HAMPSHIRE COUNTY COUNCIL

Report

Committee:	Health and Wellbeing Board
Date:	27 June 2019
Title:	Integrated Intermediate Care
Report From:	Director of Adults' Health and Care

Contact name: Debbie Butler

Tel: 01962 847226 **Email:** Debbiebutler2@nhs.net

Purpose of this Report

1. The purpose of this report is to provide the Health and Wellbeing Board with the background and the latest position with regard to the creation of an integrated Intermediate Care service to operate across the whole of Hampshire. This proposed service will bring together elements of Hampshire County Council directly provided services and Southern Health NHS Foundation Trust to support Hampshire residents to avoid unnecessary hospital admissions and to be supported to leave hospital settings in a timely manner and return to independent living.
2. The contents of this report were presented to the Health and Adult Social Care Select Committee (HASC) of Hampshire County Council on 14 May 2019 as part of the scrutiny function required for such a key service development. The approach and ambition were supported by HASC.

Recommendations

3. For the Health and Wellbeing Board to note and support the project approach and the direction of travel in seeking to create an integrated health and social care service.
4. To note the managerial, service and legal options available in creating an integrated health and social care and endorse the preferred route to organisational alignment and integration.

Executive Summary

5. This report sets out the ambition to achieve a Hampshire County Council and Southern Health NHS Foundation Trust re-designed, jointly led and integrated health and social care crisis response, rehabilitation and reablement service for the whole of Hampshire. This integrated service was a recommendation following the Care Quality Commission (CQC) Local System Review in Hampshire. This service development is a key component

of the CQC action plan this Board and the Health and Adult Social Care Select Committee have previously endorsed and received updates upon.

6. The vision of this project, and in due course the new service, is to achieve significant benefits across the whole system including:

- An improved client experience that is person-centred, seamless and integrated;
- A clear and effective pathway for individuals to promote recovery and independence;
- Improved efficiency by reducing service duplication and increasing productivity;
- Rationalising spend across the health and social care system;
- Minimising future demand for health and care services by reducing avoidable hospital admission rates, reducing length of hospital stay and reducing reportable and non-reportable hospital delays;
- To enable people to retain their independence and remain in their homes for as long as possible, thereby minimising the need for ongoing complex packages of care.

7. Hampshire Clinical Commissioning Groups (CCGs) and Hampshire County Council have developed and agreed a shared specification for a Hampshire Integrated Intermediate Care service. The specification sets out the requirements for rehabilitation, reablement and recovery services to prevent unnecessary hospital admission and promote individuals' fullest possible recovery following an episode of ill-health, including ensuring timely discharge from hospital. The service is to be made up of crisis response and standard services through a single point of access and, whilst Intermediate Care will normally take place in people's own homes (or the place they normally call home), there will be a provision for people who require a period of bed based Intermediate Care.

8. The primary providers of current services, Hampshire County Council and Southern Health Foundation Trust, have worked together to develop a Proposal for an integrated service which meets the requirements of the specification. The Proposal has been met with support by system leaders and agreed in principle, subject to the delivery of a satisfactory implementation plan and agreement through the respective governance of all commissioning and provider organisations.

The Integrated Intermediate Care Service (IIC)

9. The requirement is for a Hampshire wide service which provides all people with equity of access to Intermediate Care, although it is acknowledged that different localities and Integrated Care Partnerships (ICPs) will have varying needs dependent on geography and demographics. For this reason, precise pathways, processes and structures may vary slightly in order to accommodate local needs.

10. The proposed service model will bring together current Hampshire County Council and Southern Health Foundation Trust crisis response, rehabilitation

and reablement functions under a single management structure. It is proposed that a management team is jointly appointed to manage service implementation and delivery. At this time, it is not proposed that other staff should be jointly appointed but rather a Section 75 agreement be put in place to enable managers to direct the work of staff from the other organisation. This will not change the employer and minimise any change to current terms and conditions of staff.

11. It is proposed that there will be one Local Access Point (LAP) for each ICP two in the North and Mid system (until suitable accommodation can be identified), to manage referrals and allocate work to teams. In-reach activity, largely from acute providers, will also be coordinated from the LAPs.

12. Rehabilitation and reablement beds will be reviewed, rationalised and reconfigured to ensure that all IIC beds are of a standard and configuration to meet the requirements of the specification irrespective of ownership. This will help achieve more capacity in the system, thereby reducing delays in acute and community hospitals, whilst delivering a cost effective bed offer which ensures that people are able to access appropriate Intermediate Care beds as close to their home as possible.

