is potential that in the future, Re-ablement Services could be commissioned from external providers however in the short to medium term it is considered that the Council is best placed to provide the service.

6. GAP ANALYSIS AND DESIGN OF FUTURE PROVISION

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

The strategic objectives and associated commissioning intentions are aligned with the aims and objectives of the national guidance on Intermediate Care and are underpinned by a robust evidence base which includes the research, needs assessment and market analysis described in the preceding sections.

Strategic Objective	Rationale	Commissioning Intentions
1. PREVENT AVOIDABLE ADMISSIONS TO HOSPITAL AND SUPPORT TIMELY DISCHARGE	Individuals will receive their care in the right place, at the right time and will be able to optimise their potential for recovery and recuperation. Reduce cost of acute hospital care and manage increasing projected demand. The current provision of admission avoidance and step down beds is fragmented, costly and inefficient. Currently, 18 step up beds (+ 2 used for continuing care), are commissioned within the Magnolia Unit. There is potential to increase the provision to 28 beds. Figures collected during 2009/10 demonstrated that the Unit was not being utilised to its full potential.	Identify a Single Point of Access (SPA) for Intermediate Care services across Enfield which is readily identifiable and accessible to all referrers and which is promoted widely. Regular communication with all GP's on all aspects of the service ensuring familiarity with the referral process and availability. Regular reporting from the service to highlight use and non-use by specific GP's and to tailor assertive marketing to those areas. Develop an integrated health and social care I.T system. Commission an increased provision (to 28 beds) at the Magnolia Unit, of the full range of step down and admission avoidance Intermediate Care beds within Enfield which will also be used to meet the needs of people with more complex needs including those with Mental Health

Strategic Objective	Rationale	Commissioning Intentions
	Currently, step down beds are commissioned out of borough which does not align with the principles of providing care closer to home for residents of Enfield. There is spare capacity and in addition the potential to utilise a further eight currently unused beds within the bed based Intermediate Care service currently provided by NHS Enfield within the Magnolia Unit. Currently the Rapid Response element of the Intermediate Care team in Enfield provides an immediate service to prevent avoidable admission to the two acute hospitals. There are	needs. Further invest in the medical support to complement the existing GP and Nurse Consultant to ensure that the patients receive appropriate and timely intervention. Decommission Cost and Volume contract out of borough Intermediate Care step-down beds currently purchased from NHS Haringey. Commission Cost per case contractual arrangements with NHS Barnet and NHS Haringey demand exceeds capacity within Enfield Intermediate Care bed provision. Monitor the ongoing requirement for spot purchasing in order to inform future commissioning requirements and consider the potential for spot purchasing from Independent Sector residential care providers with support provided by the Intermediate Care Team. Increase the capacity of Intermediate Care to provide in-reach to care homes. Develop clear care pathways; • from the two acute hospitals in Enfield and out of borough acute hospitals, • via the Ambulance Service, • From Primary Care, to access Intermediate Care thereby ensuring that individuals move through the system in a

Strategic Objective	Rationale	Commissioning Intentions
	good links with the "front of House" at the A&E department at the North Middlesex Hospital where there is a dedicated assessment facility to identify people who could be returned to primary care. The facility at Chase Farm Hospital is less defined and the pathways to divert people to Intermediate Care are patchier. Very limited use is made of Intermediate Care by the Out of Hours Service during the evenings and weekends, even though Intermediate Care is available. Therefore, increasing the potential for individuals to be admitted to Acute care during these periods. Despite the marketing of the service to GPs and the Out of Hours Service, there still exists, a perception that Intermediate Care in Enfield is a week day only service. There is potential to extend the access to Intermediate Care to prevent avoidable admission by further strengthening the links with Acute care at both the North Middlesex and Chase Farm Hospitals and by the assertive and ongoing marketing with GP's and the Out of Hours service. Community Nurses have a valuable role in raising the awareness within general practice.	timely and appropriate way. Develop the capacity of the current rapid response component of the Intermediate Care Hospital Avoidance team to provide urgent community based assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. Develop the ability of the Intermediate Care service to deliver intravenous therapy at home in line with the developing expectations of a rapid response service which has the necessary skills that enable people to be treated in their own homes rather than to be admitted to hospital.

