INTERMEDIATE CARE IN CORNWALL
HAZ EVALUATION REPORT

Report to the HAZ Steering Group,
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As part of the HAZ funded programme of evaluation, a dedicated evaluator was appointed to the Elder care and Primary Care Programmes. For over eighteen months, Gaynor Bennett worked closely with individual projects, focusing in particular on Cornwall’s Intermediate Care schemes. An important part of her brief was to carry out formative evaluation, working with projects to help them find out what was working and what was not working, to identify areas where they could improve activities, to plan further developments and to measure performance. As a result, she worked closely with both front-line staff and managers from a range of statutory agencies in the design and planning of intermediate care monitoring and evaluation tools. The legacy of Gaynor’s involvement is evident in the availability of monitoring information for those schemes with which she was most closely involved (residential rehabilitation and rehabilitation care assistants). A less tangible outcome of this evaluation phase has perhaps been the willingness of local stakeholders to critically evaluate their progress, identifying areas of both success and weakness.

Due to long-term illness, Gaynor was unable to bring together her extensive knowledge of key intermediate care schemes into a summative evaluation report. Thus, although this report has been researched and written by another, it is important to acknowledge Gaynor’s longer term involvement and impact on the evaluation of intermediate care schemes in Cornwall. Her practical contribution to this report (in terms of the documentary evidence, minutes etc she had collected and transcripts of interviews, particularly around the use of rehabilitation care assistants) has also been invaluable.

Thanks should also be given to the many managers and professionals who generously gave so much of their time to providing information for and feedback on this evaluation report.
Executive Summary

Introduction (Section One)

Intermediate care has become an important part of NHS modernisation. Despite this, as the Government itself admits, evaluative evidence of intermediate care schemes is scarce. In the absence of widespread evaluation evidence, the lessons learnt from Cornwall and the Isles of Scilly, one of few areas to have established comprehensive whole systems approach to intermediate care, are of considerable value.

Intermediate Care - What, Why and How? (Section Two)

Whilst the Government has issued specific criteria that define intermediate care, there is still confusion about what does and does not constitute an intermediate care service. In Cornwall, for example, there has been a tendency to describe only new services that have an explicit brief to meet the above criteria as ‘intermediate care’ services. The fact that some activity that fulfils the Government criteria is not described or captured as ‘Intermediate Care’ undermines the extent to which local organizations can demonstrate the significant progress they have made in developing intermediate care services. It also works against the effective planning and monitoring of the whole intermediate care system.

Intermediate Care in Cornwall: Background to Developments (Section Three)

CiOS HAZ has played an important role in providing strategic direction and significant investment for Intermediate Care schemes and in engaging senior managers from partner organizations (particularly Social Services and the Independent Sector) in planned developments.

Organizational turbulence and an emphasis on developing services in accordance with local service needs and structures has affected the extent to which strong strategic direction was supported by strong strategic co-ordination and management in the early stages of intermediate care development. Local pilot schemes have also demonstrated how different Intermediate Care services could be planned and developed in Cornwall. These had tested a wide range of service models. However, they have also contributed to variations between localities in the role played by different components in Intermediate Care.

Intermediate Care Co-ordination (Section Four)

Intermediate Care co-ordination is essential for the successful development of service structures, processes and linkages. Co-ordination involves a range of strategic and operational functions.

A dedicated strategic co-ordinator was not appointed in Cornwall at countywide level. Whilst this led to some gaps in the discharge of key strategic functions, Social Services effectively assumed a strategic co-ordination role for residential rehabilitation and the use of rehabilitation care assistants. Strategic co-ordination was strong from an early stage in North Cornwall (where a whole systems approach was planned from the outset). Carrick PCT has also demonstrated good ‘whole systems’ thinking.

Strategic functions that had hitherto been inadequately addressed are being more effectively discharged in 2002. This owes much to the progress that has been made in certain localities in strengthening operational co-ordination.

Operational co-ordination has been a real strength in some parts of Cornwall. The role of the Intermediate Care Facilitator in Carrick has been largely based on that of the Intermediate Care Coordinator in North Cornwall who in turn drew upon the model pioneered in East Cornwall. North
Cornwall provides a local model of good practice, as the closest example in the county of a single point of contact for Intermediate Care.

Key areas for proactive liaison in developing a Co-ordinator role include the PCT/secondary care interface, the interface with the Community Therapy Team and other community services and the development of monitoring systems for Intermediate Care.

Factors enabling Operational Co-ordination include good strategic support, flexibility of role, inter-agency and inter-professional communication, close location with other professionals, command of places in Intermediate Care settings and a nominated budget for trouble-shooting. Operational Co-ordination demands a full-time dedicated post. Systems and procedures that are evolving together may also be easier to co-ordinate than those that are well established.

**Intermediate Care Services in Cornwall (Section Five)**

Cornwall has an impressive range of Intermediate Care services across the county. These include rapid response assessments, holding services, rehabilitation at home, the use of Rehabilitation Care Assistants at home or within a residential unit, residential-based rehabilitation, community hospital-based rehabilitation and nursing home placements. A number of community hospitals in Cornwall also provide day rehabilitation. As HAZ funding has not been used to support this part of the Intermediate Care Continuum, day rehabilitation is not considered in the evaluation report.

**Rapid Response Assessments (Section Six)**

The aim of rapid response services is to provide urgent nursing or therapy assessment to people at home to avoid unnecessary acute or community hospital admission and, in the case of therapy assessment, to facilitate earlier discharge from hospital.

Rapid Response nurse assessment is operationally well-embedded in Carrick, North Cornwall and East Cornwall where HAZ funding has been used to provide E/F grade support enabling the District Nursing Service to release G-Grades who are carrying out assessments. Despite additional funding, consideration should be given to ways in which the impact of nurse assessment work on individual primary care teams can be minimised.

Factors enabling Rapid Response Nurse Assessment include support from Intermediate Care Co-ordinators and close working relationships with Social Services Case Co-ordinators. Further consideration should be given to the differences that exist in the county regarding the role of medical assessment. Ease of access to community hospital beds also varies across localities.

Activity by Nurse Assessors is not being adequately captured by routine monitoring systems. However, on the basis of the numbers of acute hospital admissions that, according to local estimates, have been prevented, the estimated savings to the acute sector outweigh the costs of these schemes.

**Holding Services (Section Seven)**

Three main approaches have been used in Cornwall with which to ‘hold’ a situation until an appropriate package of care can be put in place. Social Services Holding Services are rarely used by groups such as Nurse Assessors. The piloted use of a voluntary sector holding service also resulted in few referrals. The increasing use of 7-day assessment beds in nursing and residential homes suggests that the provision of skilled nursing cover may be a more effective approach to holding a crisis that would otherwise result in hospital admission.

7-day assessment beds are used in North Cornwall, East Cornwall and Carrick as part of the menu of available intermediate care services. Using a straight cost-comparison, the use of a designated care home bed to divert a hospital admission is significantly cheaper than inpatient care. Even factoring in the investment made to support G-Grade Nurse Assessors (the major referrers to these homes),
overall savings are still made to the acute sector providing that placements involve a minimum of 2 days stay in Carrick and 5 days stay in North Cornwall.

7-day assessment beds are strongly supported by Intermediate Care Co-ordinators and G-Grade Nurses. However, capacity in this sector (particularly within Nursing Homes) is identified as being a major barrier to use.

Rehabilitation at Home (Section Eight)

Community therapy provision has been significantly enhanced in Cornwall since 2000, Despite this, community therapy capacity has been identified as a problem that affects throughput in a number of Intermediate Care settings. As community therapy lies at the heart of the whole system of intermediate care and impacts upon both the number of referrals and the balance of step-up and step-down referrals, this is a priority area for further investment.

The organization of therapists' working practices has altered significantly with the development of Intermediate Care schemes and this has caused some frustration. There may be a case for exploring whether Social Services procedures can be rationalized. Communication between community therapists, G-Grade nurses and Intermediate Care Co-ordinators could be improved (e.g. feedback following therapist assessment). The introduction of the Single Assessment Process may help here. Other issues that require future consideration include the scope for integrating Health and Social Services OT provision and the impact of expanding the range of standard stock available from the Loan Equipment Service.

Most the work undertaken by Community Therapy Teams is not labelled ‘Intermediate Care’ for monitoring purposes. The contribution of this essential part of the whole system could be better captured. Analysis of existing data nevertheless suggests that, on the basis of estimated savings to both the acute sector and long-term residential care, the expansion of community therapy has been cost-effective in Cornwall.

Rehabilitation Care Assistants (Section Nine)

To support the expansion of community therapy, Social Services, in partnership with HAZ, has funded a programme of Rehabilitation Care Assistant (RCA) training. The aim is to train and deploy care assistants from the voluntary, independent and statutory sectors to enable them to work to a qualified Therapist’s care plan with people in their own homes or in a residential, nursing or hospital setting for a maximum of six weeks.

As the first accredited course of its kind in the country, Rehabilitation Care Assistant training is an innovative programme, feedback about which has been very positive. However, several problems have been encountered in the recruitment, retention and deployment of RCAs. These may be addressed by recruiting more Social Services in-house care assistants to the training programme. Community therapists have expressed some frustration about the system of accessing RCAs. Concerns about lack of control over worker input may have also led to a tendency to use Therapy Technical Assistants in preference to RCAs to support rehabilitation at home. However, where individual therapists are able to work closely with RCAs (e.g. in Homeward Bound Units) their use is perceived to be very successful.

Residential-based Rehabilitation (Section Ten)

The aim of the county’s residential rehabilitation scheme is to facilitate the safe and successful return home of people who have been identified as requiring a period of intensive therapeutic intervention before being able to resume independent living. Five 'Homeward Bound Units' have been established within independent sector residential homes.
Partnership working to provide development and financial input to these schemes has been very strong at the strategic level and, at the operational level, multi-disciplinary teams comprising managers and front-line staff have invested considerable effort in developing the necessary systems, linkages, protocols and processes. There has been a weakness in partnership working at the interface with secondary care and, despite growing familiarity with the referral process, perceptions remain that this is cumbersome. There are grounds for ensuring that all localities use a single point of contact (as in North Cornwall).

There are perceptions that the entry criteria for Homeward Bound Units are too restrictive. Whilst there may be grounds for re-examining some of the eligibility criteria, it is also important to reach clarity about the purpose of the Homeward Bound Scheme. HBUs may be better designed to receive patients from Community Hospitals and to cater for people on the threshold of admission to long-stay residential or nursing home care than to directly accept step-down referrals from the acute sector. This may explain why therapists tend to look more favourably on the Units than those whose role is to find placements for medically unfit patients.

The specific contribution that residential rehabilitation can make in preventing admissions to long-term care could be more effectively conveyed to local stakeholders. However, community therapy capacity also limits the extent to which the system is effectively targeting such patients. Community therapy teams tend to focus overwhelmingly on patients who have had a recent trauma. Teams have limited capacity to deal with patients with chronic/progressive problems who, due to their growing dependency, are at risk of entering long-term residential and/or nursing care. This has an impact on the balance of step-up and step-down referrals. For 72% of the 294 patients admitted to Homeward Bound Units in 2001/2002, the reason given for admission was to facilitate discharge from hospital.

The percentage of patients experiencing an improvement in their health, well-being and ability to cope with everyday living and rates of user satisfaction with the service are very high. Therapists connected with the Units are very positive about the role played by Residential Rehabilitation in enabling patients to return to independent living in the community. Nurse Assessors and Patient Discharge Liaison officers have been more qualified in their support for the scheme.

The total estimated costs of providing rehabilitation in Homeward Bound Units in 2001/2002 were £795,412. The immediate savings made to the acute sector and the estimated savings of preventing/delaying admission to long-term residential and nursing care suggest that the Units are cost-effective for both the NHS and Social Services.

Community Hospital-Based Rehabilitation (Section Eleven)

Community hospitals undoubtedly play a critical role in the continuum of Intermediate Care within Cornwall. The county is fortunate in enjoying good historical provision in this sector and there has been growing interest in the scope for maximising the use of community hospitals for patients who require rehabilitation and nursing support but who do not need the services of an acute hospital.

The use of a Co-ordinator to proactively identify inpatients who are suitable for care within a Community Hospital and to facilitate their smooth transfer was pioneered by the East Cornwall Community Resource Bed Management Project. Elements of this model have since been replicated in North Cornwall and Carrick, where Intermediate Care Co-ordinators actively seek to identify placements for patients discharged from acute trusts.

Factors that have been identified as being key to the success of such models include the provision of a single point of referral; good liaison across professional boundaries; ensuring that roles complement each other rather than creating duplication; acknowledging that it can take time - and persistence - to develop good systems of communication; holding community hospital waiting lists; and having access to a nominated budget.
Available data for 15 community hospitals across the county suggests that the approach adopted in North and East Cornwall has had a significant impact on patient flows to community hospitals. The data support anecdotal evidence of the changing role of community hospitals which are receiving more dependent, complex patients in an earlier stage of their care than five years ago. Bed Occupancy rates in N&E Cornwall Community Hospitals also remain consistently high (monthly rates averaging 85% between April 2001 and March 2002).

To further expand the role of Cornwall’s community hospitals in the provision of intermediate care, consideration should be given to local variations in access (e.g. to consultant geriatricians, therapist input and private nursing home capacity) and ways of working (e.g. the scope for independent action by nurses). Discharge processes from RCHT (which currently differ between different localities) could also be rationalised.

**Nursing Home Placements (Section Twelve)**

Nursing home placements have been used to transfer patients who have had identified nursing needs but who have not required the level of therapy offered within a Community Hospital or Homeward Bound Scheme. This approach has been used in N&E Cornwall where Intermediate Care Co-ordinators have directed patients to Nursing Homes placements for a maximum of 8 weeks.

Intermediate Care Co-ordinators in East Cornwall and North Cornwall have valued the fact that this scheme has extended the menu of services available to them. The flexibility associated with spot purchasing has also been valued, though this has been constrained by the lack of capacity of Nursing Home beds.

**Intermediate Care in Cornwall: Assessment (Section Thirteen)**

*Service Quality*

Intermediate Care Co-ordinators in Cornwall are clearly motivated by a desire to seek more appropriate care for older people who want alternatives to hospital admission or admission to long-term care and are well placed to direct patients to appropriate care settings. The main factor that limits their ability to do this is capacity within the system.

Despite the fact that Co-ordinators and providers of intermediate care are working within a highly stretched system, evidence suggests that the quality of services provided is very high. For those service elements for which formal data are available, levels of user satisfaction and of improvements to health and well-being are high. Qualitative evidence also demonstrates the extent to which the individual needs of patients are prioritized, regardless of the time that may involve.

An important dimension of the quality of intermediate care services in Cornwall is the extent to which, in certain localities, the system operates as a whole system.

*Cost-Effectiveness*

Cost effectiveness of intermediate care schemes is a difficult area to formally evaluate. For most of the Intermediate Care services that have been developed in Cornwall, it has been possible to estimate the percentage of placements that are used to prevent inappropriate admission or long-term care or to facilitate early discharge. It is important to note, however, that these estimates reflect the judgements made by service professionals about individual patient outcomes. Some validation work could usefully be carried out in this area.

In addition to estimating the proportions of patients that are diverted from acute care, in order to calculate savings made to the acute sector, assumptions must be made regarding hospital lengths of stay. Whilst the use of condition-specific average lengths of stay provides a standardised approach, if
intermediate care placements are being targeted at patients who would otherwise face prolonged hospital stays, the use of average lengths of stay may underestimate the contribution made by early discharge.

On the evidence presented in this report, there are strong grounds for proposing that all of the intermediate care schemes that have been examined are cost-effective in terms of the savings made to acute capacity.

**Partnership Working**

The fact that such a wide menu of intermediate care services has been established in at least three localities within Cornwall owes much to the strength of strategic-level partnership working and to the influence of key players working within both Health and Social Services. The leadership role provided by HAZ is of significance here.

Partnership working has also been a real strength at the level of operational management. This owes much to the work of Intermediate Care Co-ordinators who have established widespread linkages with professional and managerial staff in Hospital and Community Health Services, primary care, Social Services and the independent sector.

Localism has nevertheless presented problems for partnership working. However, as the Cornish health sector emerges from a period of considerable organizational turbulence, many of the barriers to effective partnership working are breaking down. Front-line staff are also growing increasingly familiar with alternative service options and frustration with new ways of working receding. Indeed, there is a widespread perception that ‘change is really happening in 2002’.

**The Significance of Rurality to Intermediate Care Development**

Rural areas tend to have older demographic profiles than urban areas. Thus, there is particular pressure on rural authorities to achieve service improvements as set out in the NSF for Older People.

Partly due to the weightings attached to older age bands in the current weighted capitation formula, Cornwall’s demographic profile may account for the fact that the local health sector is under severe financial constraint. Local acute hospitals, community hospitals, homeward bound units and nursing homes are operating under considerable pressure. This not only limits the extent to which patients can be directed to the most appropriate location of care. It places individual staff under considerable pressure.

Rurality is also associated with additional costs of service provision. Travel times (and thus ratios of unproductive:productive time) for staff such as District Nurses and Community Therapists are very high in the more rural localities. Transportation has been identified as an important barrier to the transfer of patients through the intermediate care system. Where community hospital catchment areas are very large, extending consultant geriatrician cover to a wider range of intermediate care settings may not be practically feasible.

The significance of rurality to the development and implementation of intermediate care schemes nevertheless suggests that policy guidelines around national standards should be more sensitive to differences in the way in which services may need to be organised and delivered in different contexts.

**Recommendations (Section Fourteen)**

The report concludes with a series of recommendations
1 Introduction

1.1 Since the publication of the NHS Plan, intermediate care has been high on the national agenda. The Plan announced that £900 million would be made available by 2003/04 for intermediate care and related services to promote independence. A substantial component of this relates to resources allocated to Personal Social Services to provide a range of services that link to intermediate care. In addition to the £255 million earmarked specifically for the NHS, around £150 million have been made available recurrently from 2000/01 for NHS intermediate care services. In January 2001, the Department of Health (DoH) issued health and social services guidance on intermediate care schemes and the publication in March 2001 of the National Service Framework for Older People provided further direction as to how intermediate care schemes should develop nationally.

1.2 Intermediate care has thus become an important part of NHS modernisation. Despite this, as the Government itself admits, evaluative evidence of intermediate care schemes is scarce (DoH, 2001a, p.45). Whilst the Policy Research Programme at the Department of Health together with the Medical Research Council has now commissioned a national programme of intermediate care evaluation, this will not be completed until the summer of 2004.

1.3 In the absence of widespread evaluation evidence, the lessons learnt from Cornwall and the Isles of Scilly are of considerable value. Intermediate care has been identified as a priority area of development in Cornwall for some years. In February 2000, funding was approved for schemes which not only allowed significant HAZ funding to be directed to intermediate care, but that also enabled synergy with the Social Services Modernisation agenda, and access to an even larger financial stake. During 2000, new intermediate care schemes were developed and implemented across Cornwall, requiring the involvement of a range of statutory, independent and voluntary organizations. As a result, Cornwall is one of few areas which has established a comprehensive whole systems approach to intermediate care.

1.4 The following report describes and evaluates this system. It begins by discussing definitions of Intermediate Care, outlining broad service models and expected outcomes of developing Intermediate Care Services (section 2). In Section 3, the background to Intermediate Care developments in Cornwall is considered, including the role of HAZ, strategic direction and the local evidence base. Section 4 considers the range of functions that are required to carry out both strategic and operational co-ordination of Intermediate care, and identifies strengths and weaknesses in co-ordination in different parts of the county. In Sections 5 to 12, the wide range of Intermediate care Service Models that have developed in Cornwall are considered, including Rapid Response Assessments, Holding Services, Rehabilitation at Home, Residential Rehabilitation, Community Hospital Rehabilitation and the use of Nursing Home Placements. In Section 13, the report returns to the question of the outcomes that are expected of Intermediate care and draws together presented evidence of the impact of Intermediate care Developments on service quality and efficiency. Factors affecting outcomes are also considered in this section, including the strength of local partnerships and the significance of rurality to service developments. Finally, the report concludes by highlighting key themes that should inform future planning and service development.
2 Intermediate care - what, why and how?

Definition of intermediate care

2.1 According to the Government circular (DoH, 2001b, paragraph 7), services must meet all of the following criteria to meet the definition of intermediate care. Services should:

- be targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long term residential care, or continuing in-patient care;
- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- have a planned outcome of maximising independence and typically enabling patient/users to resume living at home;
- be time-limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less; and
- involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

2.2 Despite the provision of these criteria, there is still considerable confusion about what does and does not constitute an intermediate care service. In Cornwall, for example, there has been a tendency to describe only new services that have an explicit brief to meet the above criteria as ‘intermediate care’ services. Yet, a number of other services have developed in part or full intermediate care provision even though their names do not reflect this. For example, much of the work of pre-existing Community Assessment and Rehabilitation Teams involves the organization of packages of rehabilitation and care of less than 6 weeks duration. District Nursing Teams are also working cross-professionally to provide enhanced packages of care that allow patients to remain in their own homes. Because this work is part of mainstream service provision, it does not tend to be identified as ‘intermediate care’. Community hospitals also provide an important source of intermediate care provision in Cornwall. However, this is difficult to capture using current data systems.

2.3 Ambiguity about the definition of intermediate care is an important barrier to effective planning and performance monitoring. Given the complexity of Cornwall’s arrangements, local stakeholders could usefully seek countywide agreement about the range of services that meet intermediate care criteria and to ensure that data on these services are routinely captured as part of the monitoring, audit and evaluation of intermediate care.

Expected outcomes

2.4 By distinguishing intermediate care from forms of transitional care that do not involve active therapy or other interventions that maximise independence, the guidance intends to counter fears that the intermediate care strategy has been driven by a preoccupation with preventing older people from blocking acute beds (see Box 1). Rather than acting as a substitute for inpatient clinical care and rehabilitation, intermediate care should extend the menu of rehabilitation services. A key assumption here is that many older people want alternatives to hospital admission where they may run unnecessary risks of disruption to their social
networks, disorientation and hospital acquired infections (DoH, 2001a, p.41). The provision of effective care closer to home is therefore seen as a way of improving appropriateness, acceptability and choice.

2.5 The belief that an expansion of intermediate care is also important to the efficiency and effectiveness of the health and social care system is nevertheless a core assumption of the intermediate care strategy. The guidance proposes that intermediate care will ‘enable a more effective use of acute capacity, supporting targets on waiting times and enabling the NHS to respond more effectively to emergency pressures (particularly in winter). It will also help enable more effective use of capacity in continuing health care and long term care as part of a wider set of measures to reduce dependency and institutionalisation’ (DoH, 2001b, paragraph 2).

2.6 It is clear from the above that the potential benefits of intermediate care are assumed to be wide ranging. The criteria against which intermediate care schemes are assessed should reflect this range of potential outcomes. Section 13 of the report returns to the question of the outcomes that are expected of Intermediate Care and considers local evidence of the impact of Intermediate Care Developments on service quality and efficiency.

Box 1: What is Intermediate Care?

Intermediate Care IS NOT:

- About marginalising older people from mainstream services (A ghetto service).
- Transitional care of older people pending long-term placement (A hotel service).
- Solely the responsibility of one professional group (A dumping service).
- Indeterminate Care (A dustbin service).
- A means of funding all good things for older people (A honey pot service).

Intermediate Care IS:

- Patient-centred with the development of an individual care plan.
- About facilitating access to acute rehabilitation and long-term care based on need.
- About active rehabilitation.
- Time-limited, with clear entry and exit points and responsibility for managing transition.
- Part of a whole system approach to the delivery of health and social care to older people and related groups.


Service models

2.7 Intermediate care services may provide rehabilitation to people who are medically stable, but who are not yet ready to return home after their discharge from hospital (the step-down model). They can also be used as step-up facilities for people living at home who need a period of intensive rehabilitation, but who do not need the full range of inpatient services with specialist medical and nursing support on site. A key distinction between inpatient rehabilitation services and intermediate rehabilitation services is therefore the presence in the former of specialist clinical support on site (Audit Commission, 2000, p.21).

2.8 Intermediate care can be provided in a range of settings. In line with the principle of ‘care closer to home’, government guidance expects that intermediate care services should generally be provided in community-based settings (e.g. community hospitals, rehabilitation
centres, nursing homes, residential care homes). However, it also suggests that services may be provided in the patient/user’s own home or in discrete step-down facilities on acute hospital sites (DoH, 2001b, paragraph 11). A range of service models can therefore be described as intermediate care (see Box 2).