13. Community home based Intermediate Care services will be redesigned, with a single Hampshire County Council /Southern Health Foundation Trust combined workforce which is able to operate at local level, minimising travel and delays. The teams will interface with Primary Care Network Multi-Disciplinary Teams to ensure effective transitioning.

14. Urgent Community Response is a key component of an effective IIC service and a new process is to be put in place within the LAPs to ensure that hospital admissions can be avoided wherever possible and ongoing needs are minimised. The LAP will stratify IIC requests with a separate process for Urgent Community Response. Features of the Urgent Community Response service include:

    - Urgent Community Response process will avoid non-elective admissions into acute hospitals from both the community and front door (eg Emergency Departments);
    - Referrals can be made by clinicians and professionals in the community and acute settings;
    - As part of the development of Standard Operating Procedures, clear criteria for what constitutes the need and expectation for Urgent Community Response will be developed;
    - The service will operate from 07:00 to 20:00, 7 days a week;
    - Urgent Community Response will take place within 2 hours during service hours;
    - Referrals will be made by a phone call into the IIC LAP, through a designated number;
    - Referrals will be made by clinician/professional to clinician/professional to assess and agree suitability and need;
    - An IIC First Contact Responder will undertake an initial visit to the individual to assess safety and IIC need;

- Depending on the referral and need, work with the individual may commence immediately and may be for a relatively short period in order to improve an individual's condition;
- Therapists will commence work with individuals within 3 days;
- A person may undertake their IIC recovery at home or in an IIC bed depending on individual needs and circumstances and this will be determined as part of the referral process.

15. In order to develop, test and improve the different aspects of the new operating model, a forerunner programme has been in place for a number of months. Forerunners currently in train include integrating Hampshire County Council and Southern Health Foundation Trust care staff, integrating Hampshire County Council and Southern Health Foundation Trust Occupational Therapy staff, developing the Winchester Triage Hub (a future Local Access Point) and developing a frailty admission avoidance model. The next phase of forerunners has now commenced, and areas being developed and tested include: Local Access Points in each of the localities; working practice and operational structures with Primary Care Networks; and Acute hospital in-reach services.
16. Stakeholders are being asked to join Local Working Groups in each ICP to provide support and input to the delivery of the IIC service into each system. These stakeholder groups will include service user and voluntary sector representation as well as primary and secondary care providers in each ICP. The Local Working Groups will oversee the implementation of the Forerunner projects, local communication plans and demand and capacity modelling by system.

Finance

17. The redesigned and integrated Intermediate Care service is intended to provide the following benefits:
    - Yield economies of scale;
    - Stabilised workforce through improved recruitment and retention and increased workforce flexibility;
    - Increased productivity;
    - Improved service resilience;
    - Positive impact on health and care systems by enabling people to remain in good health in their own homes for longer.
18. It is not the intention to increase the current funding envelope for Intermediate Care. However, if there is a case of enhancing services beyond the specified requirements which clearly demonstrates beneficial impacts, an appropriate business case will be submitted for consideration as part of the normal financial planning process.
19. Work will be undertaken with commissioners to determine the best mechanism for funding the future integrated service. However, the current mechanism of the Better Care Fund (BCF) provides a way of both accounting for the money and also to report on elements of current (individual) service performance. The BCF is currently subject to a review at

a national level and whatever amendments or replacement may be recommended to the BCF, development of a 'pooled fund' for this service will require an additional Section 75 agreement to be put in place.

Performance

20. Performance measures and Key Performance Indicators are to be developed in line with national best practice developed by the Social Care Institute for Excellence (SCIE). The aim will be to have a set of simple measures, qualitative and quantitative, to support effective operational management of the service.

Consultation and Equalities

21. Staff engagement and consultation will take place throughout the process and formal consultation will take place if necessary, although this has yet to be determined.

22. An Equality Impact Assessment will be undertaken at the next stage of decision making and subsequent implementation.

Conclusions

23. Many areas across the country already have the equivalent of integrated Intermediate Care services in place. A huge amount of energy and organisational determination, both for commissioners and providers, is being directed into this project in Hampshire.

24. In line with the findings of the CQC Local System Review, as well as other insights, our collective resources to better support people to live independently and to avoid unnecessary hospital admission and / or return to their usual place of residence with the maximum opportunity for independent living can be best achieved through this approach.

25. The Board is asked to note and support the work being undertaken and to receive a further update later in this calendar year.