Strategic Objective	Rationale	Commissioning Intentions
2. DECREASE THE NUMBER OF PEOPLE UNNECESSARILY ADMITTED TO LONG TERM CARE FOLLOWING A HOSPITAL STAY	There is currently a high level of admissions to long term residential and nursing care directly from hospital. In 2009/10 almost 2/3 of new admissions to long term care came directly from hospital. There is currently no facility for people to have the assessment and decision making regarding their longer term care needs carried out within an Intermediate Care facility. Reduce cost of long term residential and nursing care and manage increasing projected demand for these services. Halfway Home, the Department of Health guidance on Intermediate Care (2009) states that people should not be transferred directly to long-term residential care from an acute hospital ward unless there are exceptional circumstances. For example, those judged to have had sufficient previous attempts at being supported at home (with or without Intermediate Care support). Individuals will have their assessment and decision making of their longer term care needs only after they have had the opportunity to optimise their independence in an Intermediate Care environment.	We will ensure that no one is transferred directly from an acute ward to long term residential care (unless in exceptional circumstances) without being offered a period of Intermediate Care and Re-ablement. We will provide Intermediate Care services to an individual which ensure the patient experience is of the highest quality. Establish targets and a trajectory for the reduction of numbers of patients who are admitted directly to long-term care from and Acute setting. We will ensure that assessment, review and decision making takes place in an Intermediate Care environment, rather than in an acute setting, following the opportunity for rehabilitation, recuperation and recovery. The effect of this intention will be to reduce the current number of individuals who are admitted to long term bed based care, directly from hospital. It will also have the potential to reduce the ongoing financial requirement of statutory organisations.

Strategic Objective	Rationale	Commissioning Intentions
	Unified Assessment will be key to the delivery of Intermediate Care in Enfield, taking into account, medical, nursing, therapy, mental health and social care needs and respecting the identified priorities for the individual. The national guidance encourages Intermediate Care to accommodate for the needs of people with more complex needs whose rehabilitation to reach an optimum level may require an extended time limited episode of care.	We will ensure there is a unified assessment process, trusted by all with appropriate information shared between partners. We will adjust the time limited criteria currently in place across Intermediate Care, to ensure that individuals with more complex needs have equity of access for assessment and rehabilitation, prior to decisions being made about their longer term needs. We will determine a clear Re-ablement pathway that links reablement with the self-directed support processes.
3. IMPROVE QUALITY AND MAXIMISE INDEPENDENT LIVING	Whole systems approach to the R-eablement, recuperation, rehabilitation journey for the individual to their maximum benefit. Increase patient satisfaction and maximise people's potential to live as independently as possible in their chosen community. Ensure a proactive care management component to support patients who use the Magnolia Unit.	Integrate Re-ablement into the customer journey by reconfiguring the provision of in-house home care and ensuring an integrated continuum of service provision. Develop a person centred 'menu based' approach to service provision. Ensure a dedicated care management service to the Intermediate Care step down and admission avoidance beds to ensure that people are able to move through the whole system in an appropriate and timely manner. Integrate the health and social care Intermediate Care teams to ensure that the full needs of the client can be met by the service.

Strategic Objective	Rationale	Commissioning Intentions
	Telecare has considerable potential to assist in the assessment of risk for identified individuals and manage the risks associated with independent living. It is estimated nationally, that 80% of GP consultations relate to a long-term condition, and that 60% of hospital bed usage is by people with a long-term condition Telehealth has the potential to support independent living, promote patient self-management and reduce the need for repeat hospital admissions.	Invest in Assistive Technology to support people to remain in their own homes and ensure that Telecare and Telehealth become an integral component of the rehabilitative and re-ablement processes. Ensure that the management of the Chronic Obstructive Pulmonary Disease (COPD) patients currently monitored within Intermediate Care are proactively reassessed and managed within Primary Care. Use Telehealth within the COPD service, rather than as an add-on service to Intermediate Care to assist in the support towards self-management. There would be an initial outlay of equipment costs associated with the development of this additional component and staff will require training. We will address the absence of a Community Therapy service, ensuring that this links with the service redesign programme currently underway in Enfield. Continue to commission low level Re-ablement Services from the 3rd sector.