Box 2: Intermediate Care: National Service Models

<table>
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<tr>
<th>Rapid Response.</th>
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<td>This service is designed to prevent avoidable acute admissions by providing rapid assessment/diagnosis for patients referred from GPs, A&amp;E, NHS Direct or Social Services. If necessary, rapid access is provided on a 24-hour basis to short-term nursing/therapy support and personal care in the patient’s own home, together with appropriate contributions from community equipment services and/or housing-based support services. Such a service may also be provided in conjunction with, or be supported by, appropriate step-up facilities.</td>
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<th>Hospital at Home.</th>
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<td>This service provides active intensive support by health care professionals in the patient’s own home at a level that is above that normally provided in primary care but that does not necessarily require the resources of an acute hospital. It can be used either as a way of avoiding an acute admission or to enable earlier discharge from hospital.</td>
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<th>Residential/Hospital Based Rehabilitation.</th>
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<td>This involves a short-term programme of intensive rehabilitation therapy/care (up to six weeks) in a community hospital or residential setting for people who are medically stable but need a short period of rehabilitation to enable them to regain sufficient physical functioning and confidence to return safely to their own home. It typically involves input from therapy staff, care managers and nurses, supported by auxiliary care staff to maximise functional ability and equip patients with skills for independent living. Residential rehabilitation can be step-up or step-down.</td>
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<th>Domiciliary Assessment and Rehabilitation.</th>
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<tr>
<td>This describes the use of a specialist, multi-disciplinary team that assesses the needs of people at home or who have just returned home from hospital, and organises packages of services to meet rehabilitation needs. This can facilitate early hospital discharge to continue rehabilitation programmes.</td>
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<th>Supported Discharge.</th>
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<td>This describes a short term period of nursing and/or therapeutic support at home with a contributory package of home care, sometimes supported by community equipment and/or housing-based support services, enabling people to complete rehabilitation/recovery at home at an earlier stage following an acute hospital stay. This can be provided by a community rehabilitation team or a dedicated outreach team from a local rehabilitation unit. It may incorporate home from hospital schemes with support from voluntary organizations. Supported discharge may work well when a home has been appropriately designed and equipped for provision of extra support (sheltered housing etc).</td>
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<th>Day Rehabilitation.</th>
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<td>This involves a short-term programme of intensive therapeutic support for up to six weeks, provided at a local authority or private residential home, day hospital or day centre, for people who would otherwise require an inpatient stay. Day hospitals can also provide a one-stop rapid response service with specialist and multi-disciplinary input.</td>
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Source: Intermediate Care: Classification of Terms, NHS Executive South West and Social Services Inspectorate, May, 2001

2.9 With the expansion of different services, settings or roles, concerns have been expressed that there is a danger that nobody will be prepared to take full responsibility for solving patients’ problems as different providers engage in a rush to pass the parcel on to someone else (Fitzgerald, 2002). Against this, the guidance clearly states that the process of assessment, appropriate patient/user selection and clear care plans are vital and that there must always
be clear clinical and managerial accountability for each patient or service user (DoH, 2001b, paragraph 12). A central concept of intermediate care is that it is part of a whole system, a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, support for carers and acute hospital care. There is a clear assumption that support from these linked services is essential for the successful development of intermediate care, to ensure that its benefits are fully realised (ibid, paragraph 9). The extent to which linkages within the whole system are fully embedded is thus a further issue that we explore in Section 13.

**Key Messages**

2.10 Strict guidance is given by the Government as to what services do and do not constitute intermediate care. Not all agencies within Cornwall use this guidance to label their services. This means that some activity that fulfils the Government criteria is not described or captured as ‘Intermediate Care’. This undermines the extent to which organizations in the county can demonstrate the significant progress they have made in developing Intermediate Care services. It also works against the effective planning and monitoring of the whole system.

2.11 The potential benefits of intermediate care are assumed to be wide ranging and include improvements in service appropriateness, acceptability, choice, efficiency and effectiveness. The criteria against which intermediate care schemes are assessed should reflect this range of potential outcomes.

2.12 A central concept of Intermediate care is that it is part of a whole system. Planning and monitoring activities should take account of this. Thus, individual services should not be evaluated in isolation, but with regard to their role in the system as a whole.
3 Intermediate Care in Cornwall: Background to Developments

The Role of HAZ

3.1 Cornwall and Isles of Scilly successfully bid for Health Action Zone status in 1999 and is one of only three rural Health Action Zones. The Cornwall HAZ, which is jointly chaired by the County Council and the Health Authority, and which has strong links to, and support from, Cornwall Social Services Department, provides a countywide network of more than 1,000 local stakeholders. This network includes links to other complementary strategies and initiatives in Cornwall such as Objective 1, Sure Start, Education Action Zone and the Sports Action Zone.

3.2 HAZ status was awarded to C&IoS due to the particular problems facing Cornwall as one of the more remote and isolated parts of Britain. Cornwall has the highest level of unemployment in the South West and wages in Cornwall are amongst the lowest in the country. Deprivation is exacerbated by poor transport. C&IoS also has an older population than average for England and Wales. In England and Wales there were 15.7% of people aged over 65 in 1999 whilst in Cornwall the figure was 20.0%, rising to over 22% in some districts. This trend is set to increase, especially among the very old. Deprivation, poor housing and transport difficulties particularly effect this vulnerable group (Bennett et al, 2002).

3.3 In recognition of these problems, C&IoS HAZ has provided both strategic direction and significant resources for the development of intermediate care. First, it has emphasised the role of a whole systems approach, to ensure that general practice, social care, community hospitals, acute hospitals and a wide range of other service providers mesh together in a way that promotes access, efficiency, cost effectiveness and quality of service provision. Second, key HAZ managers played a critical role in providing strategic direction and were able to engage senior managers from partner organizations in their forward-thinking strategies. At the strategic level, for example, relationships have been particularly strong with the Social Services Department and representatives of the Independent Sector. Third, HAZ has made a significant investment to intermediate care. Between 1999/00 and 2002/03, HAZ has invested in the order of £1,400,000 to local schemes. In the same period, Cornwall Social Services Department has invested more than £2.2 million directly into the development of the schemes with substantial additional funding allocated to developments that further promote the independence of older people.

3.4 The fact that HAZ has functioned on a countywide basis during a time of significant organizational change for the NHS has nevertheless proved challenging. In April 1999, five Primary Care Groups (PCGs) were established in Cornwall (merged in April 2002 to create three Primary Care Trusts). Due to an emphasis on developing services in accordance with local needs and service structures, a countywide Intermediate Care Co-ordinator was not appointed. This has led to local variation in the extent to which progress in strategic planning has been supported by strategic co-ordination and management.
Strategic Direction

3.5 In addition to HAZ, the National Service Framework for Older People Local Implementation Team Steering Group (NSF LIT SG) played a role in generating the necessary countywide overview to identify potential for improvements in service configuration and in establishing shared commitment to support new developments. Jointly chaired by the Deputy Director of Cornwall Social Services Department (SSD) and the Head of HAZ, this Group succeeded in achieving strong independent and voluntary sector involvement in strategic intermediate care development. The strength of partnership at this level provided the local health sector with an important opportunity to invest in partnership with SSD and the independent sector.

3.6 The NSF LIT SG oversaw a series of task and reference groups that brought together representatives from both strategic and operational levels to carry forward specific components of the NSF. In contrast to other key standards (stroke, falls, mental health), a countywide task group was not appointed for intermediate care. This decision was in part a response to the view that, due to the need to develop locality sensitive strategies, the implementation of intermediate care should be led by Primary Care Organizations (who were setting up their own NSF Local Implementation Teams). The Promoting Independence Group established by Social Services (the original implementation group for the County’s residential rehabilitation or ‘homeward bound’ units) was also perceived to provide a countywide structure for decision-making. Finally, recognition that intermediate care is a cross-cutting theme across different areas of the NSF influenced the decision. Thus, developments relating to intermediate care were considered by other NSF LIT task groups. For example:

- The Independent Sector Interface group provided advice and support on winter pressure planning, the provision of bank cover for nursing teams and the use of independent sector care homes for 7 day assessments.
- As part of the work supported by the Integrated Care Pathway Group, a generic pathway has been developed for older people and development work has been undertaken on pathways for Fractured Neck of Femur, Knee and Hip Replacement. These include discharge/transfer components.
- Under the Stroke Steering Group, a model for a pilot scheme for PCT-employed Stroke Care Co-ordinators to follow patients in their transition from in-patient acute and rehabilitation care to home has been established and audited by a Stroke Care Facilitator.

3.7 In the absence of a countywide task group for intermediate care, the extent to which early strategic direction at a countywide level was sustained is open to question. The recent decision to disband the NSF LIT SG removes further opportunities to provide a countywide steer.

The Local Evidence Base

3.8 In identifying areas for HAZ investment, evidence was drawn from local pilot schemes in intermediate care (see Box 3). The existence of these schemes has been significant in a number of ways.

3.9 First, they provided examples of how different service models could be planned and developed in Cornwall. Drawing upon the typology used in Box 2, the pilots provided evidence on the process and outcomes of implementing rapid response schemes, residential/hospital based rehabilitation and supported discharge. They also tested
approaches that relate to but that are not fully captured by the typology (e.g. holding service, hospital in-reach).

Box 3: Local Pilot Schemes in Intermediate Care

St Martin’s Homeward Bound Rehabilitation Unit.

This unit was established following a successful joint RCHT and Cornwall Care bid for winter pressures funding in late autumn 1997. A section of St. Martin's House, a residential care home run by Cornwall Care in West Cornwall, was converted into a 12-bedded residential unit including a 'normal house sized' bedroom, bathroom and kitchen for a more realistic rehabilitation environment. Up and running by January 1998, the unit allows patients to rehabilitate in a less medically orientated, more home-like setting. This provides them the opportunity for intensive functional rehabilitation by taking them out of an environment where they are 'cared for' into one where they are 'enabled' to care for themselves (Hawkins, 1999).

The initial winter pressures grant was augmented by Joint Finance to take the St. Martin's project up to April 2000 and, since then, HAZ and Social Services match funding has continued to support the unit. The unit was originally designed to provide only 'step down' rehabilitation to older people who are medically fit to be discharged from hospital but who are not physically or psychologically able to manage at home. Within this model, the unit was the subject of an evaluation by RCHT which was generally positive (Hawkins, 2000). 275 clients were found to have gone through the unit between January 1998 and February 2000. Of these only 9.1% and 2.9% were respectively readmitted to hospital or placed in long-term residential care. Though based on small numbers, the study also found evidence that clients improved physical function and well-being. This evaluation provided the evidence base for St. Martin's to become the model on which the new Homeward Bound Units are based. The unit now operates both as a 'step up' and 'step down' facility, linking with the Integrated Community Rehabilitation Service to provide a choice of home-based or residential rehabilitation in West Cornwall.

Integrated Community Rehabilitation Project.

The Integrated Community Rehabilitation Project was first established as a waiting list initiative in Penwith and Kerrier in September 1998. Working on a locality basis, it knitted together community therapy resources (occupational therapy and physiotherapy) to provide a single and easy referral point for rehabilitation. The majority of patients were referred by GPs, though referrals were also made by hospital consultants, hospital-based OT/PTs and District/Specialist nurses. Following referral, an assessment was made (urgent within one day, routine within one week) and where appropriate a care package is established. This could include physiotherapy, occupational therapy, equipment, visits from rehab assistants or a short stay for rehabilitation in a residential setting. A review date was agreed within six weeks. Following review, the package could continue, be modified or cease. The aim is to provide a single easy referral route for rehabilitation services and to increase the ability of clients to function better and more safely in their own homes, so preventing admission to hospital and enabling early discharge to maintain independence and make maximum use of beds. Since 1999/00, the Integrated Community Rehab service has been funded by HAZ to allow continuance of the service during transition to the PCO and to boost the occupational therapy and physiotherapy complement to allow expansion of the scheme.

3.10 Second, the pilots built upon but in themselves contributed to local differences in existing services. For example, the emphasis placed in North and East Cornwall on optimising the use of community hospital beds is consistent with a desire to promote better access to care in the part of the county where access deprivation is greatest. According to the access domain of the DETR’s Index of Multiple Deprivation, 25 of the 57 wards in North and East Cornwall are amongst the 10% most access-deprived in England (CiS HA, 2001, p.43). North and East Cornwall have traditionally made higher use of community hospital beds than the other Primary Care Trust areas in the county, although bed provision per 1000 population in this area is comparable to that of West of Cornwall. Between 1997 and 2000, for example,
community hospitals within N&E made 7176 admissions, compared to 5454 and 5525 in West and Central PCTs respectively.

Box 3: Local Pilot Schemes in Intermediate Care (continued)

The British Red Cross Care and Response Service

The Care and Response Service evolved from standards on two new services issued by British Red Cross National HQ in 1998. Red Cross Branches were encouraged to develop a Domiciliary Respite Care Service and an Emergency Domiciliary Personal Care Service. The Domiciliary Respite Care Service was to provide planned and time-limited practical help and support to people in their own homes. The Emergency Domiciliary Personal Care Service was to provide rapid response to urgent situations in order to hold crisis situations and to assist with personal care where necessary. The latter service was developed and piloted in early 1998 in the Newquay and St. Merryn areas of Cornwall. With limited resources the service could only be offered during office hours and was consequently not used very often.

During this time a great deal of networking was done with health and social services to establish whether there was a real need for an emergency-style service. Feedback indicated that an out-of-hours fast response service was indeed needed, as was planned and time-limited support. In light of this, the Cornwall Branch decided to combine and rename the two arms of the care service to encapsulate the urgent and non-urgent elements. With the advent of the C&IoS Health Action Zone, a plan was devised for the year 2000 for Care and Response to become an integral part of the HAZ Eldercare Programme. It was envisaged that the Care and Response Service would support the intermediate care schemes by holding crisis situations to help prevent unnecessary hospital admissions. HAZ funding (£15k) was allocated in order to allow 70 additional volunteers to be recruited and trained to provide adequate countywide coverage of the Care and Response Service.

East Cornwall Community Resource Bed Management Project

This project began as a pilot scheme funded by winter pressures money in January 1999 and received some financial support from HAZ before becoming a permanent service provision. The overall aim of the project is to facilitate earlier transfer of Cornish patients from the Plymouth acute and community trusts, to fully and appropriately utilise Cornwall's community hospital beds and ensure smooth, successful discharge from Community hospitals. The project has endeavoured to transfer Cornish patients closer to home, at the earliest optimum time, matching the correct patient to the correct rehabilitation environment regardless of geographical boundaries.

3.11 The Penwith/Kerrier Integrated Community Rehabilitation Project similarly built upon previous interest and investment in community-based rehabilitation. South Kerrier was one of two areas to have implemented a pilot project of Community Assessment and Rehabilitation Teams (CARTs) in 1993/94. Although the CART no longer officially existed in 1998 when proposals were drawn up for the integrated community rehabilitation pilot, it had influenced the provision of and attitudes to community rehabilitation services in the area. For example, GPs were used to having one central referral point. Historically, West of Cornwall has also benefited from a significantly larger resource of community-based physiotherapists and occupational therapists than other localities and from the existence of St Martin’s Homeward Bound Unit.

3.12 These differences in historic investment yield lessons for neighbouring localities that embark on new schemes that have been tried and tested in other areas. They have also contributed to variation between localities in the role played by different components of intermediate care. When evaluating HAZ-funded elements of the intermediate care schemes, it is therefore important to appreciate how they fit in the local system as a whole. In light of this, this report
describes the wide range of intermediate care service models in Cornwall, HAZ and non-HAZ funded.

**Key Messages**

3.13 Whole systems thinking has informed the development of intermediate care services in Cornwall. CIoS HAZ has played an important role here and partnerships have been strong between key countywide agencies. For example, the National Service Framework for Older People Local Implementation Team Steering Group (NSF LIT SG) played an early role in generating the necessary overview for improvements in service configuration and in establishing shared commitment to support new developments.

3.14 Organizational turbulence and an emphasis on developing services in accordance with local service needs and structures has affected the extent to which strong strategic direction was supported by strong strategic co-ordination and management in the early stages of intermediate care development. Although the joint chairs of the NSF LIT SG were nominally appointed as Intermediate Care Co-ordinators for the county, their remit (to provide strategic overview and direction) was somewhat different to that of a dedicated Intermediate Care Co-ordinator.

3.15 The fact that the NSF LIT Steering Group considered intermediate care as a cross-cutting theme and acknowledged the role played by the Countywide Promoting Independence Group meant that, unlike other key standards of the NSF, a countywide Task Group was not appointed for intermediate care. This may have reduced the extent to which strong strategic direction during the early stages of Intermediate Care planning was sustained. The scope for providing a countywide steer has been further affected by the decision to disband the NSF LIT SG.

3.16 Local pilot schemes have demonstrated how different Intermediate Care services could be planned and developed in Cornwall. These had tested a wide range of service models. However, they have also contributed to variations between localities in the role played by different components in Intermediate Care. Local variation is thus a key feature of Intermediate Care developments in Cornwall.
4 Intermediate Care Co-ordination

4.1 It is generally agreed that the co-ordination of intermediate care must take place at both strategic and operational levels and that in complex communities such as Cornwall, it is not possible for one person - or group - to manage both (Wilson and Stevenson, 2001).

Strategic Level Functions

4.2 In 2001, a briefing paper jointly produced by the King’s Fund Programme ‘Developing Rehabilitation Opportunities for Older People’ and the Head of NSF Implementation at the Department of Health set out the range of functions for the strategic co-ordination of intermediate care. These are listed in Box 4.

4.3 The paper sets out an ambitious array of tasks that would be challenging to fulfil in simple organizational contexts, so it is perhaps to be expected that strategic co-ordination has been fragmented in Cornwall, a county characterised by considerable organizational complexity:

- The Health Action Zone (which has provided a significant proportion of the budget for new intermediate care schemes) and Social Services Department (which is both a major funder and a key partner in the implementation of intermediate care) are countywide agencies. Yet, planning and implementation have been undertaken at PCO level.
- Lack of coterminosity has been compounded by the distances that have to be travelled in a highly rural county. For example, the fact that a small number of Health and Social Services strategic managers have to travel the length and breadth of the county to discuss planning and implementation issues within each PCO adds to the difficulties of evolving a coherent system of strategic co-ordination.
- Major organizational restructuring has taken place over the past three years. Responsibilities for key strategic functions have shifted from the level of the Health Authority to Primary Care Trusts (PCTs) and different areas have assumed Trust status (and thus specific levels of strategic responsibility) at different times. The merger of five PCOs into three PCTs in April 2002 and the disappearance of a countywide Health Authority have resulted in further organizational change with significant consequences for responsibility for service planning and delivery.

4.4 Feeling that, in their early stages, PCOs had too large an agenda to take a lead on intermediate care, Social Services effectively assumed a strategic co-ordination role for those elements that received significant support from Social Services Modernisation Funds. The Social Services Modernisation and Partnership Manager played a key co-ordination role, setting up a countywide Promoting Independence group and working closely with representatives from Cornwall Healthcare Trust (CHT). Through this work, a coherent strategy was devised for the recruitment and retention of new therapists and the training of Rehabilitation Care Assistants. Criteria, transfer protocols and care pathways were agreed for admissions to the residential Homeward Bound Units; and arrangements were set in place for the monitoring of these units. Thus, with some exceptions (e.g. the development of pooled budgets, monitoring and evaluating the use of Rehabilitation Care Assistants), many of the strategic-level functions identified in Box 4 have been addressed for Scheme 4 (residential rehabilitation) and Scheme 5 (community rehabilitation) developments.
4.5 Whilst these schemes account for much of the new intermediate care development in the county and are the elements that have also received significant HAZ funding, they do not make up the intermediate care system as a whole. Nor, examined in isolation, do they reflect the whole system of which intermediate care is a part. According to the Briefing Paper on Intermediate Care Co-ordination (Wilson and Stevenson, 2001), the purpose of strategic level co-ordination is ‘to ensure that intermediate care is integrated across the statutory and independent sectors, and across primary care, community health services, social care, housing and the acute sector’. The strategic-level functions required to fulfil this purpose imply the need of an Intermediate Care Co-ordinator. However, a dedicated co-ordinator was not appointed at countywide level and there has been variation between the localities in the approach taken to formal co-ordination.

Box 4: Intermediate Care Co-ordination: Strategic Level Functions

1. To ensure that service planning for intermediate care takes place within the context of service planning for the NSF generally and within the Joint Investment Planning process
2. To ensure that financial resources are clearly identified for intermediate care services and supported with efficient systems of financial management
3. To develop shared/pooled budgets for intermediate care across health and social services
4. To ensure that arrangements are in place to provide a consistent and integrated response across the whole system of health and social care in the designated areas
5. To map existing intermediate care provision, and check that criteria, transfer protocols and care pathways are agreed by local stakeholders and are in place
6. To ensure that arrangements are in place for monitoring, auditing and evaluating the quality and effectiveness of intermediate care
7. To ensure that explicit arrangements and clear lines of accountability are in place for the management of case managers and other staff involved in the provision of intermediate care across the whole system
8. To secure local agreement on the provision of medical services, and monitoring of standards, in support of intermediate care provided in the statutory and independent sectors
9. To develop joint protocols and decision-making and information-sharing processes within the area, across professional and organizational boundaries, where these are not yet agreed and in place, with particular emphasis on linkages with mainstream services
10. To develop data systems and evaluation measures to provide information on service performance/trends, identify gaps and outcomes for individuals
11. To evaluate the effectiveness of the overall intermediate care system, and the services within it, against agreed performance criteria
12. To develop service models/change working practices to improve the quality of existing services or to meet unmet need for intermediate care
13. To gather information from a wide network regarding research and innovation in intermediate care, and act as an expert point of reference for commissioners and service providers locally
14. To liaise with stakeholders in neighbouring localities to ensure the effective management of cross-boundary patient flow in respect of intermediate care
15. To ensure that developments in intermediate care are effectively communicated to local stakeholder organizations, staff and the public

Wilson and Stevenson, 2001

Local Models of Strategic Co-ordination

4.6 Formal structures to provide strategic direction for intermediate care were created at the outset in three localities. In the fourth, East Cornwall, the Community General Manager (now Director of Operations for North and East Cornwall PCT) promoted the development of step-down arrangements from Derriford Hospital some time before Intermediate Care was even
Strategic Co-ordination in North Cornwall

4.7 In North Cornwall, the fact that the Partnerships Manager was a previous manager within CrôS Health Authority, and one of the architects of the HAZ Eldercare Implementation Plan, has provided a critical strategic resource. North Cornwall planned a whole-systems approach to intermediate care from the outset and incorporated a whole range of new service elements into its schemes. The Partnership Manager took a lead role in developing service models, communicating developments to local stakeholders and troubleshooting where barriers to implementation arose. With established strategic links, she has been one of the most regular PCO participants at countywide partnership meetings (such as the Promoting Independence Group) and has tended to liaise directly with SSD strategic leads. Hospital consultants have been included in the North Cornwall NSF Implementation Group. North Cornwall was proactive at an early stage in addressing problems surrounding transfers from Royal Cornwall Hospital Trust (RCHT). Drawing upon the example of East Cornwall’s Community Resource Bed Management Project, it was also one of the first PCOs to appoint a local level intermediate care co-ordinator. This activity has subsequently placed North Cornwall in a strong position with regard to its intermediate care systems.

Strategic Co-ordination in Carrick

4.8 Carrick PCT has also strongly steered intermediate care developments at a strategic level. A Rapid Response and Homeward Bound Service Team was appointed early in 2000, comprising GP, District Nurse, Social Services, Heads of Occupational Therapy and Physiotherapy services and CHT representatives as well as PCG development managers. This took responsibility for a range of strategic functions listed in Box 4, particularly the development of service models, the clarification of processes and protocols and communication to local stakeholders. Representatives of various agencies ranging from RCHT to local charities supporting housing adaptations have been invited to meetings to discuss synergies. In 2001, the work of the Group refocused to examine aspects of the NSF and Intermediate Care and in mid 2001 a dedicated appointment was made to undertake a six month pilot project in which intermediate care options in Carrick were mapped and protocols developed for relevant professionals. The need for an Intermediate Care Facilitator was highlighted and a 12 month post was funded and developed.

Strategic Co-ordination in West of Cornwall

4.9 A Rehabilitation Task Group was established in West of Cornwall in April 2000. The focus and composition of this group reflected the fact that, rather than embarking upon new service developments, West of Cornwall proposed to build upon the existing Integrated Community Rehabilitation Project (ICRP) and St Martin’s Homeward Bound Rehabilitation Unit (see Box 3). Thus, the teams established as part of the ICRP were to continue to provide a single point
of referral for rehabilitation. With a remit to expand upon existing schemes, the Rehabilitation Task Group in West of Cornwall had less developmental work to undertake than its counterparts in North Cornwall and Carrick which were developing schemes from scratch. Community Rehabilitation staff made up a high proportion of its membership. Representatives from RCHT, Social Services, the PCG and Cornwall Care (an independent provider) also attended.

4.10 The minutes of early meetings reveal good strategic and operational understanding of appropriate pathways in intermediate care and the links between intermediate care and other services. Some of the problems that need to be addressed in embedding intermediate care into mainstream service provision (including geographical inequity in numbers of key staff such as physiotherapists) are well articulated. Early reference is made to the need to ensure that service planning for intermediate care took place within the context of the NSF. The significant advantage of providing a single point of entry for patients and referrers is clearly emphasised. The group also mooted the idea of appointing a local Intermediate Care Co-ordinator as early as August 2000.

4.11 The high quality of this strategic thinking is reflected in the Review of Intermediate Care developments that the Group produced for the PCT Executive Committee in September 2001. This sets out a vision of developing Integrated Primary and Community Services (IPACs) Teams that are physically co-located on a locality basis. Comprising Nurse Assessors and Social Services Care Managers as well as the current therapy staff, the aim of the Teams would be to have access to and information on the full menu of intermediate care services and be best placed to reach these.