REQUIRED CORPORATE AND LEGAL INFORMATION:

Links to the Strategic Plan

Hampshire maintains strong and sustainable economic growth and prosperity:	No
People in Hampshire live safe, healthy and independent lives:	Yes
People in Hampshire enjoy a rich and diverse environment:	No
People in Hampshire enjoy being part of strong, inclusive communities:	No

Section 100 D - Local Government Act 1972 - background documents

The following documents discuss facts or matters on which this report, or an important part of it, is based and have been relied upon to a material extent in the preparation of this report. (NB: the list excludes published works and any documents which disclose exempt or confidential information as defined in the Act.)

Document	Location
None	

EQUALITIES IMPACT ASSESSMENT:

1. **Equality Duty**

The County Council has a duty under Section 149 of the Equality Act 2010 ('the Act') to have due regard in the exercise of its functions to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct prohibited by or under the Act with regard to the protected characteristics as set out in section 4 of the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation);
- Advance equality of opportunity between persons who share a relevant protected characteristic within section 149(7) of the Act (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) and those who do not share it;
- Foster good relations between persons who share a relevant protected characteristic within section 149(7) of the Act (see above) and persons who do not share it.

Due regard in this context involves having due regard in particular to:

- The need to remove or minimise disadvantages suffered by persons sharing a relevant protected characteristic that are connected to that characteristic;
- Take steps to meet the needs of persons sharing a relevant protected characteristic that are different from the needs of persons who do not share it;
- Encourage persons sharing a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionally low.

2. **Equalities Impact Assessment:**

Staff engagement and consultation will take throughout the process and formal consultation will take place if necessary, although this has yet to be determined.

An Equality Impact Assessment will be undertaken at the next stage of decision making and subsequent implementation.

This page is intentionally left blank

Hampshire Integrated Intermediate Care (IIC)

HAMPSHIRE HEALTH AND WELLBEING BOARD

JUNE 2019

Integrated intermediate care (IIC) in Hampshire

- Hampshire CCGs and Hampshire County Council (HCC) have agreed to commission the service together, under a single service specification, planning to operate under a Section 75 agreement
- HCC and Southern Health Foundation Trust (SHFT) are the current providers of the services which are included in IIC. A joint proposal for a new operating model to jointly deliver the service has been developed

Intermediate care will:

- Maximise independent living
- Promote faster recovery from illness
- Prevent premature admission to long-term residential care
- Support timely discharge from hospital
- Prevent unnecessary acute hospital admission

The Scope of the Service

01

Bed-based rehabilitation / Reablement services

02

Community based rehabilitation/ reablement that is provided to people in their own homes, by both or either health and social care services

03

Urgent community response – these services will form part of the intermediate care response to avoid admission to a hospital or permanent care home setting

04

Acute Hospital Emergency Department admission avoidance, and supporting timely discharge

Vision

- There will be a unified IIC Service, with a combined workforce which is not bound by traditional organisational boundaries or ways of working
- IIC will be a County-wide offer but will be sufficiently flexible to blend with local structures, processes and requirements
- The Strengths Based Approach will be at the core of IIC
- Acute admissions will be avoided whenever possible, and 'pulled out' at the earliest opportunity
- Most IIC will take place in people's home or in other community settings
- There will be an IIC Urgent Community Response function to prevent hospital admission
- Care co-ordination will be managed through a central function to ensure the objectives of individuals are articulated and met

Discharge Pathways

When a patient's care needs can be met outside an acute hospital, use one of the three discharge pathways.

SIMPLE

What does the patient need?
No change in need
Patient can go back to their usual place of residence