Strategic Objective	Rationale	Commissioning Intentions
4. IMPROVE THE SKILLS AND COMPETENCIES OF THE WORKFORCE	Enable the Intermediate Care service to support people with more complex needs. For example, evidence suggests that providing intensive specialist support to people with mental health problems can reduce hospital admissions, reduce admissions to care homes and reduce home care hours. Intensive community support, providing specialist support over 6-12 weeks to older people with mental health problems who were considered to be at risk of admission to hospital or institutional care was cited as an example of good practice in Bradford in the updated Intermediate Care guidance[17]. The evaluation indicated that 26% of the service users were prevented from being admitted to a care home, 13% had a hospital admission prevented or delayed and the home care hours needed were reduced by 26%. The net savings were estimated at more than £0.5m per year.	Ensure there is ready access to the specialist skills required to enable Intermediate Care to support the needs of people with long-term conditions including those individuals with dementia and mental health needs. All Intermediate Care staff will receive core training in dementia, and appropriate access to professional support.
5. DELIVER MORE COST EFFECTIVE	Within the current and future financial and	Ensure cost effective service delivery and

[17] Intermediate Care – Halfway Home, Update Guidance for the NHS and Local Authorities (DH, 2009)

Strategic Objective	Rationale	Commissioning Intentions
SERVICES IN ORDER TO MEET CURRENT AND FUTURE DEMAND WITHIN EXISTING RESOURCES	political climate, both health and social care economies are tasked to provide best value services for the local population, within agreed budgetary constraints.	monitor outcomes of Intermediate Care and reablement service to ensure that it meets the desired outcomes of: the individual and their carers. Ensure there is a robust financial monitoring framework which links service delivery to ensure that the service is delivered within the defined budget. Commission a longitudinal study to track the impact of the redesign of Intermediate Care services on; • admissions to long term care • hospital readmissions • home based packages of care • self care • user and carer satisfaction • Cost.
6. ROBUST PERFORMANCE MANAGEMENT AND GOVERNANCE	To monitor and evaluate quality, provide accurate reporting data and to inform future commissioning intentions.	Develop and implement a robust performance management framework to ensure that future Intermediate Care provision in Enfield meets the requirements as directed by the Intermediate Care strategy. To ensure that Intermediate Care in Enfield has a detailed governance framework. This ensures that the governance arrangements are adhered to and are transparent.

7. MONITORING ARRANGEMENTS

The implementation and monitoring of the strategy will be overseen by the Older People's Partnership Board (a Thematic Action Group of the Enfield Strategic Partnership[18]).

A detailed three year implementation plan with associated targets for a reduction in avoidable admissions to hospital and long term care will be developed in partnership with NHS Enfield; the Enfield Council; and key local stakeholders. The plan and targets will be agreed by the Older People's Partnership Board who will monitor implementation to ensure that the strategy is shaping services in the way intended. A lead commissioner from NHS Enfield and the Enfield Council will be identified and they will be tasked with delivering the implementation and reporting progress and issues to the Older People's Partnership Board.

Successful implementation of the strategy will require a strong partnership approach across all commissioning partners, including the Council, PCT, Emerging GP Consortium and North Central London Sector.

[18] The Enfield Strategic Partnership is a mature partnership and brings together organisations, businesses and the third sector.

Appendix 1: Magnolia Unit Occupancy – 2009-10

Magnolia Unit Occupancy - 2009-2010	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Available Beds	16	16	16	16	16	20	20	20	20 (17+3)	20 + (8)	20 (17+3)	20 (18+2)
New episodes (NE) Vev numbers	10	13	10	11	16	10	11	11	21	21	15	19
Actual activity (AA) count on data base (OBDs2009-2010 2)	11	17	18	21	18	23	18	26	33	34	26	32
Available Bed Days (ABD)	(16x30) 480	(16x31) 496	(16x30) 480	(16x31) 496	(16x31) 496	(16x30) 480	(16x31) 496	(16x30) 480	(17x31) 527	(17x31) 527 (8x19)=152 =713	(17x28) 476	(18x31) 558
Occupied Bed Days (OBDs 2009-2010 3)	111	196	210	234	239	339	302	296	414	561	355	431
OBD/AA =LOS	10.09	11.52	11.6	11.1	13.2	14.7	15.1	11.4	12.5	16.5	14	13
% Occupancy OBDx100/ABD	23%	41%	43.8%	47.1%	48.1%	71%	61%	62%	79%	79%	75%	77.2%

Appendix 2: Current Intermediate Care Service Structure Chart