4.12 The recommendations of the Review have yet to be considered by the PCT Executive Committee and this has halted progress towards developing an integrated system of intermediate care across primary care, community services, social care, housing and the acute sector. A number of factors appear to have been at work here. Having piloted models of community and residential rehabilitation that were subsequently rolled out across the county, West of Cornwall was undoubtedly ‘ahead of the game’. Thus, unlike neighbouring localities that have had to plan and review new schemes in order to respond to new government guidance, there has been less pressure on the PCT to drive forward developments. The PCT has been forward thinking in encouraging front-line professional staff to provide strategic direction. However, whilst the concepts and protocols that have been developed by the occupational therapists and physiotherapists that sit on the Group are highly relevant and workable, they cannot be embedded without strategic management support. Finally, West of Cornwall has not had an Intermediate Care Co-ordinator to ensure that priority is given to service planning for intermediate care. This has had unfortunate consequences for the fulfilment of both strategic and operational-level functions.

Gaps in Strategic Co-ordination

4.13 As indicated above, strategic co-ordination has not been consistently present across the county. With the gradual shift in responsibility for service planning from the Health Authority to PCO areas, there has been an inevitable blurring of responsibility for strategic co-ordination. As a result, responsibility for some key strategic functions has been fragmented between organizations, duplicated by agencies or, indeed, fallen between stools.

4.14 For example, responsibility for ensuring that financial resources have been clearly identified for intermediate care (task 2 in Box 4) has been somewhat blurred, in part because the
funding streams for the various schemes are extremely complex. Whilst SSD and HAZ still provide the greater proportion of funding for new intermediate care schemes (and worked closely at a strategic level to identify key areas of investment), many of the contractual arrangements are made by PCTs who bear the ultimate responsibility for ensuring that service developments are mainstreamed. Progress in developing pooled budgets across health and social services (task 3) has undoubtedly been affected by the fact that organizational - and financial - structures have been in a state of flux. However, the fact that intermediate care schemes have been successfully established without pooled budgets has reduced the perceived need to change existing financial arrangements.

4.15 In addition to duplication in carrying out strategic tasks, the shift towards localism has created gaps both in the representation of key strategic players and in the identification of responsibility for key strategic functions. PCOs have differed with regard to the composition of their NSF implementation groups. In some cases, Social Services have not been represented by the Department’s strategic leads but by local Care Managers. Where this occurred, the local nature of SSD representation may have given rise to a tendency to focus more on operational issues than on strategic co-ordination.

4.16 Hospital consultants and other relevant professional groups within secondary care have not always been included in local implementation groups either. Where representation has been poor, there has been a weak interface between the acute sector and PCO-led developments in intermediate care. For example, transfer protocols from RCHT were not adequately developed at the outset (tasks 5 and 9). The fact that different PCOs have operated to different referral systems (task 4) has also created difficulties for the RCHT Discharge Team. Finally, insufficient thought was given to securing local agreements on the provision of medical services to support intermediate care (task 8). This raises concerns that some older patients who, on the basis of nurse or therapist assessments, have been sent directly to intermediate care settings could also have benefited from diagnostic evaluation by a geriatrician.

4.17 Due to the blurring of boundaries surrounding responsibilities and roles, gaps have also occurred around the mapping and modelling of intermediate care services. In the government guidance, the need to map levels of capacity and patterns of service provision and to identify the impact of intermediate care on the whole continuum of care is clearly identified. However, with the exception of areas for which Social Services have lead accountability and/or targeted areas for performance monitoring, systems for mapping and monitoring intermediate care have been slow to develop (tasks 5, 6, 10). Due to a lack of readily available information about capacity, transfer patterns and outcomes in the full range of intermediate care services, it is difficult to evaluate the effectiveness of the overall intermediate care system (task 11). Gaps in provision may not be adequately identified or service areas for investment (and indeed dis-investment) distinguished (task 12).

4.18 There is now growing recognition across the county of the difficulties of continuing to develop service models without strong strategic co-ordination of the system as a whole. Largely through attempts to strengthen operational level co-ordination, better strategic understanding of local intermediate care arrangements is emerging (see below). The interface with the acute sector is improving as RCHT has begun to review its own processes for improving the patient journey through the emergency admissions process. Since April 2002, the countywide Promoting Independence Group has been hosted by Central Cornwall PCT. It is hoped that this will encourage more regular attendance by PCT representatives at a meeting designed to bring strategic leads and professional representatives (from Social
As a result of these developments, key strategic functions that have hitherto been inadequately addressed are starting to be more effectively discharged. Indeed, there is a widespread perception that ‘change is really happening in 2002’.

**Operational Level Functions**

4.19 The purpose of operational level co-ordination is ‘to optimise the quality of care for individual service users by ensuring oversight and efficient management of intermediate care in a defined locality on behalf of the commissioning agencies’ (Wilson and Stevenson, 2001). Two broad tasks have been identified to this end. Each involves a range of functions that is listed in Box 5. The first task is to ensure the efficient organization and management of the referral, assessment, case management, admission and discharge arrangements (functions 1-14). The second is to ensure the efficient use of the intermediate care system (functions 15-26).

4.20 Operational co-ordination has been a real strength in some parts of Cornwall where significant progress in addressing most of the functions listed in Box 5 has been or is being made. Approaches to co-ordination have varied across localities. In North Cornwall, the Intermediate Care Co-ordinator provides a single point of contact, effectively overseeing both step-up and step-down arrangements. In Carrick, an Intermediate Care Facilitator was not appointed until December 2001. However, significant progress has been made since this time in establishing the structures, linkages and processes to carry out a wide-ranging remit. In East Cornwall, operational co-ordination has been split between different staff, though the Facilitator of the East Cornwall Community Resource Bed Management Project and the Specialist Support Nurse who facilitates the Rehabilitation Assessment Scheme (now known as Promoting Independent Assessment) have liaised well together. In April 2001, the former took on formal responsibility for leading Intermediate Care Co-ordination. Care Co-ordinators have not been appointed in West of Cornwall and Restormel. West of Cornwall is seeking to make an appointment in the near future. If the current post in Carrick is extended beyond December 2002, this will need to be rolled out to cover Restormel which is now part of Central Cornwall PCT.

4.21 Importantly, lessons learnt from existing approaches to co-ordination are being increasingly shared between localities. The Intermediate Care Co-ordinator in North Cornwall, appointed in October 2000, drew upon the experience of the Facilitator of the East Cornwall Community Resource Bed Management Project to develop assessment, case management, transfer and monitoring arrangements for step-up and step-down operations. She in turn has provided a vital source of support for the Intermediate Care Facilitator in Carrick, who has modelled her own role largely upon that developed in North Cornwall. Prompted by HAZ, these operational co-ordinators are also starting to meet regularly to explore how a consistent approach to capturing information on intermediate care can be developed across the county. They are increasingly involved in developmental work and are taking on strategic level co-ordination functions themselves. Thus, like many other partnership projects in Cornwall, intermediate care systems are being developed, in a very real sense, from the ‘bottom-up’.
### Box 5: Intermediate Care Co-ordination: Operational Level Functions

1. To provide advice to the NSF Local Implementation Team on the strategic development of intermediate care services
2. To review and develop clear admission criteria for each scheme within the locality and ensure that there is no duplication
3. To promote awareness of the intermediate care system, admission criteria and access point(s) with potential referrers
4. To ensure clinical and social care input to assessment, as well as client involvement and carer involvement where appropriate and in keeping with the client’s wishes
5. To make sure that clients enter services at the most appropriate point on an agreed care pathway, with a named case manager and individual care plan and review data, building on local assessment and care management arrangements
6. To either negotiate placements and discharges into and out of intermediate care or authorise patient transfers arranged by appropriately designated case managers
7. To ensure that appropriate service specifications are in place for all intermediate care settings
8. To monitor intermediate care services to ensure contract compliance in all aspects of care and the environment/capacity to provide high-quality care appropriate to client needs.
9. To ensure that appropriate medical cover is arranged either via a GP or hospital specialist, in accordance with arrangements established by the commissioners of intermediate care
10. To undertake regular planned reviews of client outcomes for each intermediate care setting.
11. To report data on capacity, throughputs and outcomes to the commissioner on a regular basis.
12. To instigate and co-ordinate audit of intermediate care services
13. To identify the training needs of intermediate care staff and develop ways of meeting these needs
14. To monitor costs of services and manage a budget for problem solving.
15. To identify clients who would benefit from intermediate care and ensure their smooth transfer in accordance with an agreed care plan.
16. To make plans prior to admission for those elective patients admitted to acute hospital care with an anticipated discharge pathway through intermediate care
17. To make plans for non-elective patients as soon as they are transferred
18. To monitor progress against care plans, ensuring that care is available as agreed and that clients achieve their personal outcomes
19. To set up systems to ensure day-to-day monitoring of capacity in the intermediate care system, to ensure that clients are transferred as soon as they are ready to go to their next planned destination (maximising capacity).
20. To ensure non-old age hospital consultants are engaged in the intermediate care system and the potential to refer people to more appropriate settings
21. To agree access to intermediate care out-of-office hours and at weekends (e.g. via GP co-ops) with key partners and service providers
22. To assist GPs and other referrers to access the most appropriate service, by problem solving and directing clients at the threshold of inappropriate hospital admission to the most appropriate level of care
23. To identify and speedily resolve problems and blockages in the system in order to ensure that other services can operate efficiently.
24. To ensure that systems are in place and agreed for the client’s records/care plans to be transferred through the system with them.
25. To ensure that equipment needs are identified and swiftly met and that equipment is retrieved when a client no longer needs it.
26. To ensure that systems are in place to trigger other actions whilst the client is in intermediate care (e.g. home adaptations, putting together domiciliary packages).

*Wilson and Stevenson, 2001*
Local Models of Operational Co-ordination

4.22 The three localities in Cornwall that have developed systems of operational co-ordination have evolved slightly different approaches. It is useful to explore some of these differences and to consider the lessons that can be learnt by areas that have yet to establish an operational co-ordination role. In essence:

- In East Cornwall, operational co-ordination has been largely undertaken by three senior clinical staff. The Community Resource Facilitator of the East Cornwall Community Resource Bed Management Project is based entirely in Derriford Hospital and, since January 2001, has been assisted by an additional staff member. Now known as the Intermediate Care Team Leader and Intermediate Care Co-ordinator, this team acts as a single point of contact for acute and community ward nurses, Discharge Liaison staff and bed managers who identify Cornish patients for discharge. The team then uses its knowledge of community care and capacity to identify an appropriate destination for the provision of intermediate care (see Section 11 for more detailed description). This work is complemented by the co-ordinator of the Rehabilitation Assessment Scheme (now Promoting Independence Assessment) who is entirely community-based and who oversees step-up arrangements co-ordinated by G-Grade Nurse Assessors. Responsibility for overseeing other parts of the Intermediate Care system (e.g. community and residential rehabilitation) lies with other senior managers. Thus arrangements of co-ordinating the whole system of intermediate care are still evolving.

- In North Cornwall, the Intermediate Care Co-ordinator, who is entirely community based, provides a single point of co-ordination. She liaises with the Discharge Liaison Team to discuss discharge options for North Cornish patients admitted to RCHT and with ward nurses to discuss discharges from Barnstaple into intermediate care. Patients to be discharged from Derriford are directed to her by the East Cornwall Intermediate Care Team. The Intermediate Care Co-ordinator also liaises closely with community staff to oversee step-up arrangements.

- The Intermediate Care Facilitator in Carrick works in both acute and community settings and is expected to proactively facilitate both step-up and step-down arrangements. Unlike her counterpart in North Cornwall (who organises intermediate care provision for patients identified by others), hospital in-reach is part of her remit. In other respects, she has a similar remit to that of the North Cornwall Co-ordinator.

4.23 In addition to differences in job remit, the development point at which co-ordination roles have evolved has differed between the three areas. The East Cornwall Community Resource Facilitator has been in post since 1999. She has thus had the longest lead-time in which to establish systems and linkages, though, since assuming the title of Intermediate Care Team Leader, there has been a redefinition of her role which now explicitly involves many of the functions listed in Box 5. In North Cornwall, the Intermediate Care Co-ordinator’s role evolved, since 2000, alongside the development of new intermediate care schemes. By contrast, the experience of the Intermediate Care Facilitator in Carrick, a more recent post, illustrates the processes (drawn out below) involved in developing a co-ordination role for schemes that are already established.

4.24 The examples of Carrick and North Cornwall, both of which involve a single point of co-ordination, are considered in more detail below.
Operational Co-ordination in North Cornwall

4.25 The task of operational co-ordination in North Cornwall has evolved from the post of a Patient Discharge Co-ordinator who was appointed in October 2000. In April 2002, her title formally changed to that of Intermediate Care Co-ordinator. The Co-ordinator’s role (which built upon that pioneered in East Cornwall) involves oversight and management of transfers, step-up and step-down, to a range of intermediate care settings. She thus provides the closest example in the county of a single point of contact for intermediate care and, as such holds ‘the big picture’ about capacity, throughput and outcomes throughout the system.

4.26 Factors that have supported the development of the Intermediate Care Co-ordinator’s role include:

- **The role of the Partnerships Manager in North Cornwall** (see 4.7). The Partnerships Manager has been able to offer the Intermediate Care Co-ordinator strategic vision, good linkages and practical support in negotiating intermediate care arrangements with key partners.

- **Good liaison with the Community Resource Facilitator** of the East Cornwall Community Resource Bed Management Project. This provided the Intermediate Care Co-ordinator with a model on which to base step-down procedures and monitor acute discharges.

- **Simultaneous development of a range of schemes**. Whilst an Emergency Care and Response Service was already in existence in North Cornwall, many service elements (community nurse assessment, therapy assessment, the homeward bound unit, rehabilitation care assistants) went live in the latter part of 2000. Systems and procedures that are evolving together are perhaps easier to integrate than those that are well-established. ‘Whole systems’ thinking was of benefit here.

- **Resources**. This is a dedicated post (in contrast, for example, to that of the RAS/PIA nominated lead in East Cornwall who, in addition to co-ordinating the Prevention of Admission Scheme, carries a clinical caseload as an eldercare nurse and bears a number of other responsibilities). The North Cornwall Intermediate Care Co-ordinator also holds her own budget for problem solving (e.g. spot purchasing beds, arranging transportation for patients). Although small, this gives greater flexibility in catering for the needs of individual patients. The lack of a nominated budget is a source of frustration for other intermediate care co-ordinators in the county.

- **Close location of the Intermediate Care Co-ordinator and the Community Therapy Team** (CTT). This has encouraged close liaison around therapy assessments (and thus step-up operations). The CTT also agreed to transfer organization of admissions (following therapy assessment) to the Homeward Bound Unit (HBU) to the Intermediate Care Co-ordinator, providing a single point of contact for HBU admission and information about HBU capacity.

- **The Intermediate Care Co-ordinator holds the waiting list for community hospital beds** in North Cornwall and attends community hospital liaison meetings on a weekly basis. This not only provides a single point of contact for both step-up and step-down referrals. With information about capacity in other intermediate care settings, the Co-ordinator can direct patients to alternative places of care if a community hospital bed is not the most appropriate option (a model developed in East Cornwall).

- **The Intermediate Care Co-ordinator processes Rapid Response assessments by G Grade nurses** where referrals are made to settings such as 7-day assessment beds and
Based in the community, and with good knowledge about daily capacity in the range of intermediate care settings, the Intermediate Care Co-ordinator in North Cornwall is in a good position to balance the flow of patients into and out of intermediate care from the acute sector and the community. With oversight of the whole system, she undertakes most of the functions listed in Box 5. Exceptions include tasks 8 (undertaken by contract managers), 12, 20 (no non-old age hospital consultants are based in North Cornwall), 21 and 24 (a task that should be easier to fulfil with the introduction of the single assessment process). She also fulfils several of the strategic-level tasks listed in Box 4, particularly around the development of monitoring systems, the identification of unmet need and the gathering and dissemination of information about intermediate care (tasks 6, 10, 12-15). Ensuring explicit arrangements and clear lines of accountability (task 9) is becoming part of her role, in conjunction with the overall Intermediate Care Team Leader for North and East Cornwall.

The approach taken to operational co-ordination in North Cornwall has therefore been largely successful. The intermediate care co-ordinator’s role is also continuing to develop as she takes on strategic level functions, identify gaps in operational tasks such as monitoring the full range of intermediate care options and seek to address service deficits such as the organization of transport. This approach to intermediate care co-ordination has been held up as a model of good practice and elements are already being replicated in areas such as Carrick. However, the model is continuing to evolve in response to the need to unify systems across the new PCT area of North and East Cornwall. It is also important to acknowledge the lead-time required to embed such a co-ordination role as well as the barriers that have been encountered along the way. To this end, the Facilitator’s role in Carrick, which is in an earlier stage of development, provides a useful example.

Operational Co-ordination in Carrick

An Intermediate Care Facilitator (ICF) was appointed in Carrick in December 2001 following a six month pilot project in which intermediate care options in Carrick were mapped and protocols developed for relevant professionals. According to the job description, the ICF’s role is to ‘facilitate the prevention of admission and earlier discharge of patients from acute hospitals, ensuring full use is made of the menu of intermediate care solutions and to prevent admission to long term care. This includes identifying and tracking patients through their journey of care in whatever setting and liaising with all care providers to ensure appropriate transfer to step up or down facilities or optimum discharge home’.

The ICF is expected to have ‘on-going knowledge of the whereabouts of elderly or physically disabled Carrick patients who have been admitted to acute, community or intermediate care facilities’ and ensure that ‘those patients are receiving the right service at the right time according to their needs’. This role has much in common with that developed in North Cornwall. However, the ICF’s remit also includes an element of hospital in-reach (to RCHT), a function that is undertaken in the East of Cornwall, but not by the North Cornwall Intermediate Care Co-ordinator.

The ICF has also had a shorter lead-time than her counterparts in North and East Cornwall in which to embed new systems and linkages. As a result, her experience offers valuable lessons...
about some of the processes involved and barriers encountered in developing a co-ordination role. Key areas for proactive liaison have included the PCT/secondary care interface, the interface with the community therapy team and other community services, and the development of monitoring systems for intermediate care.

The PCT/Secondary Care Interface

4.32 Reflecting upon the evolution of her role, the North Cornwall Co-ordinator has described the agreement reached with RCHT in April 2001 - seven months after she had assumed her post - to transfer control of the community hospital waiting lists as a 'turning point'. This provided the Discharge Liaison Team (DLT) at RCHT with a single point of contact for referring intermediate care patients to North Cornwall. It also allowed the Co-ordinator to direct discharged patients to appropriate intermediate care settings without having to undertake hospital in-reach (a role perceived by the DLT to duplicate its own function and one that would have stretched the Co-ordinator's capacity).

4.33 Unlike her counterparts in both North and East Cornwall, the ICF does not hold the waiting list for beds at Falmouth, the only community hospital in Carrick. Thus, in order to promote access to the full range of services available in the community, she is liaising with the DLT and undertaking hospital in-reach. This involves visiting the wards and supporting ward nurses in the identification of patients for discharge. Intermediate care charts laying out the menu of available services have also been prepared for ward staff.

4.34 The ICF's early perceptions are that ward staff value information about intermediate care options and respond well to a more proactive approach to discharge planning. In seeing her role as one that is more strongly focused on the development of active packages of post-hospital care than in facilitating discharge per se, she also makes a clear distinction between her work and that of the existing discharge team. Despite this, tensions have arisen around a potential blurring of the roles of the ICF and DLT. The scope for undertaking proactive hospital in-reach should also be reviewed in light of proposals by RCHT to establish multidisciplinary Discharge Teams. In addition to nurses, these would comprise physiotherapists, occupational therapists and social workers, professional groups that should be receptive to the development of active packages of care and to the improvement of links with community services. Should the composition of discharge teams change in this way, the role of the ICF may be better directed at providing a single point of contact for referrals, like her counterparts in the North and East of the county. This role would also be strengthened if the ICF held the community hospital waiting list for her area.

The Community Therapy Team.

4.35 As noted above, the Intermediate Care Co-ordinator in North Cornwall facilitates admissions to the local Homeward Bound Unit (step-up and step-down) following therapist assessment. In other parts of the county, including Carrick, Intermediate Care Co-ordinators have little involvement in the processing of HBU admissions. For step-up arrangements, a community nurse or GP has to fax a referral to the Community Therapy Team (CTT) which then arranges the assessment. Paperwork is then sent to the Social Services Department (SSD) in order to obtain funding approval. For a step-down referral, a therapy assessment is arranged in the hospital and, if the patient is eligible for care within the HBU, a form faxed to SSD, the HBU and CTT which accepts referrals onto a waiting list.

4.36 The process can be cumbersome. It also means that the ICF, who needs to have information about capacity across the schemes to effectively transfer patients, and who may also have

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other options if HBU beds are full, is not part of the feedback loop about patients who are considered for admission to HBU. Agreeing an effective way of ensuring that the ICF is part of the referral process is thus an ongoing area for liaison between the Facilitator and Community Therapy Team. The ICF also liaises regularly with the HBU to establish bed states.

**Other Community Services**

4.37 Like the Community Therapy Team, other key elements of the intermediate care menu in Carrick were established before the ICF assumed her post. In order to work towards acting as a single point of contact, the ICF regularly communicates with a range of local stakeholders. She attends weekly multi-disciplinary ward meetings at Falmouth Hospital. She has visited all surgeries in Carrick to establish clear lines of communication with primary care medical, nursing, therapy and social care professionals. Strong links have been forged with elderscare nurses and community nurses who have been encouraged to contact the ICF by phone when they are considering using schemes and use the ICF to procure services (thereby assuming responsibility for phoning around, filling in the paperwork, faxing SSD, planning for discharge etc). Links are being forged with all Care Home managers in the area as well as Red Cross and Age Concern managers. The ICF has met with Social Services care managers, case co-ordinators and social workers. Significantly, she is also developing links with related services such as sheltered housing (the manager of which has been included in local Promoting Independence meetings) and Care and Repair. The use of sheltered schemes as a potential source of intermediate care is currently under consideration as is the need to ensure that housing improvements are considered as part of overall care plans.

**Monitoring of Intermediate Care Schemes**

4.38 Monitoring is seen as a key function of the ICF’s role and a prerequisite of effective co-ordination. To this end, monitoring forms have been devised for all HBU admissions, holding situations, rapid response assessments, 7-day nursing or residential home assessments, community therapy assessments, community hospital admissions and day hospital cases. Guidelines have also been disseminated to help professionals capture activity that meets intermediate care criteria.

4.39 The ICF has also been proactive in piloting service models, such as the use of a Rapid Assessment Team in A&E and the Emergency Medical Unit at RCHT; and the use of Social Services Cash for Change monies (held by RCHT) to free up community hospital capacity.

**Progress in Operational Co-ordination**

4.40 In order to fulfil a clear goal of acting as a single point of contact for intermediate care schemes in Carrick, the ICF has developed a complex remit. In addition to a detailed job specification (which suggests good strategic thinking on the part of Carrick PCT), this has been informed by discussions with the North Cornwall Co-ordinator and the gathering of information regarding research and innovation on intermediate care. The ICF now has good strategic and operational knowledge about intermediate care structures, systems and linkages, barriers to implementation, and developments in neighbouring localities. As a result, she can act as an expert point of reference for local commissioners and service providers.

4.41 The ICF’s remit includes all of the functions listed in Box 5, with the exception of tasks 7, 8, 12, 14, 21 and 24. She has also assumed a number of strategic level functions, including tasks...
5 to 10 and 12 to 15 in Box 4. In order to act as a single point of co-ordination, however, the ICF has had to explore how her role can fit into existing structures and procedures. Whilst progress is being made in bringing rapid response assessments by G-Grade nurses into her purview, more barriers have been encountered in ensuring that the ICF can play an effective role in the facilitation of early hospital discharge and Homeward Bound admissions. Like the North Cornwall Co-ordinator, the ICF enjoys good strategic and practical support from PCT managers. This could be usefully harnessed in negotiating control of the community hospital waiting list. Supplementing the existing equipment budget with a nominated budget to allow flexibility in setting up alternative packages of care could empower the ICF. Finally, consideration should be given to the value of including hospital in-reach in what is already a large and complex remit.

Factors enabling Intermediate Care Co-ordination

4.42 Those responsible for co-ordinating Intermediate Care in Cornwall have developed roles and functions in a complex, changing environment. The organizational turbulence associated with the transfer of responsibility for planning, commissioning and reviewing services from the Health Authority to PCOs did result in early gaps in the fulfilment of both strategic and operational level functions. The Social Services Department played an important role in providing countywide direction for key schemes such as the development of Homeward Bound Units and the training of Rehabilitation Care Assistants. Certain PCO areas in Cornwall have also developed good local-level systems of co-ordination. Considering the three areas in which coherent systems of operational co-ordination exist, a number of factors appear to influence success:

Strategic Support

4.43 The role played by the North Cornwall Partnership Manager as a ‘product champion’ has been identified as a key factor in embedding whole systems thinking, involving key agencies and stakeholders and addressing barriers to the development of intermediate care schemes. Carrick PCT has similarly been proactive in planning and reviewing intermediate care developments. In both areas, links between operational co-ordinators and local implementation groups are strong. In West of Cornwall, by contrast, an operational-level group has taken a lead in providing strategic thinking around Intermediate Care. Whilst the Rehabilitation Task group has been highly skilled in identifying potential for improvements in service configuration, it does not have the power to take this forward, suggesting that the PCT does need to play a stronger role here. In East Cornwall, the vision of the then Community General Manager provided good strategic thinking at a very early stage. However, the PCG did not assume Trust status until it amalgamated with North Cornwall in April 2002 and, as a result, did not establish a Local Implementation Team. Responsibility for many of the functions listed in Box 4 was perceived to lie with the Health Authority and, whilst the co-ordination of key elements has been strong, arrangements for the co-ordination of the whole system were not initially embedded in East Cornwall.