What happens?
Restart & Return package/placement

Restart Return

SUPPORTED

What does the patient need?
Additional support needed
Rehabilitation/reablement

What happens?
Refer to Integrated Intermediate Care

IIC

ENHANCED

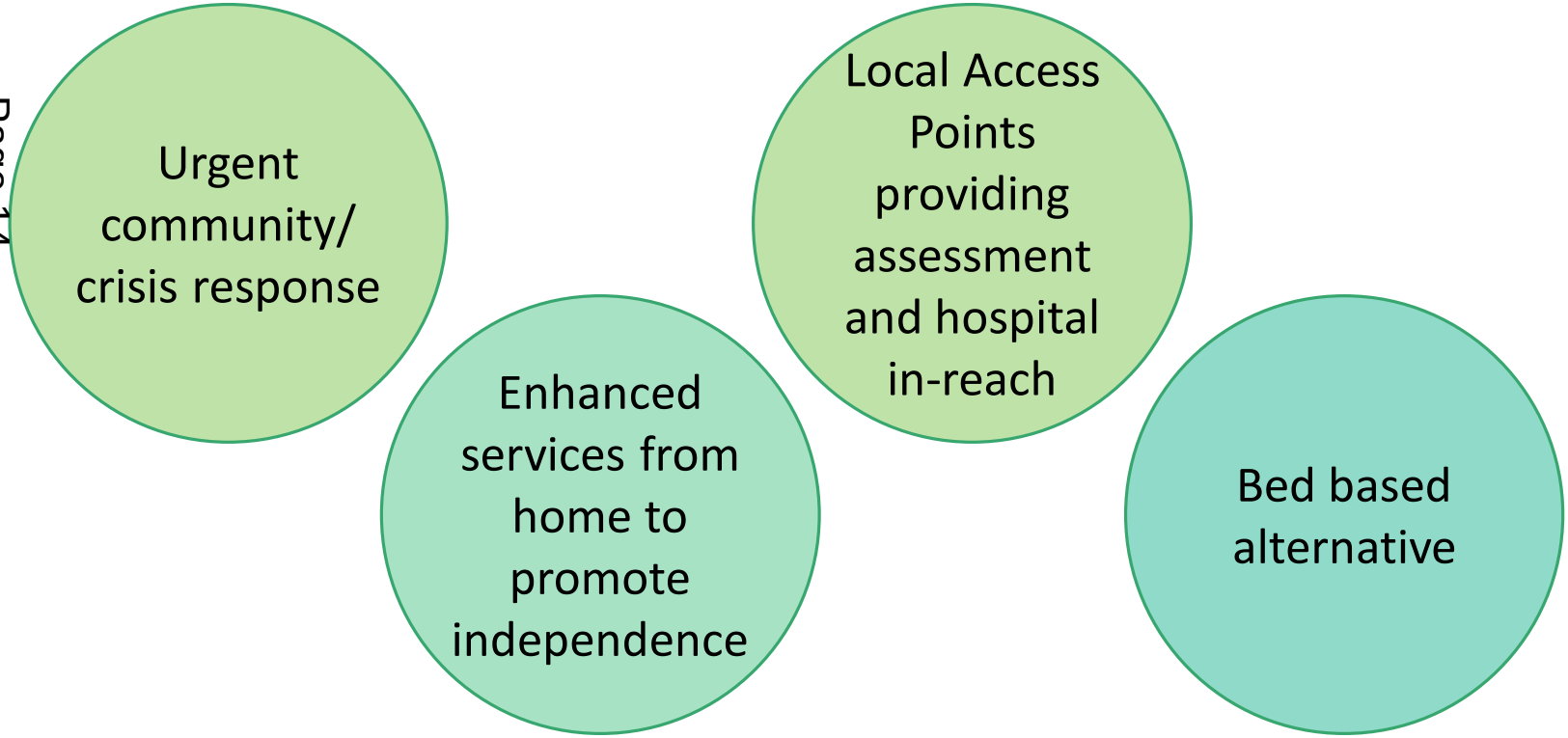
What does the patient need?
Complex needs
For example; continuing care, safeguarding concerns, lacks mental capacity

What happens?
CHC Checklist (where appropriate)
CHC Assess (5 days for majority)
Social Care Assessment by HDT
D2A

New Placement or Package

IIC operating model

Four core elements:



IIC Forerunners/test projects

Commenced Autumn 2018, to test, learn and implement for different functional parts of the operating model across different parts of the County.

Current forerunners are:

- Care staff integration – SE
- Occupational Therapy integration
- Hub development – Winchester

Phase 2 forerunners include:

- Admission avoidance ‘iFit’ (Integrated Frailty Intervention Team) – Basingstoke
- In-reach model into acute settings – UHS and PHT
- Local Access Point development
- IIC/Primary Care Network multidisciplinary team working

Local Working Groups

IIC Local Working Group to be set up in each of our 3/4 local delivery systems/ICPs to develop and optimise the implementation by system

Key next steps in Organisational Development

1. Undertake joint appointments
2. Co-locate staff wherever possible
3. Undertake further scoping work and preparation to deploy a s.75
4. Bring forward final recommendations for preferred structure following joint consultation with HCC and SHFT staff

Timeline

- Intermediate care providers commenced developing operating model through forerunners November 2018
- Health and Social Care Commissioners developed a joint specification, signed off in January 2019
- Operational Delivery Group commenced work on operating model January 2019. Delivery of Operating Model proposal March 2019
- Development of Implementation and Transition plan May 2019
- Forerunners expanding to introduce and test key service elements by system
- HCC Executive Member decision day to agree the future service October 2019
- Full service roll out April 2020

HWB Recommendations

- To note and support the project approach and direction of travel to create the Integrated Intermediate care service

- To note the managerial, service and legal options available in creating an Integrated Intermediate Care service and endorse the preferred route to organisational alignment and integration

This page is intentionally left blank