Flexibility

4.44 Whilst a strategic approach has been beneficial in North Cornwall and Carrick, the lack of strong strategic direction has not prevented the Intermediate Care Team Leader in East Cornwall from developing a system of oversight and efficient management of step-down and step-up arrangements. Thus, this is a model that has evolved from the ‘bottom-up’. The co-
ordinators in North Cornwall and Carrick have also been given considerable scope to develop their own systems of management. Both link the freedom they have enjoyed with their ability to respond flexibly to individual patients’ needs. Flexibility in moving money around the system has also been identified as a key factor in helping to develop appropriate responses. To this end, access to Cash for Change money and to a nominated Intermediate Care budget have been advantageous.

Funding Dedicated Posts

4.45 In East Cornwall, the RAS/PIA nominated lead bears a number of other responsibilities, limiting the time that she can dedicate solely to co-ordination. The Intermediate Care Team Leader is appointed to a dedicated post and, since January 2002, has been supported by an additional hospital-based Co-ordinator. As a result, this team provides a more constant point of contact and is playing an increasingly important role in facilitating step-up arrangements with community-based professionals such as GPs and district nurses. This, together with the examples of the Intermediate Care Co-ordinators in North Cornwall and Carrick suggest that developing a single point of co-ordination implies the existence of a fully dedicated resource.

Communication

4.46 In all three areas, care has been taken to develop ways of clearly communicating the purpose of intermediate care services to potential referrers and, though to a lesser extent, users (for example, user representatives have been encouraged to attend West of Cornwall’s Rehabilitation Task Group). In North Cornwall and Carrick, the Partnerships Manager and members of the Rapid Response and Homeward Bound Service Team respectively took an early lead on this. Intermediate care charts have been prepared and local stakeholders personally visited. As operational co-ordination roles have become established, communication has become a core function of the Intermediate Care Co-ordinators. One factor that may increase receptivity to messages is shared professional or organizational background. In Carrick, for example, the GP and District Nurse representatives of the Rapid Response and Homeward Bound Service Team took responsibility for informing general practice staff of new developments. In East Cornwall, the fact that the Intermediate Care Team Leader was a District Nurse with good community knowledge may have smoothed relations with members of the Discharge Liaison Team in Derriford, most of which are also District Nurses by background. Perceptions of inter-professional barriers to communication are held by local co-ordinators. Thus, front-line staff could perhaps benefit from opportunities for shared reflection and discussion.

Close Location

4.47 The North Cornwall Co-ordinator is located in the same building as the Community Therapy Team. This partly accounts for the fact that she closely liaises with the Team around therapy assessments. Close team working has developed between the East Cornwall RAS/PIA co-ordinator and one of the CART teams, with which she shares an office. The close proximity of the East Cornwall Team to Social Services staff based in Derriford has also enabled effective communication. In the absence of close or co-location, other mechanisms (such as regular meetings) should be used to facilitate team building.
**Command of Places in Intermediate Care Settings**

4.48 Holding the community hospital waiting lists was identified as a key factor in enabling the Intermediate Care Co-ordinators’ role. This not only determines their ability to maintain ongoing knowledge about local capacity. It enables them to direct patients to the most appropriate setting to meet their needs (a task that sometimes involves releasing a community hospital bed in order to place a new patient). The extent to which Intermediate Care co-ordinators are acting as a single point of referral (thereafter organising placements and ensuring continuity of care) relates to the effectiveness with which they can carry out their co-ordination functions.

**Key Messages**

4.49 Intermediate Care co-ordination is essential for the successful development of service structures, processes and linkages. Co-ordination involves strategic and operational functions.

4.50 Strategic co-ordination has been fragmented in Cornwall due to the major restructuring within the health sector, a blurring of responsibilities between countywide and local organizations and the difficulties of working in a complex rural context. A dedicated strategic co-ordinator was not appointed at countywide level. However, Social Services effectively assumed a strategic co-ordination role for those elements that received significant support from Social Services Modernisation Funds.

4.51 Formal structures to provide strategic direction for intermediate care were created in North Cornwall, Carrick and West of Cornwall and good strategic thinking was present at an early stage in the East. Having planned a whole-systems approach to intermediate care from the outset and incorporated a whole range of new service elements into its schemes, strategic co-ordination has been particularly strong in North Cornwall. Carrick PCT has also demonstrated very good ‘whole systems’ thinking.

4.52 Responsibility for some key strategic functions has been fragmented between organizations, duplicated by agencies or fallen between stools. Particular gaps have occurred around the mapping and modelling of intermediate care services, resulting in a lack of readily available information about capacity, transfer patterns and outcomes in the whole system.

4.53 Key strategic functions that have hitherto been inadequately addressed are being more effectively discharged in 2002. This owes much to the progress that has been made in certain localities in strengthening operational co-ordination.

4.54 The role of the Intermediate Care Facilitator in Carrick has been largely based on that of the Intermediate Care Co-ordinator in North Cornwall who in turn drew upon the model piloted in East Cornwall. North Cornwall provides a local model of good practice, as the closest example in the county of a single point of contact for Intermediate Care.

4.55 Key areas for proactive liaison in developing a Co-ordinator role include the PCT/secondary care interface, the interface with the Community Therapy Team and other community services and the development of monitoring systems for Intermediate Care.

4.56 Factors enabling Operational Co-ordination include strategic support, flexibility of role, inter-agency and inter-professional communication, close location with other professionals, command of places in Intermediate Care settings and a nominated budget for trouble-shooting. Operational Co-ordination demands a full-time dedicated post. Systems and
procedures that are evolving together may also be easier to co-ordinate than those that are well established.

4.57 Like many other partnership projects in Cornwall, the role of Intermediate Care Co-ordination has developed from the ‘bottom-up’. This approach has much to commend it. However, concepts and protocols developed by front-line staff cannot be embedded without strategic management support.
Intermediate Care Services in Cornwall

5.1 As a recent District Audit report identified (Lyle et al, 2001), Cornwall has an impressive range of Intermediate Care services across the county. The report noted wide variation in the terminology used to describe services, a factor that may cause confusion for GPs whom the report describes as key gatekeepers of services. The use of many different names certainly affects rehabilitation services, which are variously provided by Community Assessment and Rehabilitation Teams (CARTs), Community Therapy Teams (CTTs) and Community Physiotherapy and Occupational Therapy Services. In some areas, however, this may be of less significance to the accessing of intermediate care services than the report implies.

5.2 Where Intermediate Care Co-ordinators are acting effectively as single points of contact, their knowledge of the menu of available services (regardless of their nomenclature) is likely to be a more important determinant of access than that of individual GPs. Thus, the fact that the District Audit found GPs’ awareness of ‘community rehabilitation teams’ and ‘residential rehabilitation units’ to be significantly lower in North Cornwall than the other localities needs to be carefully interpreted. This may be more of a reflection of the fact that, in order to procure access to schemes, GPs (or, more frequently, their G-Grade District Nurses) work through the Intermediate Care Co-ordinator. In West of Cornwall, by contrast, the fact that 71% of GPs surveyed had good or reasonable knowledge of community rehabilitation teams could reflect the fact that the latter are direct referral points for community rehabilitation.

5.3 Whilst confusion over terminology may not necessarily create a barrier to access, it does make challenging the task of describing the range of intermediate care options. Thus, for the sake of simplicity, the following sections focus on the general service models that have been developed in Cornwall. These include:

- Rapid response assessments (Section 6)
- Holding services (Section 7)
- Rehabilitation at home (Section 8)
- The use of Rehabilitation Care Assistants at home or within a residential unit (Section 9)
- Residential-based rehabilitation (Section 10)
- Community hospital-based rehabilitation (Section 11)
- Nursing Home Placements (Section 12)

5.4 A number of community hospitals in Cornwall also provide day rehabilitation, expanding menu options still further. HAZ funding has not been used to support this part of the Intermediate Care Continuum. Consequently, day rehabilitation is not considered in this report. Supported by a National Health Action Zone Fellowship, a clinical leader based in Central Cornwall PCT has completed preparatory work for the development of a ‘Hospital at Home’ service (Lyndon, 2002). This approach has not yet been piloted in practice in Cornwall. Thus, it is not considered in the report either.
6 Rapid Response Assessments

6.1 The aim of rapid response services is to provide urgent nursing or therapy assessment to people at home to avoid unnecessary acute or community hospital admission and, in the case of therapy assessment, to facilitate earlier discharge from hospital. Assessments can be carried out by G-Grade District Nurses, Occupational Therapists or Physiotherapists.

6.2 In step-up referrals, patients suitable for assessment are most commonly identified during the course of a District Nurse visit, a GP call (e.g. following a fall) or a visit by Social Services staff, though other potential referrers include A&E and NHS Direct. Points of contact for step-up referral are the patient’s surgery (for a Nurse assessment) or the Community Therapy/Rehabilitation Team. In order to facilitate early discharge, a Therapy Assessment may also be requested by acute hospital ward staff and/or therapy staff in the acute sector. The following section considers the role of G-Grade Nurse Assessors.

6.3 In Carrick, the contact point for Nurse Assessment is the patient’s surgery. In North and East Cornwall, one contact telephone number is provided. Having assessed a patient at their own home (in East Cornwall, a GP must also make a visit), G-Grade nurses can access a wide menu of services including:

- The direct provision of an enhanced package of nursing/social care at home
- An emergency care package from Social Services to hold the situation at home pending full assessment for up to 72 hours
- An admission for assessment for 7 days to a designated nursing or residential home where comprehensive assessment is undertaken by medical, nursing, therapy and/or Social Services staff to determine a suitable care plan or provide intermediate care and rehabilitation
- A qualified therapist assessment if rehabilitation at home or residential-based rehabilitation is appropriate
- A short programme of intensive therapeutic support (via the Care Manager) in a residential-based rehabilitation (Homeward Bound) centre
- A short programme of intensive therapeutic support (via the practice GP) in a day hospital or day centre
- A short programme of intensive rehabilitation therapy/care in a community hospital

6.4 The specific menu available varies between local areas. West of Cornwall, for example, has not yet introduced the use of designated nursing or residential home beds for 7-day assessments.

Inputs

6.5 Rapid Response nurse assessment is operationally well-embedded in Carrick, North Cornwall and East Cornwall where HAZ funding has been used to provide E/F grade support enabling the District Nursing Service to release G-Grades who are carrying out assessments. In Carrick, for example, all primary care teams with the exception of one had a nurse assessor in place by October 2000 as well as an F-grade nurse within the practice who could cover for the G-Grade.
6.6 Despite additional funding, concerns have been expressed about the time involved to undertake assessments (between one and a half and three hours) and the impact on general District Nursing time. In some areas, provision has been made to purchase bank cover. However, this has proved so difficult to access at short notice that the impact of nurse assessments tends to be absorbed by individual primary care teams. The assumption of responsibility by Intermediate Care Co-ordinators for subsequent processing of assessments and referrals has been an important factor in protecting District Nurses time to carry out their clinical duties. North and East Cornwall is also planning to pilot the use of G-grade nurses who work across the locality (rather than practice catchments) to minimise the impact of nurse assessment work on individual primary care teams.

6.7 In West of Cornwall, District Nursing Provision has been bolstered through the use of Social Services Continuing Care funds. However, due to previous under-provision, the service has been levelled up, but not sufficiently enhanced to create the capacity to embed the use of Nurse Assessors. As a result, community therapists carry out the greater proportion of rapid response assessments in West of Cornwall. This has limited the range of options available to prevent avoidable hospital admissions.

6.8 Under current arrangements, District Nurses in Carrick are available until 10pm and services are provided over the weekend. In East Cornwall, by contrast, no evening or weekend service is available. Discussions are currently taking place in Cornwall to identify whether an out-of-hours nursing service would help to ensure that people are enabled to remain at home.

Process issues

6.9 There has been some local variation in process of assessment and referral. In Carrick District Nurses may arrange admissions to 7-day assessment beds and qualified therapist assessments (but not community hospital beds) on behalf of the GP. In East Cornwall, by contrast, a GP assessment is required before care packages can be set up in order to confirm that referral to intermediate care is clinically appropriate. Once a patient is identified as being medically stable, Nurse Assessors independently organise care packages and can liaise directly with the Intermediate Care Co-ordinators to obtain access to a community hospital bed. Referrals are usually made via the RAS/PIA co-ordinator as this is convenient to District Nurses. Unlike North Cornwall, however, it is not obligatory. The close involvement of GPs in East Cornwall in the assessment process may explain why, in the District Audit survey, they had the highest levels of awareness of intermediate care services in the county. 86% and 48% of GPs in this area had good or reasonable knowledge of community rehabilitation teams and residential rehabilitation units respectively.

6.10 Considering the role of G-Grade nurse assessments in Carrick, a number of factors appear to have influenced the extent to which rapid response has been embedded:

- Intermediate care arrangements have evolved gradually in Carrick and in the early stages of development, attention focused particularly on the development of Rapid Response and Homeward Bound Schemes.
- With only one community hospital in Carrick and a limited number of nursing homes, priority has been given to the need to strengthen the support available to people in their own homes. Rapid Response is seen as a key part of this.
• A G-Grade District Nursing Sister took responsibility for taking the Rapid Response Service forward. Supported initially by a GP who has been proactive in piloting new service models, she has taken a strong lead in service development.

• The Nurse Assessors’ role developed simultaneously to a pilot project (the Health and Social Care Integration Project) in which Care Managers and Case Co-ordinators from Social Services were co-located alongside community nurses in general practice premises. As part of this pilot, District Nurses have been empowered to carry out simple financial assessments to put in place a flexible range of social care packages (reducing duplication of assessments and the time from assessment to service provision).

• The need to ensure that the menu of available options included the direct provision of an enhanced package of nursing care received high priority and nurses were encouraged to work proactively to help patients remain at home. As part of the Health and Social Care Integration Project, District Nurses can access equipment from Social Services equipment stores. Arrangements were also set in place to provide a budget to enable the spot purchasing of equipment.

6.11 The G-Grade Nurse Assessors in Carrick thus take a proactive approach to rapid response, setting up their own care packages as well as referring patients to other appropriate services. Their example suggests that, with training and support, District Nurses can work well autonomously, providing a more direct pathway from initial assessment to service provision.

6.12 There are local differences in opinion concerning nurse autonomy, however. In East Cornwall, where there is a concern that nurses and therapists may not have the diagnostic skills to identify potential or actual physiological problems at an early enough stage, medical assessment by a GP is a prerequisite of access to Intermediate Care. In Carrick, by contrast, emphasis is currently being placed on ensuring access to medical services - general and specialist - when this is needed. To this end, the potential for providing access to a consultant geriatrician for patients in a range of intermediate care settings is being explored.

6.13 Ease of access to community hospital beds also varies across localities. In Carrick, admissions to GP beds in community hospitals have to be made by a patient’s GP (a requirement that can add hours to the process of setting up a package of care). To further expand the menu of services that they can directly assess, the scope for providing Nurse/Therapy run intermediate care beds in community hospitals is being considered. The example of North and East Cornwall suggests that, as part of such a development, Nurse Assessors should liaise closely with Intermediate Care Co-ordinators. This would help to ensure that community hospital referrals are appropriate and that data are captured for monitoring purposes.

6.14 A final process issue that requires attention is the difficulty of sustaining awareness amongst potential referrers of the use of alternative routes to intermediate care, such as nurse assessments. Awareness about new and/or pilot projects tends to be raised by the developmental work that is involved in service innovation. However, in a rapidly changing context, interest can be diverted as new developments take priority on the service agenda. There is a perception of a declining use of nurse assessors to access intermediate care services, as GPs return to traditional routes such as Social Services Case Co-ordinators.
Outcomes

6.15 The formal monitoring of Rapid Response Assessment has varied between localities. However throughout Cornwall, rapid response assessments do not appear to be comprehensively captured.

- In East Cornwall, the RAS/PIA Co-ordinator records rapid assessments that prevent a hospital admission and that result in a referral to an intermediate care service (e.g. to a designated nursing or residential home, therapist assessment, community hospital etc.). However, when District Nurses provide enhanced packages of nursing/social care at home or when rapid response assessments result in acute admission, this is not recorded. According to the RAS/PIA Coordinator’s records, between the months of February and July 2002, the 9 G-Grade Nurse Assessors in East Cornwall carried out 76 assessments that prevented hospital admission.

- In North Cornwall, only assessments that result in an admission to a designated care home are routinely recorded as ‘HAZ assessments’ by the Intermediate Care Co-ordinator (n=16 between April and September 2002). Thus, although community hospital admissions, homeward bound unit admissions etc are recorded separately by the Intermediate Care Co-ordinator, these cannot always be linked to an original G-Grade nurse assessment.

- The data system used in Carrick presents similar problems. The Intermediate Care Facilitator has introduced a separate monitoring form for rapid response assessments. However, patients who are referred through the system are more likely to be linked to the service to which they are referred than to the original assessment. Insofar as the monitoring forms for these services include source of referral, it is possible to gauge the number of referrals made to different service elements by District Nurses. However, the proportions of these that have taken place on a rapid response basis are not indicated.

6.16 198 patients have been entered to date on the Carrick Intermediate Care Facilitator’s database (i.e. between January and September 2002). Of these, 51 accessed intermediate care services via a District Nurse. The ICF believes that, due to problems in ensuring that all referrals are recorded, data are only held on a proportion of assessments. The database nevertheless yields useful information about some of the characteristics of and outcomes for patients who are assessed by G-Grade Nurses.

- Reduced mobility was given as the reason for referral in 35% of cases. 24% were considered to be at risk of a fall.

- The largest groups by main diagnosis were falls patients (29%) and stroke patients (14%).

- 71% of referrals by District Nurses were targeted at preventing an acute admission; 18% at preventing admission to long-term care.

- 19 patients (37%) were referred to a 7 day designated nursing or residential home; 22 patients (43%) for a qualified therapist assessment; and 2 patients (4%) were referred to the local community hospital.

- 10% of patients who were originally referred to intermediate care by a District Nurse were subsequently admitted to acute hospital. 6% were admitted to a community hospital and 8% to long-term care. 33% remained home with no package of further care. 27 remained home with a supporting package of care on discharge. 2% of patients died.
• An estimate of bed days saved is attached to 41 patients. In total, District Nurse referrals in Carrick are estimated to have released 240 bed days (range 3-9 days per patient) which would equate to a saving of £68,400 to the acute sector.

• In addition to ‘step-up’ referrals by District Nurses in Carrick, 33 patients who were located in their own homes on referral accessed intermediate care services via a GP; 13 via Social Services Staff; 10 via other community nurses and 16 via a therapist. These groups made significantly less use of 7-day assessment beds (8% of referrals) than District Nurses, the vast majority of their referrals being made to the community therapy team for assessment.

6.17 In addition to data held by Intermediate Care Co-ordinators, G-Grade nurses are encouraged to enter Rapid Response Assessments (as ‘HAZ assessments’) in hand-held computers that are inputted into the ICS system. Significant variation between the records kept by Intermediate Care Co-ordinators and ICS data suggests that only a small proportion of assessments is captured by the ICS system. This varies geographically, the lowest rate of return occurring in Carrick. Even in East Cornwall, where recording appears to be most reliable, the ICS system underestimates overall activity. The RAS/PIA Co-ordinator’s records (which, as noted above, do not capture the provision of enhanced packages at home) show that 51 rapid response assessments prevented hospital admission in February and March 2002. By contrast, the ICS system only records 26 total assessments in the same period in East Cornwall. Thus, ICS data which show that, between April 2001 and March 2002, 132, 46 and 13 assessments were carried out in East Cornwall, North Cornwall and Carrick respectively should be treated with caution.

Cost-Effectiveness

6.18 In Carrick, HAZ funding has been used to promote appropriate practice nursing staff to F-grades in order to release G-Grade Nurse Assessors. With existing F-grade staff already in place in a number of practices, the costs of grade inflation have been relatively low (£15,881 in 2000/2001). This investment supports the work of 9 Nurse Assessors, implying an average monthly cost per practice of £147 to support the Rapid Response Assessment scheme. An additional allocation (£30,000 per annum for Carrick as a whole) was made to fund the spot purchasing of bank staff to provide additional cover for G-Grade nurses. However, due to the difficulties of accessing bank nurses, this has not been drawn upon, the additional time required to carry out assessments being absorbed by individual practices.

6.19 In North Cornwall, £30,900 was spent in 2001/02 on E-grade replacement hours to release the 7 G-Grade Nurse Assessors. This implies an average monthly cost of £368 per Nurse Assessor. In East Cornwall, by contrast, the funding available to support the Rapid Assessment Scheme was not used to cover replacement hours but to support Intermediate Care Co-ordination.

6.20 Variation in investment undoubtedly reflects local differences in existing district nursing capacity. It is also possible that the higher costs in North Cornwall reflect the higher travel times of Nurse Assessors in this highly rural locality. Local variation nevertheless makes it difficult to estimate the cost of this scheme and thus to compare costs with potential savings.

6.21 The current cost per acute bed in Cornwall is £285 per bed day. As noted above, the average monthly cost per Nurse Assessor has been estimated as £147 in Carrick and £368 in North Cornwall. This implies that, in order to make savings to the acute sector, each Nurse Assessor...
in Carrick would have to save an average of 0.58 bed days per month. In North Cornwall, an average of 1.29 acute bed days would have to be saved.

- The ICF’s records show that, between January and September, District Nurses in Carrick carried out at least 36 assessments that prevented hospital admission (an average of 0.44 per nurse per month). With an average length of stay of around 5 days in Cornwall for Falls and Stroke patients, this implies an average monthly saving of 2.2 bed days per district nurse, exceeding the investment made to support rapid response.
- In North Cornwall, the 7 G-Grade Nurse Assessors carried out 16 assessments between April and September 2002 that prevented a hospital admission and resulted in an admission to a 7-day designated nursing or residential home. On the basis of this activity alone, district nurses achieved an average monthly saving of 1.9 bed days.
- In East Cornwall, the 9 G-Grade Nurse Assessors carried out an average of 1.4 assessments per nurse per month between February and July 2002. With a higher rate of rapid response assessment and a lower level of investment than Carrick and North Cornwall, the Rapid Assessment Scheme in East Cornwall has undoubtedly been cost effective.

6.22 It should be noted that the analysis above does not include hospital admissions prevented by the direct provision of enhanced packages of care at home by G-Grade nurses (a factor that would increase the savings made). The analysis also excludes the costs of other services that are accessed following assessment (a factor that would increase the overall costs). However, most District Nurse referrals in Carrick result in a 7 day stay in a designated nursing or residential home or a therapist assessment. If this is taken into account, Rapid Response Assessments still provide a cost-effective alternative to hospital care.

6.23 As noted in Section 2, the perceived benefits of intermediate care lie not only in its impact on cost-effectiveness, but on service quality. A qualitative account of the kind of work carried out by G-Grade Nurse Assessors is given in Box 6. This demonstrates the potential impact of rapid response assessment, not only in preventing avoidable hospital admissions, but in reducing duplication between health and social services. The case study also illustrates the advantages of having ready access to community equipment.

**Key Messages**

6.24 District Nurses are well placed to identify patients at risk of an inappropriate admission to hospital or long-term care who could benefit from active therapy, treatment or opportunity for recovery.

6.25 G-Grade Nurse Assessors have a wide menu of services that they can access for Intermediate Care patients. Their ability to do so is enhanced if they can work through an Intermediate Care Co-ordinator who has ongoing knowledge about capacity in Intermediate Care settings. By assuming responsibility for the processing of assessments and referrals, Co-ordinators can also protect District Nurses’ time to carry out their clinical duties.

6.26 Despite additional funding to support the Nurse Assessor role, it is doubtful whether the cover available to fill in for G-grade time has been sufficient. Consideration should be given to ways in which the impact of nurse assessment work on individual primary care teams can be minimised.
6.27 Consideration should be given to the case for developing an out-of-hours District Nursing Service to accommodate crisis situations that arise outside working hours. As part of this, cost-effectiveness and the challenges of working in a highly rural county should be considered.

6.28 Co-location of community nurses and Social Services Case Co-ordinators in general practices within Carrick appears to have promoted a proactive and more autonomous approach to Nurse Assessment. Empowered to put in place social care packages and to directly access equipment, District Nurses in this area have been particularly active in directly providing enhanced packages of care for patients at home.

Box 6: Rapid Response Assessment - Case Study

I was bleeped by the GP at 8am one morning to visit Mr W who had fallen in the night. I visited, accompanied by a Student Nurse. Mr W has a blood clotting disorder and is prone to periods of instability and has fallen in the past. Both Mr W and his wife were very keen for him to remain at home, but as he was completely immobile at present they were very concerned about how they would cope. In the past, Mr W had regained his normal level of functioning within a few days.

I assessed Mr W’s health needs to exclude any obvious deterioration in his health and asked the GP to visit later to confirm he did not need hospital admission. Our first priority was to reassure Mr W and make him comfortable, so the Student Nurse and I gave him a bed bath, assessed his pressure areas and his mobility. I felt confident that Mr W could be safely managed at home, so I discussed the services we have available with him and Mrs W to ensure they felt safe with the package of care we could offer. I left Mr W with the Student Nurse whilst I went to our loan equipment store and collected a commode, urinal and pressure relieving mattress for his use.

I completed the assessment form and the financial assessment in the house and set up a care plan in the patient held record. I assessed that Mr W would require the following care from Social Services:
- Double handed care four times daily from care assistants for personal care, toileting etc.
- Night care for two nights – a care assistant/trained volunteer to come into the house at night to ensure Mr W was safe

Mrs W could manage meals and other aspects of Mr W’s care and she was happy with the suggested package. As Mr W often recovered after a few days I decided to wait until after the weekend before referring for a physiotherapy and occupational therapy assessment.

I returned to the surgery and faxed the completed assessment to Social Services Department. I spoke to the Case Co-ordinator based at our Practice and explained the package that needed to be organised and she was able to arrange for the first carers to visit within two hours. I explained that I would review the package in two days. Because the Case Co-ordinator had been saved a visit by my completing the financial assessment, she suggested she call that afternoon to check on Mr W’s progress. This saved me a visit as I know she would feed back to me if his condition had worsened or she was not happy – that’s teamwork!

Mr W’s package of care prevented the need for admission to acute care or a nursing home. As expected he did recover during the next few days and regained his normal level of independence. The care package was gradually decreased as improvement progressed. Both Mr and Mrs W were extremely satisfied with the speed and efficiency of the service the team could offer and delighted that he was able to remain at home.

Source: Carrick Health and Social Services Integration and Rapid Response Project

6.29 There are differences in the county regarding the role of medical assessment. In some areas, this is prerequisite of access to Intermediate Care. In others, emphasis is placed on ensuring access to medical services if and when this is needed. When considering the role of medical assessment, the potential for providing access to specialist diagnosis within Intermediate Care settings should also be explored.
Ease of access to community hospital beds varies across localities. The requirement to admit patients via GPs can add hours to the process of setting up a package of care. This can be overcome when an Intermediate Care Co-ordinator can directly organise a community hospital admission (as in North and East Cornwall). The provision of Nurse/Therapy run intermediate care beds in community hospitals is another option.

Activity by Nurse Assessors is not being adequately captured by routine monitoring systems. The recording of assessments that result in the direct provision of an enhanced package of nursing/social care at home is particularly problematic. Whilst this is being addressed by Intermediate Care Co-ordinators in the county, consideration should also be given to how data entry to the ICS system can be improved.

Taking into account the investment that has been made to support Rapid Response Assessments in North Cornwall, East Cornwall and Carrick and the numbers of acute hospital admissions that, according to local estimates, have been prevented, the estimated savings to the acute sector outweigh the costs of Rapid Response Schemes.

Attention should be given to how awareness about schemes can be sustained once new developments start to take priority on the service agenda.
7 Holding services

7.1 Even with the development of rapid response assessments, the time taken to set up a care package can exceed acceptable limits in some crisis situations. Various approaches have been developed in which to ‘hold’ a situation until an appropriate package of care can be put in place. The aim of these ‘Holding Services’ is to enable people to remain in the community during a crisis rather than entering a hospital, residential or nursing home.

Social Services holding services

7.2 Social Services Care Managers can arrange for a trained assistant to come to a patient’s home and ‘hold’ a situation pending a thorough assessment. This service is available 24 hours per day, 7 days per week, 365 days a year and is accessed through Care Managers. The carers are trained, carry equipment to provide personal care and can access equipment such as commodes. They have mobile phones and can maintain contact with the Care Manager and GP if necessary. A situation can be held for up to 72 hours (an increase from the initial allowance of 48 hours which was not sufficient to provide weekend or bank holiday cover) and is reviewed on a 24 hour basis.

7.3 Since the expansion of countywide intermediate care schemes, Social Services has expanded its out-of-hours service, recruiting carers through both the Home Help Service and independent providers. Despite this, there are perceptions that the service is hard to access. Due to the difficulties of recruiting sufficient numbers of carers at short notice to provide a patient with 24-hour cover, patients who are frail enough to require support around the clock are more likely to be referred to a designated care home. The fact that therapist assessments can be arranged at short notice also limits demand for holding services for patients who are likely to benefit from rehabilitation at home. Quantitative data on service use are not available, however as, within the CMS system, no distinction is made between a holding package and any other care package.

The British Red Cross Care and Response Service

7.4 In 2000, the Cornwall branch of the British Red Cross received £15,000 of HAZ Eldercare Programme funding to recruit and train 70 additional volunteers for the Care and Response Service. It was envisaged that the expanded service would provide a countywide, 24 hour, 7 day a week holding service for urgent referrals (thus avoiding acute hospital admission) as well as receiving non-urgent referrals for practical help and support. A full evaluation report on this scheme (Bennett, 2002) was presented to the CioS HAZ Steering Group in March 2002. The following summary is based on that report.

7.5 Non-urgent referrals could be made to the service by contacting British Red Cross Headquarters in Truro during office hours. A separate Care and Response number was provided for out-of-hours emergency referrals and an answer-phone provided the contact number for the on-call member of staff. The service was widely advertised, through the distribution of publicity material (in hospitals, GP practices, supermarkets etc) and networking amongst professional and voluntary groups. By the end of 2000, the full complement of 70 volunteers had been recruited and trained.
Although the Red Cross succeeded in expanding the volunteer base as planned, the expected increase in referrals to the Care and Response Service did not materialise. Pre- and post HAZ funding, the Care and Response Service received approximately 43 referrals per quarter. None of the post-HAZ referrals were for an emergency holding service to prevent admission to hospital as had been envisaged. Instead, the service was primarily used to provide non-urgent carers’ support. Rates of satisfaction amongst those who received such help were very high (87% of respondents rating it as excellent, 10% as good; n=39). A questionnaire survey administered to front-line professionals and carers also found high levels of agreement that the service was generally useful and needed.

A number of factors appear to have prevented the Care and Response Service from becoming a fully integrated and utilised element of the intermediate care schemes, including a failure to fully explore and define the level of support that would be required to hold an emergency situation. In part because of a failure to include British Red Cross staff in intermediate care planning and intermediate care meetings, the necessary level of statutory commitment was not attained and there remained a lack of clarity about the purpose and function of the service.

There is a need for local statutory agencies to reflect on whether they engaged with the Red Cross on equal terms (particularly in relation to service agreements, communication, inclusion and representation in decision-making forums) and whether the Red Cross was adequately supported in the task it had been asked to undertake. Such reflection may provide valuable lessons for the future, particularly in light of the current re-configuration of Red Cross services (to offer home support and a telephone service manned by trained volunteers that targets elderly and vulnerable clients).

### Assessment in designated care homes

In order to hold a crisis that would otherwise result in hospital admission, more specialist support may be required than that provided by a trained volunteer or care assistant.

A proposal submitted by Kernowdoc (an out-of-hours GP co-operative in Cornwall) to the first round of HAZ bidding made the case for developing an out-of-hours nursing service. Within this proposal, Kernowdoc suggested that, in a typical week, a skilled nurse could have appropriately dealt with an average of 5 calls per session. These figures did not capture admissions to A&E that could have also been assisted by such a service (though they did include situations that do not strictly relate to intermediate care, such as terminal care).

Kernowdoc’s proposal was not approved for HAZ funding, primarily because the available funding was insufficient and follow-on funding had not been identified. However, the increasing use of 7-day assessment beds in selected Nursing and Residential Homes suggests that the provision of skilled nursing support may be a more effective approach to holding a crisis that would otherwise result in hospital admission than the use of Social Services and Voluntary Holding Services.

7-day assessment beds are used in North Cornwall, East Cornwall and Carrick as part of the menu of available intermediate care services. Commonly, a G Grade nurse makes the assessment and is the lead clinician in deciding suitability/appropriateness and in implementing the placement. The patient’s GP retains medical responsibility. Once a patient is admitted, therapist assessment can be sought and may lead to the development of an active package of rehabilitation at home or within a Homeward Bound Unit. In order to secure
appropriate discharge, comprehensive assessment by medical, nursing, therapy and social services staff is usually essential.

7.13 A limited number of designated homes were initially selected from the Independent Sector on the basis of quality criteria. However, due to growing demand for this service and the sheer lack of beds in a sector that is rapidly reducing in capacity, the type and number of homes rapidly expanded to include virtually all dual-registered nursing and residential homes. Capacity remains a problem, however, particular of homes that cater for elderly mentally infirm.

7.14 Assessment beds are secured through Continuing Care arrangements (and are therefore not subject to means testing). Beds were originally available for 48 hours for a maximum of 160 nights in each district. In 2001, agreement was reached to extend the available assessment period to 7 days to allow a more realistic time in which to arrange assessment and appropriate discharge.

7.15 The database established by the Intermediate Care Facilitator in Carrick includes information on 27 referrals made to 7-day Nursing or residential home beds between January and September 2002.

- Most patients (n=24) were located within their own homes on referral
- 19 patients were referred by a district nurse, 3 by their GP; 1 by Social Services staff, 2 by other community nurses and 2 by acute therapists.
- Sequelae of medical condition was given as the reason for referral in 9 cases. 6 patients were considered to be at risk of a fall. 4 were admitted as a result of a carer crisis. 3 were suffering from reduced mobility and 3 from reduced confidence/coping.
- The largest groups by main diagnosis were falls patients (n=9) and stroke patients (n=7).
- 24 referrals were targeted at preventing an acute admission; 1 at preventing an admission to long-term care.
- 3 patients were admitted to acute hospital; 3 to community hospital and 3 to long-term care. 9 were discharged home with no package of further care. 5 were given a supporting package of care on discharge. 1 patient died. Rates of discharge to hospital and long-term care are higher for patients admitted to 7-day nursing beds than for G-Grade assessments in general and community therapy team patients, reflecting the higher dependency of this group of patients.
- An estimate of bed days saved has been attached to 25 patients. This totals 149 bed days (range 3-9 days per patient) which would equate to a saving of £42,465 in the acute sector; or £17,880 in the community hospital sector.

7.16 The current cost per bed night of a stay in a designated care home is £53.64. In East Cornwall, additional PCG funding has been used to pay for GP cover (at £80 per RAS admission). The current costs per acute bed are £285 per day.

- In Carrick 27 referrals were made to 7-day assessment beds between January and September 2002 (an average rate of 36 per annum). Even factoring in the total annual costs of funding G-Grade Nurse Assessors (the major referrers to care homes), the break-even point at which the use of designated assessment beds makes savings to the acute sector occurs at an average of two days of stay. The costs of 36 2-day stays at £53.64 are £3862. Combined with the annual £15,881 investment to the Rapid Response
Scheme in Carrick, this yields a total cost of £19,743. The savings made from 36 2-day spells in acute hospital are £20,520.

- In North Cornwall, 16 referrals were made to 7-day assessment beds between April and September (an average rate of 32 per annum). Factoring in the total annual costs of funding G-Grade Nurse Assessors, the break-even point at which the use of designated assessment beds makes savings to the acute sector occurs at an average of five days of stay. The costs of 32 5-day stays at £53.64 are £8,582. Combined with the annual £30,900 investment to the Rapid Response in North Cornwall, this yields a total cost of £39,482. The savings made from 32 5-day acute spells are £45,600.

- By factoring in the costs of funding G-Grade assessors, the total costs of using 7-day assessment homes are over-estimated, as Nurse Assessors refer to other intermediate care services than these homes. This approach also means that the relative cost-effectiveness of designated care homes increases with length of stay.

**Key Messages**

7.17 In order to hold a crisis that would otherwise result in hospital admission, more specialist support may be required than that provided by a trained volunteer or Social Services care assistant. The increasing use of 7-day assessment beds suggests that, if Holding Services are to be further expanded, these should provide access to nursing care. To this end, the rapidly reducing capacity in the Nursing Home sector should be addressed.

7.18 Taking into account both the costs per bed night of stays in designated care homes and the investment made to support G-Grade Nurse Assessors (who are the major referrers to these homes), placements to 7-day assessment beds make overall savings to the acute sector providing that they involve a minimum of 2 days stay in Carrick and 5 days stay in North Cornwall.
8 Rehabilitation at Home

8.1 The provision of rehabilitation at home is a key component of Intermediate Care schemes in Cornwall, reflected in the significant expansion of community therapy teams. By improving arrangements by which an emergency response can be triggered, creating single points of contact for community therapists and developing systems for joint assessment, the aim is to proactively reach out to patients who could benefit from a short period of rehabilitation at home.

8.2 Rehabilitation at home may be delivered in response to a crisis or impending crisis that, if not actively managed, could result in an admission to hospital or long-term care. Alternatively, patients discharged from hospital may need special short-term support. The aim in either case is to enable patients to re-gain sufficient physical functioning and confidence to live safely and independently at home.

8.3 Patients receiving rehabilitation at home can access three broad types of support:

- Occupational therapy, physiotherapy and/or speech and language therapy provided by an appropriate therapist or a technical assistant (considered in this Section).
- An intensive, low-technology rehabilitation care package from a trained Rehabilitation Care Assistant (RCA). Community Therapists act as key workers for such a care plan, alongside Social Services Care Managers (see Section 9).
- Support from community nursing and other services such as housing. G-grade nurses and Intermediate Care Co-ordinators play a key role here in the direct provision of community nursing and in facilitating the procurement of community equipment and/or housing adaptations (see Section 6).

8.4 Referrals to Community Therapy Teams can be made from health professionals (GP, G-Grade Nurse Assessors, specialist nurses), intermediate care co-ordinators or Social Services staff. A Countywide referral form is used, in which referrers are asked to highlight whether an occupational therapy or physiotherapy assessment is indicated. They can also request an assessment on a rapid response basis, in which case a therapist will act within 24 hours (though some areas such as Restormel do not have the resources to provide a rapid response service).

8.5 Following assessment, therapists may embark upon a direct course of therapy, devise a package of care that involves a Rehabilitation Care Assistant or refer a patient to a Homeward Bound residential unit. The vast majority of assessments result in the direct provision of therapy within the patient’s home.

Inputs

8.6 Promoting Independence, Continuing Care and HAZ funding has been used to significantly enhance therapy provision since 2000, Social Services alone committing over £650,000 in 2001/2002 to employ more therapists in each PCO (approximately 28 wte therapy and administrative staff). This has allowed new community therapy or rehabilitation teams to be established in Carrick, North Cornwall and Restormel and existing community therapy provision to be enhanced in West and East Cornwall. By December 2001, the total community
rehabilitation staff (including administrative and clerical) was 47.6 wte (16.4 wte occupational therapists, 17.1 wte physiotherapists, 9.7 wte OT/PT technical assistants and 4.4 wte administrative and clerical staff). Nine Community Rehabilitation/Therapy teams have now been established around the county.

8.7 Despite this expansion, there is a widespread perception that therapists still do not have the capacity to fulfil the growing demand for their services. For example, there is not sufficient flexibility within the system to deal well with absenteeism due to sickness. The lack of therapy cover out-of-hours and at weekends impacts upon the smooth flow of transfers, particularly from acute hospitals. There are particular shortfalls in community physiotherapy (Lyle et al., 2001). There is also significant geography inequity in the distribution of community therapy staff. In Restormel, for example, there has been a shortfall in dedicated community physiotherapists - existing staff providing day hospital and inpatient cover as well as working in the community. Staff numbers per 1000 population aged 65+ range from 0.38 in Central Cornwall PCT to 0.45 in North and East Cornwall to 0.63 in West of Cornwall.

8.8 Capacity has also been raised as a factor determining client focus. Community therapy staff deal overwhelmingly with patients who have had a recent trauma (e.g. a stroke or fall). Whilst this makes a significant contribution to the prevention of hospital admission and the facilitation of early hospital discharge, there is not capacity to provide rehabilitation for patients with chronic or progressive disease. As a result, there may be gaps in the extent to which the system is catering for people on the threshold of admission to long-term residential and nursing care.

Process Issues

Recruitment

8.9 Within the context of a national shortage, the recruitment of therapists represented a particular challenge in Cornwall. Amongst many concerns, the need to avoid internal competition for therapists between the PCOs and between the PCOs and Social Services indicated a need for co-ordination and consistency of approach to therapist recruitment across the county. Multiple fractions of posts were required to create adequate therapy cover. The temporary nature of funding streams also presented difficulties in creating recruitable posts, a problem overcome when Cornwall Healthcare Trust (CHT) agreed to run the (largely technical) risk of employing staff on permanent contracts. The process of agreeing an approach to therapy recruitment thus required strong partnership working between Social Services, CHT and the PCOs (Bennett, 2001).

New Working Arrangements

8.10 Rehabilitation lies at the heart of Intermediate Care, core aims of which are to maximise people’s physical functioning, build confidence and re-equip them with the skills they need to live safely and independently at home. These aims have long been the business of therapists which sets them somewhat apart from other professional groups working in intermediate care who are making decisions and taking actions that are traditionally beyond their scope of practice.

8.11 Although the core functions of therapy staff have not changed, the organization of their working practices has altered significantly with the development of Intermediate Care schemes. Having traditionally worked within hospital environments, therapists have been
appointed to community teams where the greater proportion of therapy is carried out within a patient’s home. They have thus had to adjust to a change in balance between ‘productive’ therapy time and ‘unproductive time’ due to travel, particularly in the more rural localities. The amount of paperwork produced as a result of working in partnership with Social Services is also perceived to cut into productive clinical time. Increased response times are expected of therapists within Intermediate Care schemes. They are also expected to work with new service elements (e.g. Rehabilitation Care Assistants) and there has been some resistance to this (see Section 9).

8.12 As part of the expansion of service options, lines of accountability have altered. Therapists are no longer located in narrow health management hierarchies but are increasingly accountable to Social Services Care Managers regarding their reasons for making specific recommendations. The fact that Care Managers can potentially question clinical judgements has heightened professional sensibilities (Bennett, 2001). Whilst such concerns appear to be receding as the respective clinical and managerial roles of therapists and Care Managers have become clearer, the fact that Care Managers question the financial justification of recommended care packages remains a point of contention. The fact that, in order to conform to Intermediate Care criteria, Rehabilitation Care Assistants are only available for 6 week periods has also caused frustration amongst therapists who suggest that many patients have ongoing needs.

Team Working

8.13 There have been differences across the county in the extent to which community therapists form part of a distinct ‘team’ and provide a single point of referral. With previous investment in community-based rehabilitation, East Cornwall and Penwith in the West of Cornwall have the most established teams of community-based therapists in the county. These provide centralised referral points and, through weekly team meetings, opportunities for different therapy staff to regularly liaise. The Community Therapy Teams in Carrick, North Cornwall, South Kerrier and North Kerrier have explicitly moved towards working as coherent teams and provide central points of referral. In Carrick, for example, co-location of Therapists in Falmouth Hospital and weekly joint allocation meetings have promoted good liaison. In North Cornwall, distance has provided a barrier to regular meetings between community therapy staff based at Stratton and Bodmin. However, the latter provides a base referral point. Team leadership also provides co-ordination in North Cornwall, as in Restormel, Carrick, South Kerrier and Penwith. Restormel has a community team, but not dedicated staff as therapists work in both hospital and community settings.

8.14 To date, Community Therapy Teams only comprise Therapists and Technical Assistants employed by the health sector. This can result in some duplication of service, individual clients receiving home visits from both Health OTs and Social Services OTs (whose main function is to provide equipment and organise complex housing adaptations). In light of growing national interest in the potential of integrating OT provision, some consideration could be given to the merits and disadvantages of incorporating Social Services OTs and, indeed, other professionals (such as community nurses) into multi-disciplinary Community Rehabilitation Teams. According to this model, an expansion of the numbers of staff sharing core skills could potentially create the space for individual staff members to provide specialist skills (e.g. stroke rehabilitation, complex housing adaptations, hand therapy).
Communication

8.15 The extent to which community teams have a centralised referral point with clerical support determines ease of communication across professional and organizational boundaries. For example, Social Services managers have experienced problems in accessing peripatetic community therapy staff. On the part of therapists, frustration has been expressed about the time taken to (a) identify which Care Manager to fax paperwork to and (b) wait for confirmation that a care package can go ahead. Following discussion of these issues at countywide Promoting Independence meetings, contact details of pagers have been distributed to ensure that OTs and PTs can be bleeped for a faster service. Social Services have agreed to ensure that a Care Manager is available at all times to deal with Homeward Bound referrals. These are marked urgent and fast tracked to the duty Care Manager when the designated Care Manager is not available. The lack of common IT systems (or indeed electronic mail within Social Services) nevertheless increases the time spent on processing paperwork.

8.16 By offering opportunities to discuss operational-level barriers to partnership, meetings such as the Promoting Independence group are invaluable in helping managers set up processes and procedures that smooth the implementation of intermediate care. In this respect, the Group could usefully focus on continued barriers to communication between therapists, G-grade nurses and Intermediate Care Co-ordinators. Whilst therapists feed back to GPs on a regular basis, District Nursing staff are not automatically included in this feedback. A lack of consistency in feeding back decisions following therapist assessment has also limited the ability of co-ordinators to track patients through their journey of care. Problems of capacity, a lack of understanding about the Intermediate Care Co-ordination function and the fact that Therapy and District Nursing Teams have held separate patient records have had a role to play here. The introduction of a Single Assessment Process is expected to improve the extent to which client information can be centrally co-ordinated.

Access to Equipment

8.17 Community therapy teams access any required equipment through the NHS Loan Equipment Service. With greater complexity of need, increasing demands and increasing costs the Service’s budget has been over-stretched resulting in waiting lists (Clapperton and Culley, 2001). Short-term loan wheelchairs have been in particularly short supply, posing significant difficulties for staff trying to organise provision to enable discharge.

8.18 The availability of NHS stock has also been largely limited to a standard range. Thus, if therapists identify a need for special equipment, they have to apply to Social Services’ Loan Equipment where an assessment of need will be undertaken by a Social Services Occupational Therapist or Case Co-ordinator. Although Case co-ordinators can generally visit new clients very quickly, clients referred to an Occupational Therapist may experience a delay. Waiting times vary from area to area however new referrals are prioritised to ensure those in greatest need are seen first (Clapperton and Culley, 2001).

8.19 Having undertaken their own qualified assessments of clients’ need for special equipment, the requirement for an additional assessment by a Social Services OT can be frustrating for community staff. Health OTs cannot formally liaise with Social Services OTs until a referral has been made and allocated by a Care Manager. As a result of these processes, the wait involved in obtaining stock can be up to eight weeks. To reduce professional duplication and unnecessary administration time whilst speeding up delivery, it has therefore been agreed
that the range of stock available to NHS Therapists will be extended. From July 2002, 31 items have been added to the standard range of stock available from the Loan Equipment Service. These have been identified by Therapists as equipment that their clients would often benefit from, but which are not available at present without making a referral to social services.

Outcomes

8.20 Although a significant proportion of the work undertaken by community therapists fulfils the criteria set down by the Department of Health circular, this does not tend to be labelled as such for monitoring purposes. When referrals are given a label that links to a particular intermediate care scheme (e.g. Scheme 5), this may relate more to the funding source of the particular therapist than the patient’s circumstances, care plan and planned outcome.

8.21 In discussing the criteria for Intermediate Care, many therapists also expressed the view that the 6-week cut-off point stipulated by the Department of Health is a distraction. The aim of rehabilitation, regardless of the length of treatment, is to promote independent living and, whilst not all courses of therapy may be targeted at patients who would otherwise be immediate candidates for long-term care or hospital admission, early therapeutic intervention can prevent crises arising in the longer term.

8.22 In fact, the vast majority of therapist activity is completed within a 6-week period. In 2001/2002, for example, OTs across the county dealt with 1450 new referrals. Under 200 of these had more than 6 visits and most of these are likely to have involved patients with progressive neurological conditions for whom intensive rehabilitation is inappropriate. Because most of the patients seen by community therapists in Cornwall are those who have had a recent trauma, much community therapy is targeted at people who may otherwise have faced an inappropriate admission to a hospital or home or an unnecessarily prolonged stay.

8.23 Thus, there may be good justification for the view taken by therapists that virtually all of their work does contribute to the aims of intermediate care. However, lack of awareness of the Government’s criteria and the subsequent failure to distinguish intermediate care referrals from routine work does make it difficult to demonstrate the impact of community therapy on intermediate care arrangements. Consideration should thus be given to how the contribution of community therapy can be formally monitored as a key part of the continuum of intermediate care.

Social Services Monitoring of Community Therapy Teams

8.24 In November/December 2001, the Social Services Department undertook a ‘snapshot’ evaluation of the work of community therapy teams, primarily to assess rates of use of Rehabilitation Care Assistants (RCAs). The aim of this was to provide an audit of all patients seen and discharged by teams during a two-month period. However, due to staffing problems, a lack of clarity on the part of therapists about the purpose of the evaluation and concerns about the duplication of monitoring, only a small proportion of forms was returned. In East Cornwall, for example, the two CART(s) teams provided therapy at home to an average of 95 patients per month during the first six months of 2002. Yet the snapshot evaluation (which sought to measure therapy provided across all settings) only captured 26 therapist referrals in East Cornwall during the two month period. Rates of return varied geographically, North Cornwall and West of Cornwall returning the highest number of forms, Carrick and Restormel the lowest. Returns were also significantly higher in November (63% of the total) than December.
Designed to capture the use of RCAs, the form made no distinction between assessments that took place on a rapid (urgent) basis and those that were ‘routine’. It explicitly asked for information on reason for referral that conforms to Intermediate Care criteria (prevention of admission to residential care, nursing care and hospital and facilitation of discharge from hospital). However, the vast majority of forms (73%) indicated ‘other’ reasons for referral, some of which may overlap with the reasons above. For example, ‘promoting independence’ was cited as a reason for referral in 16% of cases. The returns also only include referrals that appear to have resulted in a therapy programme. Thus, patients who are not judged to be suitable for rehabilitation following assessment were not captured.

As a vehicle for monitoring the role played by community therapy teams in providing intermediate care, the snapshot evaluation has clear shortcomings. It nevertheless gives some information about patterns of care and outcomes following therapy assessment:

- The average age of clients seen during the two month period was 75 (n=159). 89 were women and 59 men (in 11 cases, sex was not recorded).
- In 11 cases (7%), the reason given for referral is the prevention of admission to residential or nursing care. In 16 cases (10%), prevention of a hospital admission is explicitly cited. Similarly, 16 patients were supported for facilitate discharge from hospital (these are distinguished from a further 6 who received therapy assessment as a follow-up to hospital discharge). The implication that only 27% of community therapist referrals directly supported intermediate care arrangements is at odds with therapists’ own perceptions of their work. The responses are likely to reflect the tendency of therapists to describe referrals according to clinical rather than intermediate care criteria.
- The vast majority of clients received a programme of therapy within their own home (74%, n=159). Only 1 received therapy in a Homeward Bound unit. The remainder received treatment in a residential home (8%), nursing home (4%) or unknown location.
- 66% of clients are reported to have experienced an improvement in their health, well-being and ability to cope with everyday living. In 23% of cases no improvement was reported (for 11% no information was recorded).
- Only 3% of patients were admitted to hospital during the two-month period. 6% were admitted to a residential home, 3% to a nursing home. 33% were discharged with no package of further care, 21% retained their original package of care, 2% had a reduced package of care, 2% an increased package and 1% a new package of care. In 13% of cases, therapists reported ‘increased independence, ongoing rehabilitation or improved mobility’, categories that do not fit easily with the outcome measures above. 3% of patients were undergoing further investigations. Information is not recorded for the remaining patients.

Social Services Monitoring of Patients’ Perceptions of Therapy

In addition to requesting information of therapist referrals, Social Services prepared a patient questionnaire as part of its snapshot evaluation of therapy provision. 80 questionnaires were returned during the period of November and December 2001. 50% of patients had received therapy from an occupational therapist, 50% from a physiotherapist. Responses suggest that user satisfaction with the therapy services they had received was high:

- 84% felt that they had received their first visit quickly enough
• 75% felt that they had received all the therapy services necessary to meet their needs. 49% agreed that the therapy services they had received would allow them to resume their usual everyday activities and 64% agreed that that therapy had improved their confidence in being able to cope.

• 64% had felt involved in their therapy and 84% felt that the therapist paid attention to their opinions. 86% found that information was given clearly by the therapist and a further 74% that the therapist had helped them to understand their abilities and difficulties. 79% agreed that the therapist had taken their normal lifestyle into account and 63% that the needs of their family and/or caregivers had been considered.

• 81% knew how to contact their therapist when they needed to and 85% agreed that the therapist kept appointments.

• 73% agreed that the number and lengths of therapy sessions were sufficient to meet their needs.

• 84% had confidence in their therapist and were satisfied with the service that they had received.

Routine Monitoring Data

8.28 According to the County’s Occupational Therapy Service, between April 2001 and March 2002, Occupational Therapists in Cornwall dealt with 1450 new referrals. 601 were within North and East Cornwall, 444 in West of Cornwall and 397 in Central Cornwall PCT (of which 95 were based in Restormel). The respective numbers of wte occupational therapists in the three PCTs were 6.1, 6.0 and 4.3, yielding respective rates of 98.5, 74.0 and 92.3 referrals per therapist per annum.

8.29 32% of patients who are referred for a therapy assessment in Cornwall received no further therapy from an occupational therapist. 20% had one subsequent therapy session; 35% up to 6 follow-up sessions; 9% had 7-12 follow-up sessions and 4% over 12 sessions. Balance of relative therapy input is broadly comparable between localities, with the exception of North Cornwall, which had a significantly lower proportion of ‘assessment only’ referrals (19%) and a significantly higher proportion of referrals that involved more than 7 follow-up sessions (25%).

8.30 Breaking down referrals to community therapy teams by patient diagnosis, the highest modal groups (in descending order) are stroke patients (14%), falls patients (14%), patients with progressive neurological disorders (13%), patients experiencing functional problems (10%), patients with problems of immobility (8%), patients with arthritis (8%) and patients who have suffered a fracture (7%).

8.31 To make an overall saving to the acute hospital sector, each occupational therapist would have to contribute to an average saving of around 105 acute bed days per year. With an average length of stay of around 5 days in Cornwall for Falls and Stroke patients, this implies that each therapist would have to help to prevent an average of 21 acute admissions every year to cover their salary costs. To make an equivalent saving to long-term residential care, 845 bed days per annum would have to be saved per therapist. To break even, this would imply preventing or delaying admission of 28 patients for one month; 9.3 patients for three months; 4.6 patients for six months or 2.3 patients for a whole year.

8.32 Occupational Therapists in Cornwall handled an average of 88 referrals per year in 2001/2002. Extrapolating the figures yielded by the Social Services snapshot evaluation, if only 20% of referrals have prevented a hospital admission or facilitated hospital discharge, an
average of 88 acute bed days (17.6 patients x 5 days) will have been saved per therapist. At £285 per acute bed day, this amounts to £25,080. To break even, each therapist would have had to save an additional 139 days to long-term residential care. This equates to the prevention or delay of admission of 4.6 patients for one month, 1.5 patients for 3 months or 0.76 patients for 6 months. Extrapolating the figures yielded by the snapshot evaluation, each occupational therapist has prevented an average of 6.2 admissions to long-term care. Thus, each admission would only have to be delayed by an average of 23 days to make community therapy cost-neutral in overall terms. As it is likely that this break-even point is being exceeded, this analysis suggests that community therapy is highly cost-effective.

8.33 In addition to countywide data, the database established by the Intermediate Care Facilitator in Carrick includes information on 117 referrals made to the community therapy team between January and September 2002.

- Most patients (73%) were located within their own homes on referral to the community therapy team.
- 23 patients (20%) were referred by their GP; 22 (19%) by a District Nurse, 13 (11%) by Social Services staff, 9 (8%) by other community nurses and 12 (10%) by community therapists themselves. 23 patients (20%) were referred by acute and community hospital therapists, 4 (3%) by acute and community hospital doctors.
- Reduced mobility was given as the reason for referral in 44% of cases. 21% were considered to be at risk of a fall.
- The largest groups by main diagnosis were falls patients (20%) and stroke patients (14%).
- 11% of referrals are described as having facilitated discharge from hospital. 44% were targeted at preventing an acute admission; and 37% at preventing an admission to long-term care. Given the wide divergence between these proportions and those recorded in the Social Services Snapshot Evaluation (which may admittedly underestimate contribution to intermediate care criteria) further work could be usefully carried out to validate estimates of prevented admissions to acute and long-term care.
- Only 3% of patients were admitted to acute hospital during the community therapy spell. Less than 1% were admitted to long-term care. 46% were discharged with no package of further care. 33% were given a supporting package of care on discharge. 3% of patients died.
- An estimate of bed days saved has been attached to 69 patients (59%) receiving community therapy. This totals 440 bed days (range 3-9 days per patient) which would equate to a saving of £125,400 in the acute sector; or £52,800 in the community hospital sector.

Key Messages

8.34 Community therapy provision has been significantly enhanced in Cornwall since 2000. 9 Community Rehabilitation/Therapy teams have now been established around the county.

8.35 Community therapy capacity has been identified as a problem that affects throughput in a number of Intermediate Care settings. The lack of out-of-hours cover presents a barrier to the organization of referrals to Homeward Bound Units over the weekend and impacts upon the smooth flow of transfers from acute hospitals. A lack of capacity may have limited the extent to which the system is catering for people on the threshold of admission to long-term
residential and nursing care. Hospital-based therapists may also be reluctant to discharge patients who require intensive therapeutic input to the community due to awareness of capacity problems.

8.36 As community therapy lies at the heart of the whole system of intermediate care and impacts upon both the number of referrals and the balance of step-up and step-down referrals, this is a priority area for further investment. Current uncertainties about funding after April 2003 when Social Services commitment to funding community therapy provision comes to an end deserve immediate attention.

8.37 The organization of therapists’ working practices has altered significantly with the development of Intermediate Care schemes and this has caused some frustration. Whilst new lines of accountability have become clearer, the fact that Social Services Care Managers can question the financial justification of recommended care packages as part of their budget management remains a point of contention. The amount of paperwork produced as a result of working in partnership with Social Services is also perceived to cut into productive clinical time. There may be a case for exploring whether procedures can be rationalized.

8.38 Communication between community therapists, G-Grade nurses and Intermediate Care Coordinators could be improved (e.g. feedback following therapist assessment). The introduction of the Single Assessment Process may help here.

8.39 As, since the development of Intermediate Care schemes, NHS and Social Services Occupational Therapists are now both working within the community, some consideration could be given to the scope for integrating OT provision.

8.40 The recent expansion of the range of standard stock available from the Loan Equipment Service is intended to address the delays experienced by therapists in accessing necessary equipment to support patients at home. The impact of this decision should be reviewed.

8.41 Most the work undertaken by Community Therapy Teams is not labelled ‘Intermediate Care’ for monitoring purposes. Consideration should be given to how the contribution of this essential part of the whole system can be better captured.

8.42 A snapshot evaluation of community therapy work undertaken by the Social Services Department found that the majority of clients (74%) received a programme of therapy within their own home and experienced an improvement in their health, well-being and ability to cope with everyday living. Only 12% of patients seen were admitting to hospital, a residential home or a nursing home. User satisfaction with therapy services is also high.

8.43 Routine monitoring data from the County’s Occupational Therapy Service show that Occupational Therapists handled 1450 new referrals between April 2001 and March 2002. This amounts to an average of 88 referrals per therapist per annum.

8.44 Taking into account staffing costs and estimated numbers of acute hospital admissions that have been prevented, early hospital discharges that have been facilitated and admissions to long-term care that have been prevented or delayed, Community Therapy in Cornwall appears to be highly cost-effective.
9 Rehabilitation Care Assistants

9.1 The additional demands associated with community-level work have been acknowledged strategically. To support the expansion of community therapy, Social Services, in partnership with HAZ, has funded a programme of Rehabilitation Care Assistant (RCA) training. The aim is to train and deploy care assistants from the voluntary, independent and statutory sectors to enable them to work to a qualified Therapist’s care plan with people in their own homes or in a residential, nursing or hospital setting.

Inputs

9.2 A range of agencies worked together to undertake the developmental work for this innovative programme. This included Social Services, Cornwall Healthcare Trust (CHT), RCHT, CioS Health Authority, representatives from independent and voluntary sector care providers and some individual GPs. Advice was also sought from St Martin’s Residential Home which had pioneered the use of RCAs. A successful application for £50,000 was submitted to the first round of HAZ funding to support a training programme for Rehabilitation Care Assistants.

9.3 150 candidates were initially selected for RCA training, using a Panel process, from 28 organizations in Cornwall whose employees or volunteers provided support in a domiciliary, day or residential setting. In order to ensure equity in provision of RCAs across the county and to guarantee that each location would have a sufficient number of RCAs to provide intensive daily support, 7 days a week, each employing agency was invited to submit 6 candidates for training. Agencies included the Social Services in-house Home Care Service, Age Concern and residential homes from the independent sector (the majority group).

9.4 The RCA training course was developed in partnership between staff from RCHT, SSD, CHT, CioS Health Authority, Truro College and Cornwall Care. The programme consists of two weeks intensive training; one week taught theory, one week practical experience and assessment, overseen by an occupational therapist (2.5 days) and physiotherapist (2.5 days). Taught elements include understanding the nature of disability, understanding the concept of rehabilitation, developing effective interpersonal skills in rehabilitation settings, developing skills in multi-team working, and enabling people to improve their mobility and function through exercise. Within placement sites (mostly community hospitals), candidates are observed carrying out tasks, which are then signed off by an appropriate member of staff (see Box 7).

9.5 Successful candidates are awarded a Certificate in Promoting Independence (the first accredited course of its kind in the country) at NVQ level 2. A separate certificate is also issued for Moving and Handling Training. The first group of 150 RCAs received their certificates at an award ceremony at Truro College in July 2000. A second cohort of trainees embarked upon the course in September 2000, supported by Social Services Funding. As a result, a total of 300 RCAs have now been trained.

9.6 The costs of training each cohort of RCAs is £50,000. This includes tutor, assessor, internal verifier and accreditation fees, travelling costs for tutors and participants, administration costs, locum costs and the cost of OT/PT time during practice placements. Partners have been
asked to offer the majority of venues and hospitality for the training at nil cost and, where possible, to not seek locum fees for their staff to participate in training.

9.7 Once trained, RCAs are deployed, following a Therapist’s assessment and recommendation for a care plan, through Social Services Care Management on a spot purchasing basis. They can be engaged for a period of up to 6 weeks.

Box 7. Rehabilitation Care Assistant Training: Practical Tasks

<table>
<thead>
<tr>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Communication: Demonstrate ability to communicate a task in therapy to a patient with a communication project (i.e. blind, deaf, speech problem, dementia, confusion, depression)</td>
</tr>
<tr>
<td>b) Environment: Consider safety aspects in preparation for mobility and transfers</td>
</tr>
<tr>
<td>c) Environment: Prepare the environment</td>
</tr>
<tr>
<td>d) Transfer 1: Supervise a patient/client getting up and down from a chair</td>
</tr>
<tr>
<td>e) Transfer 2: Supervise a patient/client moving in bed</td>
</tr>
<tr>
<td>f) Transfer 3: Assist a patient in getting up/down from a bed</td>
</tr>
<tr>
<td>g) Transfer 4: Assist a patient/client to transfer from a bed to chair/wheelchair/commode</td>
</tr>
<tr>
<td>h) Transfer 5: Supervise a patient using walking aids</td>
</tr>
<tr>
<td>i) Personal hygiene 1: Promote independence in personal hygiene during washing/shower sessions</td>
</tr>
<tr>
<td>j) Personal hygiene 2: Supervise the patient/client when washing face, cleaning teeth and grooming</td>
</tr>
<tr>
<td>k) Personal hygiene 3: Promote independence in dressing and undressing</td>
</tr>
<tr>
<td>l) Therapeutic activity 1: Encourage a patient to participate in an activity session (e.g. remedial Game for hand function, memory training, work related tasks etc)</td>
</tr>
<tr>
<td>m) Therapeutic activity 2: Demonstrate knowledge and ability to supervise an exercise programme</td>
</tr>
<tr>
<td>n) Food preparation: Assist in a further assessment by taking responsibility for encouraging independence in at least one task identified by your assessor</td>
</tr>
<tr>
<td>o) Community: Fit an item of equipment together with your assessor to facilitate independence in the home</td>
</tr>
<tr>
<td>p) Feeding: Supervise the patient/client when feeding</td>
</tr>
<tr>
<td>q) Mobility: Supervise an exercise programme</td>
</tr>
<tr>
<td>r) Carers: Reassure an anxious carer that the patient/carer is not being put at risk</td>
</tr>
<tr>
<td>s) Personal choice: Supervise a patient/client in independent choice/beliefs</td>
</tr>
<tr>
<td>t) Behaviour: Encouraging an anxious or unmotivated client to undertake a set task</td>
</tr>
<tr>
<td>u) Reporting: Completing a sample communication form</td>
</tr>
</tbody>
</table>

Process Issues

Strategic Direction

9.8 As an innovative initiative, RCA training programme illustrates a number of process issues involved in setting up new intermediate care schemes. Good partnership was achieved between a range of agencies, representatives of which committed significant time to support the development work involved in planning the service. However, key architects of the scheme were appointed to new organizations early in 2000. Consequently, Social Services had to play an important role in maintaining momentum and commitment. The presence of a stable partner in a period of organizational turbulence is a critical factor in service innovation.

Recruitment of Trainees

9.9 One of the features of Cornwall’s approach to the development of intermediate care has been the extent to which Independent sector partners have been engaged. In identifying potential candidates for RCA training, there has been a clear commitment to involve organizations from all sectors. This resulted in some early tensions about the use of statutory funding to
develop the independent sector. These were largely overcome by acknowledging the advantages of cultivating a promoting independence ethos throughout the system. However, the provenance of RCAs has continued to be a source of tension due to the perceived difficulties of accessing Independent sector RCAs who cannot be released at short notice for work in the community (see below). In light of this, there may be grounds for recruiting a higher proportion of trainees from Social Services’ in-house Home Care Assistants.

9.10 The emphasis placed on developing staff within the independent sector is also linked with the difficulties that have been encountered in achieving geographical equity in the distribution of RCAs. Many independent sector homes have not been able to release staff to attend the training because of the difficulties in covering their work. This has left gaps in some parts of the county, notably Penzance. At a district level, numbers of RCAs per 1000 people aged 75+ in March 2001 were 5.5 in North Cornwall, 4.1 in Kerrier, 3.5 in Carrick, 2.9 in Penwith, 2.6 in Caradon and 2.2 in Restormel.

9.11 A final barrier to recruitment has been the required qualification for entry to the scheme. The assessment tool demands a certain level of literacy (which has presented problems for some RCA trainees who were practically able to undertake tasks but who experienced difficulties in articulating this on paper). In line with the nature of the assessment, RCA training originally required care workers to have completed a minimum of NVQ2 training. Some agencies struggled to identify staff at this level. Entry requirements were adapted to include staff embarking on an NVQ2 course but such trainees were found to have insufficiently embedded learning skills to fully benefit from such a short period of training. Thus, the original entry requirements were reinstated.

Training

9.12 The RCA training programme was designed on the basis of both national and local research and the course content discussed with occupational therapy and physiotherapy staff before being finalised. The programme was then piloted before its final introduction. Despite this, some problems were encountered in the implementation of the programme.

9.13 One of the most significant has been the difficulty in arranging placements with OTs and PTs who, having trained RCAs at some cost to their time, found subsequent difficulties in accessing them. This created some reluctance to continue to participate in the Programme, though numbers of placements have subsequently increased. The fact that Community Therapy Teams were not yet established in parts of Cornwall also resulted in the use of hospital-based placements (with the exception of St Martin’s House), despite an expectation that RCAs would be working within the community.

9.14 Ensuring that trainees received practical training in the full array of tasks proved challenging, not least because they could not expect to encounter a sufficiently wide variety of patients in the short placement period. The option of incorporating follow-up training within the workplace was explored. Due to concerns about capacity, therapists were not initially keen to assume formal responsibility for this. However, there is growing recognition of the need to build up practical skills over time and to introduce some follow-up evaluation of training (e.g. to ensure that competency has been maintained). Community therapists could play a key role here, which would both address the gap in community-based training and promote better awareness and confidence amongst community staff in the skills of RCAs (see below).
Retention

9.15 Retention of trained RCAs has been a major problem. For care assistants who are generally paid a low wage, RCA training has understandably been viewed as a route for career development. Some have been successful in obtaining posts as technical officers in hospital settings. Others are aiming to undertake training as therapists. Still others have left their jobs as care assistants to take up unskilled employment with better pay and more sociable hours. For example, the opening of a new supermarket in one area resulted in the immediate loss of several RCAs. In Launceston and Callington, only one of the five assistants who had received training during the first phase of the Programme was still in post by November 2001.

9.16 It is hoped that recruiting a higher proportion of Social Services in-house Home Helps may increase retention. Efforts are also being made to maximise job satisfaction in the RCA role. One approach to this is to ensure that RCAs are more closely integrated with, and feel part of Community Therapy Teams. To this end, a pilot scheme has been proposed in Carrick, in which a number of RCAs will be attached to the Community Therapy Team. In some areas, however, co-location is not likely to be feasible given the size of the patch covered by individual teams. RCAs tend to be deployed in settings that are close to their place of employment. In the more rural districts, this can be geographically distant from their Therapists’ base.

Accessing RCAs

9.17 Employed by a range of organizations and accessed through Social Services Case Co-ordinators, there is a widespread perception that RCAs are difficult for Therapists to access at short notice. Therapists have also suggested that RCAs are often tied up on existing care packages and cannot be released, as their agencies are unable to backfill their time through recruitment. However, difficulties of access were not highlighted in the snapshot evaluation of community therapy undertaken by the Social Services Department. In 68% of cases, an RCA was not used because this was ‘inappropriate’, insufficient skill level was cited in 10% of cases and the need for a qualified OT in 7% of responses. In 159 responses, there was only one referral where an RCA was needed but not used because of lack of availability.

Confidence

9.18 The responses to the snapshot evaluation suggest that it may have taken time for confidence in the skills of RCAs to develop. In parts of the county, there appears to have been limited understanding amongst community therapists of the content of the RCA training programme and of the level of expertise of RCAs.

9.19 There has been some confusion about lines of accountability for RCAs. Therapists have been uncertain as to whether they are ultimately responsible (and legally accountable) for the work of RCAs or whether responsibility remains with Social Services staff or RCA employers. Frustration has been particularly expressed about communication, which sometimes takes place via a Case Co-ordinator rather than directly with an RCA. This raises concerns that RCAs are being instructed by professionals other than Therapists, that care plans may be amended without their prior agreement and that insufficient feedback is provided about a client’s progress.

9.20 Finally, there has been a perception that there is a potential duplication between the functions of RCAs and those of Technical Assistants. In light of this, some teams have mooted the possibility of diverting the resources to support the training and deployment of RCAs to
employing and training more technicians. The latter, it is argued, tend to be more skilled, can provide a more consistent input, and are available for direct liaison. Issues of ownership are also at work here. Unlike RCAs who come under the domain of Social Services, Technicians are part of the Therapy Teams.

9.21 Technical assistants are clearly valued by Therapists and, in the snapshot evaluation, were used in 46% of cases when an option other than an RCA was used. Most of these referrals were for promoting independence and improving mobility. Nevertheless, there are clear cases where therapists have developed confidence in the role of RCAs and deploy them regularly.

9.22 A key determinant of success appears to be the extent to which individual therapists are able to work closely with their RCAs, to give direct input and provide regular guidance. The fact that the use of RCAs is widely perceived to be more successful in residential settings than the community may thus be partly attributed to the day-to-day contact enjoyed by therapists and RCAs working in Homeward Bound Units. In other cases, RCAs have attended assessment meetings prior to hospital discharge and, having been part of the assessment from the start, continue to link well with both therapists and case co-ordinators.

Financial Assessment

9.23 Where there has already been a care package in existence, clients have not been charged for the use of RCAs. However, in other cases, they are means tested. There has been considerable concern amongst therapists about the appropriateness of conducting financial assessments. The fact that clients may be charged for the use of RCAs within their own home whilst patients admitted to Homeward Bound Units (and who benefit from input from RCAs) do not pay for this service is seen as being inconsistent. Whilst Social Services have emphasised the fact that there appears to be no concrete evidence that service users are declining the service because of cost, many Therapists have a fundamental objection to charging for treatment that they think should be provided free at the point of use.

Outcomes

9.24 The development of an accredited course in Promoting Independence is a significant outcome in its own right, as the successful completion of the course by the targeted number of candidates. Problems have been identified, however, in the uptake of RCAs. Lack of confidence in the RCA commissioning system and lack of control over worker input have been raised as issues. Spot purchasing the packages of care has been particularly problematic for independent service providers. The recruitment of more Social Services in-house care assistants may help in this respect, though home helps are also likely to be tied up with existing care packages. The development of methods to ensure that Therapists have more regular contact with RCAs and control over their input would also be desirable.

9.25 The snapshot evaluation undertaken by Social Services of the work of Community Therapy teams recorded a very low uptake of use of RCAs. Only 6% of referrals were assessed by Therapists as needing an RCA and one was used in 5% of cases. The snapshot was undertaken in 2001, however, when many Therapy Teams had only recently been established and therapists still may have lacked confidence about the system of accessing and using RCAs. Anecdotal evidence suggests that the level of uptake now is higher and this may be captured when Social Services repeats the snapshot evaluation later in 2002. To this end, efforts should be made to achieve a higher rate of return.
In 2001, Social Services also sent a questionnaire to 209 RCAs to examine various aspects of their work. 136 were returned (a response rate of 65%). The number of returns was highest in North Cornwall (n=40) and lowest in Penwith (n=9).

- 67 RCAs (49%) reported that they had been used in the last 6 months in a therapy led programme.
- Of the 66 RCAs who indicated where they had been used, 29% had worked in service users’ own homes, 24% in a Homeward Bound Unit, 16% in another residential home, 8% in a nursing home, 18% in a hospital and 5% in a day care setting. This does correspond with evidence that therapists are more likely to request a RCA if they can work with them in an institutional setting.
- In only a minority of cases (9) did RCAs report that they had worked with no therapy lead (n=62). However, this should not be happening at all.
- 68% of RCAs reported that they did not have a therapy-led communication sheet to complete (n=66).
- Different areas use different recording mechanisms. In Carrick and Penwith, for instance, RCAs have used their own individual agencies’ recording sheets, whilst in North Cornwall a daily communication sheet has been devised specifically for RCA use.
- 96% of RCAs felt clear about their role (n=78). 81% felt that they were adequately briefed and supported to carry out their roles (n=71). 15% answered ‘partly’. In these questions, it is likely that RCAs are variously commenting on both the training they were given and the support received in assisting individual clients. In further comments provided, several RCAs indicated that insufficient instructions were given about clients.
- 86% of RCAs said that their other work commitments did not prevent them from completing the rehabilitation programme (n=73). In further comments, some suggested that time and staffing levels in their agencies could present difficulties. In other cases, however, clients did not require all of the time allocated for an RCA.

In addition to responding to structured questions, RCAs were invited to provide further comments. In these, the training course mostly receives praise:

‘An excellent training programme, I enjoyed immensely. Very interesting and worthwhile’
‘Training so very useful in my employment as Day Care Centre Manager. Able to rehab so many clients now’.
Thanks for the opportunity to do the course. I am finding it most rewarding and very useful.’

Communication is highlighted as a problem:

‘Sometimes the only contact was with the Case Co-ordinator’;
‘They did not know I was coming so I was left on my own’;
‘It’s best if the Case-Co-ordinator lets us have contact with the OT/Physio direct but sometimes the case co-ordinator likes to be in control and treats us as the lowest of the low and we will just do as we are told’;
‘It’s nice to start the package with some contact from OT/Physio and to be explained to what is wanted and to have a contact number’.

The disappointment of not being able to apply the skills received in training is also raised:
‘Since taking my rehab course I have done no work at all using the skills I learnt. My time at college and Hospital were extremely rewarding and I was looking forward to putting these new skills into practice. However, I have been disappointed and let down that I have had no programmes.’

‘Since my RCA training I have not been involved in any therapy whatsoever. I feel greatly let down that the skills I learnt have not been put into practice.’

‘We would very much like to be used for rehab. I have three members of staff available. We need to put our training into practice in the very near future’.

**Qualitative Evidence**

9.30 In addition to commissioning a questionnaire survey, the Modernisation and Partnership Schemes Co-ordinator in Social Services organised the collection of some qualitative case studies of the work of Rehabilitation Care Assistants (see Box 8). These demonstrate the use of RCAs in a range of tasks, including transfer (using walking aids), personal hygiene and therapeutic activity. Importantly, the ability to encourage clients and boost confidence has been encouraged.

**Box 8: Case Studies of the Work of Rehabilitation Care Assistants**

**Case Study 1:** Mrs A was diagnosed as severely arthritic with severe deformity of her right knee, giving her constant pain. Surgery would have been very hazardous and the risk of complications would be great. Therefore, in addition to medication, a course of physiotherapy was requested to assist her mobility. An assessment was carried out by the Physiotherapist who then requested that a walking calliper be provided to reduce pain and improve stability when walking. Intensive rehab input was necessary to educate the patient on the use of the calliper, including the knee locking mechanism and also to advise on sitting, standing and balance. Instruction was given by the Physiotherapist to the Rehab Care Assistant on the application of the calliper and supervision of walking practice, which was then carried out by the Rehab Care Assistant. The patient did experience difficulty and discomfort initially but was encouraged to continue as the improvement in knee support and weight bearing would be of such considerable benefit in the long term. With practice, Mrs A gradually increased her ability to walk well with the calliper, her posture improved and after six months, she felt much better and was very cheerful.

**Case Study 2:** Mrs B, who suffered from swollen legs and heart failure, had a fracture of the left hip and at the same time appeared to suffer a minor stroke affecting the right side. She was making a rather slow recovery in hospital, therefore physiotherapy was requested to aid her rehabilitation when she was discharged. The patient was issued with a frame but had difficulty moving her right leg, transferring and walking. Balance and co-ordination improved with physiotherapy, the patient became more independent and was able to walk well with her frame. She was then given supervised practice with sticks and continued to improve significantly. A Rehab Care Assistant, following guidance from the Physiotherapist, worked with Mrs B every morning to help her regain her confidence whilst washing and dressing. The Rehab Care Assistant was also able to motivate and encourage Mrs B. She was then able to cancel her morning help as she was managing all her own personal care. Although six months later Mrs B deteriorated, due to another possible minor stroke, she was then given further physiotherapy. She regained her confidence and mobility, so that she was then able to walk again with sticks as before.

**Case Study 3:** Mrs C had a hip joint removed and was awaiting the second stage (i.e. replacement of the joint). She was experiencing some pain and was walking with the aid of two elbow crutches. Following her operation, she was a patient at St Martin’s Homeward Bound Unit, where an exercise programme was arranged. On discharge, a physiotherapist was requested to supervise the exercise programme at home and a Rehab Care Assistant was requested to supervise Mrs C washing and dressing, so that she could regain independence in self care pending the replacement operation. The Rehab Care Assistant was also requested to motivate and encourage the patient. Some equipment needs were identified and provided to assist the patient with personal care and, after a few visits, the Rehab Care Assistant requested an increase in the time allocated to enable all the tasks to be supervised. After three weeks, Mrs C had improved very considerably and was able to manage her own washing and dressing, so that the Rehab Care Assistant was no longer needed.

*Source: Modernisation & Partnership Schemes Co-ordinator, Cornwall Social Services*
Key Messages

9.31 As the first accredited course of its kind in the country, Rehabilitation Care Assistant training is an innovative programme, feedback about which has been very positive. Consideration should nevertheless be given to the need to provide follow-up training to ensure that competency has been maintained.

9.32 Good partnership was achieved between the range of agencies that supported the development work involved in planning the RCA service. Movement of key representatives to new appointments has created some instability, however.

9.33 Several problems have been encountered in the recruitment, retention and deployment of RCAs, particularly those employed by Independent Sector homes. Some agencies have struggled to identify staff who have the required qualification for entry to the scheme (a minimum of NVQ2 training). Difficulties have also been encountered in achieving geographical equity in the distribution of RCAs. Rates of attrition have been high, low-wage care assistants viewing the training course as a route for career development. Small independent sectors are often unable to release RCAs to therapists as they are unable to back-fill their time. Problems have also been experienced in accessing Rehabilitation Care Assistants in more rural districts where their place of employment may be geographically distant from either the Therapist’s base or clients’ homes.

9.34 For therapists, the need to communicate via a Social Services Case Co-ordinator rather than directly with an RCA has been frustrating. The fact that clients may be charged for the use of RCAs within their own homes may prevent therapists from deploying them for work in the community. There are also uncertainties about legal accountability for the work of RCAs. Concerns about lack of control over worker input have led to a tendency to use Therapy Technical Assistants in preference to RCAs to support rehabilitation at home.

9.35 A key determinant of success is the extent to which individual therapists are able to work closely with RCAs, to give direct input and provide regular guidance. The use of RCAs is widely perceived to be very successful in Homeward Bound Units (see Section 10). These assistants provide a more consistent input for both therapists and patients.

9.36 In contrast to the use of RCAs within residential rehabilitation settings, their use of RCAs to support rehabilitation at home has been problematic. In order to address the problems that have been encountered in deploying RCAs within the home, there is an intention to recruit more Social Services in-house care assistants to the training programme. This may help to overcome problems with retention and obtaining access to RCAs.
10 Residential-based Rehabilitation

10.1 The aim of the county’s ‘Homeward Bound’ scheme is to facilitate the safe and successful return home of people who have been identified as requiring a period of intensive therapeutic intervention before being able to resume independent living. The Homeward Bound scheme is modelled on similar schemes such as Outlands in Plymouth. However, whilst Outlands is based in a former local authority residential home and provides 23 rehabilitation beds, the provision of one centralised residential rehabilitation unit in as rural a county as Cornwall would have proved inaccessible to the vast majority of the population. Consequently, the decision was taken to provide smaller units in each PCO area. These are based in five independent sector residential homes.

10.2 Homeward Bound Units offer residential rehabilitation for a period of up to six weeks. GPs, nurse assessors or case-ordinators may identify patients within the community as possibly in need of residential rehabilitation. They are then referred for a therapy assessment and, if Homeward Bound admission is recommended, the paperwork must be channelled through the Social Services Care Management system for funding approval. For a step-down referral, a therapy assessment is arranged in the hospital and, if the patient is eligible for care in a HBU, a form faxed to Social Services, the Community Therapy Team and the Unit itself.

Inputs

10.3 The planning and implementation of the Homeward Bound scheme has required significant input, both developmental and financial. Key developmental activities have included the selection of Residential Homes to house HBUs; training and orientation; the development of protocols and procedures; and ongoing communication with both strategic managers and front-line staff. More tangible inputs have been seen in the significant financial resources that have been achieved in partnership to support the Homeward Bound scheme.

Selection of the Homeward Bound Units

10.4 In June 2000, following initial written consultation with the PCOs, the Social Services Department invited interested parties to tender for the establishment of the Homeward Bound Units. Following Cornwall County Council best practice guidelines, a service specification was developed and issued with the invitations to tender. The specification included outlines of the physical environment, equipment/resources, staffing levels and minimum staff training requirements the units would be expected to provide (Bennett, 2001).

10.5 A small selection panel consisting of three Social Services and three PCO representatives was established to support the tendering, short-listing, screening and selection process for the units. Weighted criteria were identified for evaluating the tenders, approximately 75% based on quality issues and 25% on cost. In early August 2000, following the closing date for tenders, the selection panel used the weighted criteria to short-list possible sites and began a process of visiting each in turn to assess suitability. Service contracts were awarded to the successful sites commencing 1st September 2000 for two years (Bennett, 2001).
Homeward Bound Units in Cornwall

10.6 In addition to St. Martin's in West Cornwall (the original pilot site in Cornwall), three of the four new Homeward Bound Units are run by Cornwall Care for the Elderly, the fourth by the Guinness Trust. Geographically, this leaves the urban areas of Penzance and St. Austell without an immediately local Homeward Bound Unit.

Box 9: The Homeward Bound Units

<table>
<thead>
<tr>
<th>PCO Location</th>
<th>Name and Location</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrick</td>
<td>Mountford House, Truro</td>
<td>Cornwall Care</td>
</tr>
<tr>
<td>Restormel</td>
<td>Penberthy House, Newquay</td>
<td>Cornwall Care</td>
</tr>
<tr>
<td>North Cornwall</td>
<td>Atheslton House, Bodmin</td>
<td>Cornwall Care</td>
</tr>
<tr>
<td>West Cornwall</td>
<td>St Martin's House, Camborne</td>
<td>Cornwall Care</td>
</tr>
<tr>
<td>East Cornwall</td>
<td>Tamara, Torpoint</td>
<td>Guinness Trust</td>
</tr>
</tbody>
</table>

10.7 Each of the new units has six rehabilitation beds, St Martin’s Unit has 12 beds. The units are functionally separate from the rest of the residential care home that houses them and are staffed by a manager and a co-ordinator (Cornwall Care) and have occupational therapy and physiotherapy cover (generally employed within Community Therapy Teams but Social Services funded). The units have single rooms for residents and, following the St. Martin's model, incorporate a 'normal house sized' kitchen and bathroom to provide a realistic rehabilitation environment (Bennett, 2001).

Funding

10.8 In each of the new 6 bedded units, Social Services have purchased 4 beds, and 2 beds have been purchased using HAZ funding. The weekly residential care is in the region of £371. In addition, HAZ/SSD funding covers managerial support for HBUs.

10.9 As well as residential care costs, the schemes incur rehabilitation costs. Part of the expansion of community therapy teams in Cornwall through Scheme 5 and Continuing Care Funds has been in support of HBUs. This budget has covered the appointment of occupational therapists, physiotherapists and care managers who support the provision of rehabilitation packages at home as well as in HBUs. The rehabilitation staffing costs for residential units are not formally distinguished from those of community therapy.

Process Issues

Partnership Working

10.10 Significant input has been made to the development of the Homebound Bound Scheme across the county, in terms of both dedicated funding and the time invested in partnerships. As the interim review of Intermediate Care developments in Cornwall presented to CIoS HAZ Steering Group in 2001 found (Bennett, 2001), considerable effort was required to create structures and linkages and to support them. Communication barriers such as differences of language, mistrust, ownership and differences in organizational ethos have had to be worked through. Where front-line professionals have worked together for the first time and/or within new systems, time has been required to embed those new systems into practice and to develop the mutual trust and understanding to make the systems work. A high level of commitment to the concepts being promoted and to ongoing communication has been
required on the part of partners. The Report concluded that such commitment had been evidenced at every possible level.

10.11 At the strategic level, partnership between the Social Services Department, Health and the Independent Sector has been particularly strong (independent sector involvement in policy developments being perhaps greater in Cornwall than elsewhere). Inter-professional and inter-agency partnerships have also been forged around operational issues at Countywide level. For example, a Homeward Bound Unit Evaluation Group was formed, comprising representatives from Social Services, HBU's, Senior Therapists and the HAZ Eldercare Programme Evaluator. Its remit was to ensure that data collection tools were in place that would capture the activities, impact and outcomes of the HBUs.

10.12 Operational partnerships have also been forged at PCO level. For example, in Carrick, a Homeward Bound Unit Monitoring Group was established to allow HBU co-ordinators and managers, therapists, nurse assessors and care managers to review operational issues and to close any loopholes in procedures. Similarly, in North Cornwall, a multi-disciplinary Community Rehabilitation Team meeting involving therapists, community nurses, community psychiatric nurses, care managers case co-ordinators, the discharge co-ordinator, consultants and community hospital staff allowed discussion of the front-line difficulties arising in the implementation of intermediate care schemes, including Homeward Bound.

10.13 Against such successes, the development of the Homeward Bound scheme has faced a number of challenges. Although the existence of PCOs ensured that each intermediate care scheme was developed in accordance with local needs and service structures, in many ways this also created difficulties, particularly for the countywide organizations liaising with them. In the absence of an agreed individual/agency strategic lead for the schemes, an essentially countywide service development struggled with the complexities of communication with the new PCOs.

10.14 There has also been a weakness in partnership working at the interface with secondary care. There was generally little involvement or consultation with secondary care in the development of the Homeward Bound Units. This is perhaps surprising given the fact that the St. Martin's Homeward Bound Unit, the model on which the new units were based, was developed within secondary care. A further factor that should have signalled the requirement for liaison with secondary care, particularly the RCHT Discharge Team, was the new configuration of the St. Martin's unit within the new schemes. Within the new schemes, St. Martin's was to operate both as a 'step down' and as a 'step up' facility. However, little consideration was given to explaining the changed nature of this Unit's operation or to the development of systems and protocols for 'step down' referrals to the new units. There has been some evidence that this weak linkage had an impact during the early implementation phase of the schemes (Bennett, 2001).

**Entry Criteria for the Homeward Bound Units**

10.15 There are perceptions that the entry criteria for HBUs are too restrictive. These are based on those used at St. Martin's which, in turn, had been developed from examples of good practice elsewhere in the country (particularly Outlands). The criteria were set to ensure that patients with ongoing medical needs or those who were unlikely to rehabilitate to a level where they would be able to return home (even with Social Services support) were not transferred to the unit inappropriately (Hawkins, 1999). The criteria are in line with those later stated in the
DoH guidance (HSC, paragraphs 7,8,12 and 13). Patients are only eligible for homeward bound rehabilitation if;

- They are medically fit
- They have the desire to be at home
- They can transfer with one and have the potential to mobilise independently or with a walking aid
- They were independent in personal care prior to admission, with or without social services care or other input
- They have the potential to rehabilitate in six weeks
- They are able to co-operate mentally and psychologically with the rehabilitation programme
- They are continent or self-managing incontinence
- There are not identified nursing needs
- Any heart, metabolic or respiratory condition is stable and well controlled
- The client and family have made an informed decision to co-operate with the rehabilitation programme

10.16 The requirement that patients are sufficiently medically fit and mobile to transfer with one has been identified as a major barrier to use by both Nurse Assessors and hospital discharge facilitators, many of whose patients are too frail and/or unwell to meet the eligibility criteria for Homeward Bound admission. In response to such concerns, there has been an agreement to re-examine the criteria at the Countywide Promoting Independence Meeting.

10.17 Before doing so, it is important that clarity is reached about the purpose of the Homeward Bound scheme. In similar schemes such as Outlands and Exebank, the purpose of residential rehabilitation has been specifically focused on preventing admission to long-term residential and nursing care. By contrast, Homeward Bound Units have been promoted as part of a general menu of services designed to prevent admission to hospital and to facilitate early hospital discharge as well as prevent admission to long term residential or nursing care. Indeed, all of these reasons for admission are included in the HBU monitoring form.

10.18 The case for re-examining the entry criteria should perhaps be considered alongside the case for narrowing the purpose of the residential rehabilitation schemes. The problems encountered in diverting medically unfit patients from hospital care may be less of a reflection of HBU entry criteria than of gaps in the provision of Nursing Home beds, convalescent wards and 24-hour nursing cover in the community. The fact that HBUs may be better designed to cater for people on the threshold of admission to long-stay residential or nursing home care may also explain why therapists tend to look more favourably on the Units than those whose role is to find placements for medically unfit patients.

Outcomes

Routine Monitoring Data

10.19 With the support of the then HAZ Evaluator of Primary Care and Eldercare Projects, the Homeward Bound Evaluation Group has developed, piloted and implemented a number of evaluation tools and therapeutic measures. These are designed to review throughput, therapeutic outcomes, discharge outcomes and user satisfaction with HBUs and therapy. In May 2002, Social Services compiled information collected from HBUs over a full year from
April 2001 to March 2002 (Cornwall Social Services Department, 2002). The Units had been up and running since November 2000.

10.20 Admissions to Homeward Bound Units:

- 294 patients were admitted to the five Homeward Bound Units (total 36 beds) in the period April 2001 to March 2002. This is comparable to the 105 admissions to Exebank (19 beds) in its first year of operation and the 77 admissions to Broom Hayes Residential Rehabilitation Unit in Rotherham (6/9 beds) in 1998/99 (Sanderson and Wright, 1999).
- Admission rates were broadly comparable between the Units. St Martins (a 12 bedded unit) admitted 90 patients in the year. Tamara admitted 54, Penberthy 53, Mountford House 52 and Athelstan House 45.
- Bed occupancy rates are subject to seasonal fluctuations. As in 2001, there was a peak in use in February 2002. Average bed occupancy rates during the 12 month period for the county as a whole were 74% (range 61% to 89%). Mountford House had the highest average bed occupancy over the year (84%), Penberthy the lowest (67%).
- The average age of patients ranged from 81 in St Martin’s House to 76 in Mountford House. 64% of patients were female. 74% of patients lived alone (rising to 90% of patients in Athelstan House). 20% had a carer.
- 86% patients were admitted to a Homeward Bound Unit for the first time.
- The average length of stay ranged from 35 days in Mountford House to 28 days in Penberthy (compared with 23 days in Broom Hayes, 29 days at Exebank and 42 days at Outlands). All units had a number of patients who exceeded the 6 week length of stay (31% of admissions to Athelstan House, 29% to Mountford House, 27% to St Martins, 17% to Tamara and 15% to Penberthy).
- The use of HBUs is strongly focused on moving people from hospitals. In 72% of cases, the reason given for admission was to facilitate discharge from hospital. This ranged from 82% in Mountford House to 57% in Penberthy. 11% of admissions were to prevent a hospital admission (ranging from 16% in St Martins to 5% in Penberthy).
- 54% of patients had been admitted from an acute hospital, 22% from a community hospital. Mountford House received the highest proportion of patients from the acute sector (61%), Tamara and Penberthy received the highest proportions of patients from community hospitals (39% and 25% respectively).
- Only 6% of admissions were to prevent urgent admission to residential care. This rose to 18% in Athelstan House. 1% of admissions were to prevent urgent admission to nursing care. Athelstan House received the highest number of patients from home (25%), Tamara the lowest (10%).

10.21 Therapeutic and Discharge Outcomes:

- Therapeutic outcomes are measured in Homeward Bound Units using the Barthel assessment tool that considers whether there has been any improvement in service user health, well-being and ability to cope with everyday living. Rates of return on the Barthel scores section of the monitoring form have significantly improved since the Interim Evaluation Report. 78% of patients are recorded as having had an
improvement. 7% showed no improvement and in 16% of cases, no answer was recorded.

- 78% of patients were discharged to their own homes (40% with no care package, 8% with their original package of care, 8% with a reduced package, 7% with an increased package and 15% with a new care package). 8% were admitted to hospital, 7% to a residential home and 2% to a nursing home. These figures are comparable to those recorded at Broom Hayes Residential Home.

10.22 User Satisfaction:

User satisfaction with the Homeward Bound Units was very high (n=226):

- 94% rated the standard of meals as good (19%) or very good (75%)
- 98% rated the standard of accommodation as good (16%) or very good (82%)
- 100% rated the helpfulness of the staff when they asked for assistance as good (6%) or very good (94%)
- 100% rated the visiting arrangements as good (18%) or very good (82%)
- 100% rated the overall service as good (9%) or very good (91%)

10.23 User satisfaction with therapy received was also assessed. Interestingly, significantly higher scores were attained for therapy provided in HBUs than therapy provided at home. A number of factors may be at work here. Patients who enter HBUs have made an informed decision to embark on a rehabilitation programme. They are not cognitively impaired, whereas a significant proportion of patients at home has cognitive and social problems. They tend to receive more therapeutic input than patients at home and become more familiar with the staff, including RCAs who are used regularly to follow-up therapists’ treatment plans. These factors contribute to make user satisfaction with the therapy services they have received in HBUs very high (n=220):

- 92% felt that they had received their first visit quickly enough
- 91% felt that they had received all the therapy services necessary to meet their needs. 78% agreed that the therapy services they had received would allow them to resume their usual everyday activities and 88% agreed that that therapy had improved their confidence in being able to cope
- 79% had felt involved in their therapy. 93% found that information was given clearly by the therapist and a further 93% that the therapist had helped them to understand their abilities and difficulties. 93% agreed that the therapist had taken their normal lifestyle into account and 78% that the needs of their family and/or caregivers had been considered
- 75% knew how to contact their therapist when they needed to and 83% agreed that the therapist kept appointments (the only responses to have received lower agreement than in the survey of community therapy referrals).
- 86% agreed that the number and lengths of therapy sessions were sufficient to meet their needs.
- 97% had confidence in their therapist and 95% were satisfied with the service that they had received.
10.24 In April 2002, an evaluation report submitted to the HAZ steering group on the Eldercare Programme included a provisional cost-savings analysis of Homeward Bound Unit provision (Asthana et al., 2002). Costs were based on support allocated to the Homeward Bound Scheme by SSD and HAZ and an estimate of the proportion of community therapy staff time used to provide rehabilitation in HBUs. Savings were based on the national average cost of rehabilitation periods in NHS Trusts.

10.25 There are grounds for refining this analysis:

- The non-recurrent funds attached to the Homeward Bound Scheme by CIoS Health Authority have included the funding to support G-Grade Nurses. Yet rapid response assessments result in a wider range of pathways than residential rehabilitation. Thus, this element could be excluded from the costs linked to the Homeward Bound Scheme.
- Due to the rapid growth of rehabilitation provided in the community, the proportion of community therapy staff time that is dedicated to residential rehabilitation is likely to have been overestimated in the original analysis.
- National average costs per acute bed are lower than local costs. The costs attached to supporting residential rehabilitation in Cornwall should ideally be compared against local savings.
- Given current pressures on capacity, patients entering Homeward Bound Units are unlikely to have received a full spell of rehabilitation in hospital (national average length of stay = 20 days). In order to quantify possible savings, the Social Services Department has drawn on research sponsored by the Centre for Evidence-based Social Services that found that people going to a HBU spent approximately 6 days less in community hospital.

10.26 Weekly residential care in Homeward Bounds costs in the region of £371. The total cost of purchasing 36 beds during the year is £694,512. Approximately 18 hours per week of senior OT/PT time is dedicated to providing rehabilitation in each residential unit. 6 half-time posts throughout the county will cost around £100,900. The total estimated costs of residential rehabilitation in 2001/2002 were thus £795,412. This excludes the costs of managerial support.

10.27 If the 294 patients attending Homeward Bound Units had received a spell of rehabilitation (at the national average length of 20 days) in a NHS Trust (at the national average cost of £3586), this would have cost £1,054,284. Using local costs, a 20-day spell within an acute bed would have cost £1,675,800 and in community hospital bed £705,600. If patients had received rehabilitation in community hospitals at the same average length of stay of HBU provision (28 days), this would have cost £987,840. This implies that:

Residential rehabilitation is more cost-effective than providing rehabilitation in a hospital environment - acute or community - for the same given length of treatment.

10.28 With current pressures on local capacity, it is of course doubtful that patients admitted to HBUs would have received a full course of rehabilitation in either an acute or community hospital setting. If each admission to a Homeward Bound Unit saves an average of 6 days in hospital, and 72% of admissions to HBUs facilitated early hospital discharge, £361,973 was saved by the acute sector alone between April 2001 and March 2002. This exceeds the NHS contribution to the Homeward Bound Scheme (12 beds at £231,504 per year).
The potential savings made to the funding of long-term placements to nursing and residential care homes should be added to this figure. If, as suggested by therapists working in HBUs, the provision of residential rehabilitation increases independence and prevents/delays admission to nursing and residential care, HBUs would have had to have prevented/delayed an average of 42 days per patient in residential care to be cost-neutral in overall terms. The break-even point for Social Services (which contributes £463,008 annually to the schemes) occurs after 44 days. If the longer term outcomes for HBU patients are comparable to those of Broom Hayes Residential Unit, where over four fifths of those discharged home were still there six months after discharge, it is likely that this break-even point is being exceeded.

The immediate savings made to the acute sector and the estimated savings of preventing/delaying admission to long-term residential and nursing care suggest that Homeward Bound Units are cost-effective for both the NHS and Social Services.

Professional views

Therapists connected with the Homeward Bound Units are very positive about the role played by Residential Rehabilitation in enabling patients to return to independent living in the community. Although it has taken time for different professionals involved in the system to become familiar with processes of referral, HBUs are now perceived to work more smoothly. The opportunity to provide an intensive period of rehabilitation is strongly valued and the involvement of RCAs in Homeward Bound Units is considered to be one of the strengths of the initiative. Given pressures on hospital capacity and on the capacity of community therapists, the Homeward Bound Scheme is seen as a critical way of ensuring that patients who can benefit from rehabilitation receive an adequate package of care.

As indicated above, Nurse Assessors and Patient Discharge Liaison officers have been more qualified in their support for the scheme. Processes of referral have been considered to be cumbersome by many health professionals. It has proved difficult to promote awareness amongst GPs of the schemes. A further source of reservation is the fact that HBUs cannot be used to place patients who are too frail or medically unfit to meet the HBU eligibility criteria. It is likely that these concerns would be more appropriately addressed by expanding intermediate care capacity in community hospitals and nursing homes than by relaxing the criteria for entry to the residential units.

Key Messages

Balance between step-up and step-down admissions

The fact that Homeward Bound Units have continued to admit a significantly higher proportion of patients who have been discharged from hospital than patients from the community has been a source of concern amongst local stakeholders. As a core function of residential rehabilitation is to provide intensive rehabilitation to patients who are on the threshold of entering long term residential or nursing care, this is a valid concern. However, the client mix in Homeward Bound Unit may reflect the emphasis that has been placed in general on preventing hospital admission and facilitating early hospital discharge. As a result, the case for using residential rehabilitation for a more specific purpose may not have been sufficiently conveyed to local stakeholders.
10.33 A second factor hindering the expansion of step-up referrals to HBUs has been the capacity of community therapy teams. At present, these are focusing overwhelmingly on patients who have had a recent trauma. Teams have limited capacity to deal with patients with chronic/progressive problems who, due to their growing dependency, are at high risk of entering long-term residential and/or nursing care. Without continued expansion of community therapy, the balance of admissions to Homeward Bound Units may therefore remain biased towards step-down transfers.

10.34 Third, problems have been encountered in raising GPs’ awareness about the role of HBUs (though the impact of this is likely to be influenced by the role played by Intermediate Care Co-ordinators in accessing schemes -see paragraph 5.2). The fact that Homeward Bound entry criteria state that a patient must be medically stable may also lead GPs to seek specialist diagnosis in the first instance. Consideration should be given to embedding access to specialist skills within the community so that patients can see a geriatrician without having to be admitted to an acute hospital or consultant-led bed in a community hospital.

**Process of Referral**

10.35 Despite growing familiarity with the referral process, perceptions remain that the process of referring patients to Homeward Bound Units is cumbersome. In contrast to admissions to community hospitals, which are increasingly being channelled through single points of contact, potential referrers to HBUs need to organise a therapist assessment, identify the appropriate Care Manager, fax through paperwork and wait for funding approval. Whilst assessment itself clearly has to remain a responsibility of therapy staff, there are grounds for moving towards a single point of contact (as in North Cornwall) for the processing of referrals in other localities.

**Mainstreaming Homeward Bound Units**

10.36 Within a constrained financial context, the spotlight has been on Homeward Bound Units to demonstrate cost-effectiveness. The figures provided above suggest that Residential rehabilitation is more cost-effective than providing rehabilitation in a hospital environment - acute or community - for the same given length of treatment. If the alternative is not to provide intensive rehabilitation, the immediate savings made to the acute sector and the estimated savings of preventing/delaying admission to long-term residential and nursing care still suggest that Homeward Bound Units are cost-effective for both the NHS and Social Services.

10.37 Further support for mainstreaming comes from the extremely high levels of satisfaction expressed by patients in both the Homeward Bound Units themselves and in the therapy provided within Residential Care. Therapists value this service and, with a perceived reduction in the opportunities available to provide intensive rehabilitation within hospital settings, view it as an essential part of the continuum of services within Intermediate Care. The Homeward Bound Scheme has also demonstrated the value of using Rehabilitation Care Assistants - in the right setting.

10.38 If Homeward Bound Units are to be mainstreamed, some consideration should be given to the fact that, in certain localities, bed occupancy rates could be improved. The fact that HBUs cannot cater for patients who are too unwell or frail to benefit from residential rehabilitation also needs to be addressed. There may be grounds for re-examining some of the eligibility criteria (e.g. cognitive ability, continence, the need to transfer with one). However, the
frustrations experienced by Nurse Assessors and Discharge Co-ordinators may be better addressed by focusing attention on how partnership initiatives of the kind that has been successfully piloted by the Homeward Bound Scheme could be expanded to cover Nursing Homes. To this end, lessons can be drawn from the experience of the East Cornwall Community Resource Bed Management Project which, in addition to facilitating transfers from acute to community hospital settings, has piloted the implementation of an Intermediate Care Nursing Home Scheme (see Section 12).
11 Community hospital-based rehabilitation

11.1 Cornwall has a wealth of community hospitals. Some patients are under the care of consultant geriatricians (and are thus not technically receiving intermediate care), and others are in the care of their GP. Within the county, there are 213 geriatric beds and 220 GP beds in Community Hospitals. The relative balance of consultant/GP beds varies across the county. In North and East Cornwall, 34% of community hospital beds are consultant-led (n=152). In Central Cornwall PCT, 47% are consultant led (n=136), whilst this rises to 67% in West of Cornwall (n=145).

11.2 Variation in access to consultant care is an important factor determining transfer flows within the continuum of services from the acute setting to home. The lack of an on-site geriatrician can lead to reluctance on the part of consultants within acute hospitals to transfer more unstable patients to community hospitals. For example, patients discharged from Barnstaple may be sent to Holsworthy rather than Stratton due to the lack of a consultant eldercare physician. This clearly affects the extent to which patients within North Cornwall enjoy good access to the full range of intermediate care services. There is, moreover, growing recognition of the importance of embedding access to specialist skills within the system so that patients receiving intermediate care can see a geriatrician without having to be admitted to an acute hospital or consultant-led bed in a community hospital.

11.3 There has been growing interest in the scope for maximising the use of community hospitals for patients who require rehabilitation and nursing support but who do not need the services of an acute hospital. The East Cornwall Community Resource Bed Management Project has led the way in this respect. Following a pilot scheme in 1999 (see Box 3), this has employed a Community Resource Facilitator to proactively identify Cornish inpatients who were suitable for care at a Community Hospital and to facilitate their smooth transfer. Elements of this model have since been replicated in North Cornwall and Carrick, where Intermediate Care Co-ordinators actively seek to identify placements for patients discharged from acute trusts.

11.4 The main focus of the Bed Management Project has been the transfer of appropriate patients from acute to community hospital settings. However, the Facilitator of the Project has also piloted a co-ordination role in facilitating transfers to Nursing Homes. In light of the perceived need for more Intermediate Care places for patients who are too medically unstable or frail to be returned to home or admitted to a residential rehabilitation unit, this part of the Facilitator’s remit deserves further examination. It is therefore considered in the next section.

The East Cornwall Community Resource Bed Management Project

The Pilot Project

11.5 This project was first established as a 3 month pilot in 1999 staffed by a District Nursing sister (Facilitator) with knowledge of East Cornwall’s community resources and a Specialist Social Worker who was attached to all four of East Cornwall’s Community Hospitals. Their remit was to proactively identify Cornish patients who were suitable for transfer within Derriford and Mount Gould Hospitals, to identify placements within Community Hospitals and to facilitate transfer out of Community Hospitals (e.g. by liaising with Social Services to set up home care packages). As part of this remit, the Facilitator reviewed inpatient and community
resources, highlighted service deficiencies that might hinder transfer to Community Hospitals and discharge to another service provider or home, and kept statistics on Cornish patients admitted and discharged to Community Hospitals (Shacklady and Browne, 1999).

11.6 In order to facilitate the identification and transfer of patients, project staff liaised closely with ward staff in both acute and community settings. Multidisciplinary ward meetings were attended where possible, as were weekly Winter Pressure meetings at Derriford. Social Services Referrals were also scrutinised. The rehabilitation needs of patients were carefully assessed to ensure that patients were transferred to units with the appropriate rehabilitation facilities. The method of referral also changed, so that the team could directly accept referrals to Community Hospitals.

11.7 On measuring the impact of the project, the pilot found 41% more patients were transferred than during the same period in the previous year. Community Hospital bed occupancy rates were higher in the first two months of the pilot than in January and February 1997 and 1998. Average lengths of stay decreased at Lamellion (a Community Hospital that offered specialist rehabilitation), a trend interpreted by the project’s staff as reflecting the Specialist Social Worker’s influence in planning earlier discharges from this hospital. Increases in average length of stay in the other Community Hospitals were believed to relate to the fact that they were receiving patients at an earlier stage in their care. Related professional staff expressed support for the project which, it was felt, had increased the range of care options available for patients and rationalised the process of placement. In relation to this, the project report emphasised the extent to which the service facilitated placements to appropriate sources of care (see Box 9).

Box 9 Case study of the work of the Community Resource Facilitator

Mrs A is 75 years old and lives with her husband in a static caravan where she fell and fractured her left hip and arm. An insulin-dependent diabetic, Mrs A had had a cerebral vascular event 15 years previously and previous hip surgery. She suffers from confusion. The hip was surgically repaired but the arm was conservatively treated with a collar and cuff cling. She was more confused post-operatively. Initially the ward wished her to go to her local community hospital for nursing for 6 weeks until she could begin to use her aim, then commence rehabilitation with them.

The ward physiotherapist assessed her for transferring with a hoist and it was established that she was only able to stand using a Standaid hoist with the physiotherapist. This hoist was only available at Lamellion Hospital. The problem was that this lady did not live within the geographical catchment area for Lamellion Hospital.

Acting as the lady’s advocate, the Community Resource Facilitator discussed the case with the consultant and his secretary so that she would not divert the referral. The result was a successful transfer to Lamellion Hospital, 5 days after surgery. On arrival to the community hospital, the Specialist Social Worker began assessing for discharge.

If the Community Resource Facilitator had not come across this lady, she might have been transferred inappropriately to a community hospital without the correct rehabilitation facilities. We speculate that she might not have been able to return home because she would have remobilised enough to manage the caravan steps without intensive physiotherapy and rehabilitation. This is an example of how a patient might end up in long term care.

Source: Shacklady and Brown, 1999

A Permanent Service

11.8 Following the 3-month pilot, the East Cornwall Community Resource Bed Management Project has received regular funding (including HAZ funds) and has now become a permanent service. The focus of the Community Resource Facilitator’s job has expanded to not only include the proactive identification of suitable patients but to also seek appropriate
placements in the community. This partly reflects growing awareness amongst Discharge Liaison Nurses and Bed Managers within Derriford Hospital of the potential of transferring patients to community settings, reducing the need for the Facilitator to proactively in-reach and locate Cornish Patients in the wards.

Process Issues

11.9 The East Cornwall Community Resource Bed Management Project has been identified as a local model of good practice and elements of the scheme have been replicated in North Cornwall and Carrick. Factors that have been identified as being key to the success of schemes of this type include:

- Providing a single point of contact
- Good liaison with Discharge Liaison Teams, Consultants, Social Services, District Nurses, GPs, Housing etc
- Ensuring that roles complement each other rather than creating duplication. Historically active in-reach into hospital wards has led to potential overlap with the role of Discharge Liaison Nurses. The Community Resource Facilitator (now the Intermediate Care Team Leader) believes that her role is more appropriately focused on the development of active packages of post-hospital care than on facilitating discharge per se. The North Cornwall Discharge Co-ordinator (now the Intermediate Care Co-ordinator) has adopted a similar approach.
- Acknowledging that it can take time - and persistence - to develop good systems of communication and that inter-professional differences can present a barrier here.
- Holding community hospital waiting lists allowing patients to be prioritised according to individual needs
- Having access to a nominated budget, which can be useful for catering for individual patients’ needs at short notice.

Outcomes

11.10 The project co-ordinated the transfer of 739 patients in 1999/2000, 1170 patients in 2000/01 and 1278 patients in 2001/02. These figures include the transfer of patients from Derriford Hospital to local Community Hospitals and the planning work that is undertaken to discharge Community Hospital patients (Shacklady, 2001a; 2002a).

11.11 A subjective calculation of the number of bed days saved by facilitating the early transfer of patients is made for each patient. This is based on average length of stay for a particular condition. In 2000/01, the project estimates that approximately 5401 acute and community hospital bed days were saved as a result of its activity. This increased to 7500 in 2001/02. A breakdown of the numbers of bed days saved in acute and community hospitals respectively is not provided in project reports.

- The project estimates that in 2001/02, approximately twice as many acute trust patients accessed a community hospital bed than in 1998.
- 75% of patients who were transferred were over 75 years old on admission.
- Examining patients transferred by specialty, 31% were medical and 16% orthopaedics. 16% were labelled ‘community’ and a further 11% ‘intermediate care’, indicating that a significant proportion of discharge planning work now takes place with community and community hospital patients.
• The ordering of equipment (such as beds and hoists) and pressure relieving aids for discharge planning has been incorporated into project work. Specialist equipment has been regularly hired in order to facilitate a safe discharge home or to transfer to a Community Hospital. In 2001/02, 40 patients benefitted in this way.

Impact on Community Hospital Throughput

11.12 Available data for 15 community hospitals across the county suggests that the approach adopted in North and East Cornwall has had a significant impact on patient flows to community hospitals within this PCT. It is important to note, however, that the use of Community Hospitals for Intermediate Care purposes is not distinguished from routine use for monitoring purposes. Since 1997/98, the largest changes in both numbers of admissions and the number of discharges per available bed have occurred in North and East Cornwall. Here, the Community Hospitals have seen a significant decline in total numbers of admissions and a decline in numbers of patients discharged per bed (see Table 1). Average length of stay in North and East Cornwall (with the exception of Passmore Edwards and Stratton, both of which do some theatre work) is higher than average. For example, Warleggan Ward, the primary function of which is the rehabilitation of older patients, has the highest average length of stay in the county.

Table 1: Community Hospital Throughput data

<table>
<thead>
<tr>
<th>Hospital (by PCT)</th>
<th>Medical cover</th>
<th>No of beds 2001/2</th>
<th>LoS 2001/02</th>
<th>No of Disch 97/98</th>
<th>Disch /bed</th>
<th>No of Disch 01/02</th>
<th>Disch /bed</th>
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<tr>
<td>West of Cornwall</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Cambourne/ Redruth</td>
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<td>71</td>
<td>27.9</td>
<td>806</td>
<td>11.35</td>
<td>873</td>
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<td>Edward Hain</td>
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<td>14</td>
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<td>309</td>
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<td>269</td>
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<td>579</td>
<td>17.03</td>
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<td>34</td>
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<td>142</td>
<td>4.18</td>
<td>382</td>
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<td>Fowey</td>
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<tr>
<td>Warleggan</td>
<td>Consultant</td>
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<td>34</td>
<td>226</td>
<td>10.3</td>
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<tr>
<td>East Cornwall</td>
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<tr>
<td>Passmore Ed</td>
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<td>12.5</td>
<td>514</td>
<td>27.05</td>
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<td>GP</td>
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<td>21.90</td>
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<td>17.1</td>
<td>451</td>
<td>17.08</td>
<td>414</td>
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11.13 The figures support anecdotal evidence of the changing role of Community Hospitals in North and East Cornwall. According to the North Cornwall Intermediate Care Co-ordinator,
local Community Hospitals are receiving more dependent, complex patients at an earlier stage in their care than five years ago. The types of patients that were previously discharged from the acute to the community hospital sectors are now more likely to step-down directly to Homeward Bound Units or to be actively supported at home. Thus, heavily dependent patients who in the past would have had prolonged stays within the acute sector are entering the community hospital sector where multi-disciplinary teams work proactively to help them to return to independent living. In North and East Cornwall, 71% of discharges from Community Hospitals are to the usual place of residence, compared to 62% in West of Cornwall. Central PCT has a higher figure still (79%), though this in part reflects the different case mix of patients admitted to Central PCT Community Hospitals. Bed occupancy rates within N&E Cornwall Community Hospitals also remain consistently high (monthly rates averaging 85% between April 2001 and March 2002).

11.14 Despite active therapy, not all patients will regain sufficient functional status to return home. In North and East Cornwall, 6% of discharges from Community Hospitals enter long-term residential or nursing care. The respective figures for West of Cornwall and Central PCT are 12% and 4%. Anecdotal evidence suggests that improvements in the active rehabilitation of patients are linked to improvements in the assessment procedure for placement to long-term care. Recognising the extent to which options for restoring functional status are now being fully explored, it is suggested that a smaller proportion of Community Hospital patients in N&E Cornwall are turned down for placement today than five years ago.

Strengthening the Role of Community Hospitals Countywide

11.15 The throughput figures give in Table 1 have remained fairly steady in Community Hospitals in West of Cornwall and, to a lesser extent, Central Cornwall. This suggests that there may be some scope for strengthening the active transfer of patients into and out of these hospitals to create additional capacity for patients who would be expected to benefit from a spell of rehabilitation. To this end, consideration should be given to (a) the need for and resource implications of improving and modernising Community Hospital services and (b) areas where linkages within the wider system require strengthening.

11.16 There is already a strong focus on rehabilitation within the Community Hospital sector. For example, Cambourne and Redruth Hospital provides a consultant-run eldercare ward that specialises in rehabilitation, two additional wards that provide rehabilitation for less complex cases and a discharge planning service that is well experienced in finding placements within the community for patients who no longer need inpatient care. Helston, Falmouth and St Austell Hospitals have been similarly praised for their eldercare services (MacMahon and Coupe, 2002). Significantly, some hospitals have introduced nurse-led beds that specifically focus on the provision of intermittent re-assessment and rehabilitation.

11.17 Against this, there are areas where the services available in Community Hospitals could be improved. A recent HAZ-funded PCT-led Review of Cornwall’s Community Hospitals identified the following issues:

- The smaller community hospitals have been starved of capital development in recent years and are operating in premises that are inadequate for the needs of patients today
- There are significant differences between community hospitals in the scope given for independent action by nurses (e.g. relating to prescribing and discharging patients). Where nurses are put in charge and properly supported, the system appears to work well
• Discharge planning processes could be improved. For all patients admitted to a community hospital, a discharge plan and timetable should be compiled within 5 working days
• The restricted availability of allied health professions (especially physiotherapy and occupational therapy) and aides is contributing to delays in getting and keeping patients home
• The uneven distribution of community hospitals creates inequities for patients and relatives and confusion among acute hospital staff

Of the problems identified, the need to increase scope for independent action by nurses was seen as particularly important by the steering group of the Review.

11.18 In addition to investing in Community Hospitals themselves, it is important to acknowledge problems within the wider system. According to the PCT-led Review:

• Community hospitals in Cornwall operate as part of a chain of services but are run largely as autonomous units. There needs to be greater mutual awareness in each part of the system of what the other parts can, and cannot do. There need to be formal arrangements to ensure that staff have a thorough, up-to-date knowledge of the capacity and constraints of other parts of the health care system. To this end, the planned movement of staff, between community hospitals and the District General Hospital to which they most closely relate, should be formalised
• The reduction in the availability of capacity in the private nursing sector, particularly that which caters for patients with dementia, is a significant contributor to delays in discharging patients. A policy that permits patients and relatives choice operates less where the range of choice available is diminishing.
• There are problems in the availability of equipment to support the discharge of patients home

Key Messages

11.19 Community hospitals undoubtedly play a critical role in the continuum of Intermediate Care within Cornwall. The county is fortunate in enjoying good historical provision in this sector and, through the work of Intermediate Care Co-ordinators, has used its community hospitals to good effect to respond to Government requirements to strengthen Intermediate Care.

11.20 The East Cornwall Community Resource Bed Management Project has led the way in this respect. Following a pilot scheme in 1999, this has employed a Community Resource Facilitator to proactively identify Cornish inpatients who were suitable for care at a Community Hospital and to facilitate their smooth transfer. Elements of this model have since been replicated in North Cornwall and Carrick, where Intermediate Care Co-ordinators actively seek to identify placements for patients discharged from acute trusts.

11.21 Factors that have been identified as being key to the success of such models include the provision of a single point of referral; good liaison across professional boundaries; ensuring that roles complement each other rather than creating duplication; acknowledging that it can take time - and persistence - to develop good systems of communication; holding community hospital waiting lists; and having access to a nominated budget.

11.22 Monitoring data from the East Cornwall Community Resource Bed Management Project suggest that the transfer of 1278 patients (75% of whom were aged 75+) was co-ordinated in
2001/02. As a result of this activity, the project estimates that 7500 acute and community bed days have been saved.

11.23 Available data for 15 community hospitals across the county suggests that the approach adopted in North and East Cornwall has had a significant impact on patient flows to community hospitals. In this area, Community Hospitals have seen a significant decline in total numbers of admissions and a decline in numbers of patients discharged per bed since 1997/98. This supports anecdotal evidence of the changing role of community hospitals which are receiving more dependent, complex patients in an earlier stage of their care than five years ago. Bed Occupancy rates in N&E Cornwall Community Hospitals also remain consistently high (monthly rates averaging 85% between April 2001 and March 2002.

11.24 Throughput figures have remained fairly steady in Community Hospitals in West of Cornwall and, to a lesser extent, Central Cornwall. This suggests that there may be some scope for strengthening the active transfer of patients into and out of these hospitals to create additional capacity for patients who would be expected to benefit from a spell of rehabilitation.

11.25 To further expand the role of Cornwall’s community hospitals in the provision of intermediate care, consideration should be given to levelling up local variations in capacity. Differences in access to specialist diagnosis and treatment from a geriatrician exist within Cornwall, particular gaps being found in North and East Cornwall. There are also variations in the amount of therapist input that is available in different hospitals and, across the county, therapy cover is not available over weekends. As with community therapy, consideration should be given to the need to strengthen therapy provision within community hospitals.

11.26 Reduction in the availability of capacity in the private nursing home sector has had a significant impact on delays in discharging patients from community hospitals. The current policy of offering choice to patients requiring long-term care contributes to this. Instead of patients waiting in community hospitals until a place in their or their relatives’ choice of home becomes available, there are ground for making temporary placements in available nursing or residential homes.

11.27 Local variations in ways of working should also be addressed. There are significant differences within the county in the relationship between consultants, GPs and nurses in the running of community hospitals. Increasing the scope for independent action by nurses has been made as a key recommendation by the recent PCT-led review of Cornwall’s Community Hospitals.

11.28 Discharge processes from RCHT (which currently differ between different localities) could be rationalised. Acute hospitals tend to underestimate the potential role of community hospitals in actively managing complex patients. The experience of the Intermediate Care Co-ordinators in North and East Cornwall suggests that, with good liaison and a single point of contact, discharge processes from the acute sector can be significantly improved. In addition to appointing Intermediate Care Co-ordinators or Discharge Co-ordinators who have good knowledge of capacity within the community, initiatives to improve the awareness of key workers of the issues and problems faced by colleagues in different healthcare facilities may help to promote between understanding and communication.

11.29 At present, the use of Community Hospitals for Intermediate Care purposes is not distinguished from routine use for monitoring purposes. There are some inconsistencies in data audited at source by the Intermediate Care Co-ordinators and that entered by wards into
the Patient Administration System. There are also variations in available resources and the case mix of patients admitted to different community hospitals. All of these factors make it difficult to map the relative contribution of Community Hospitals to the whole system of Intermediate Care.

11.30 Another monitoring issue that requires further consideration is that of how to quantify the impact of schemes of this type on hospital activity. For every patient discharged from the acute hospital, an estimate is made by the East Cornwall Bed Management Project of the number of acute bed days that have been saved on the basis of average length of stay (LoS) for a particular condition. This model is currently being rolled out on a countywide basis. However, if intermediate care placements are being targeted at patients who would otherwise face prolonged hospital stays, the use of average lengths of stay may underestimate the contribution made by early discharge. Thus, the validity of this system could usefully be tested through comparison with multi-disciplinary clinical assessments of individual outcomes.
12 Nursing Home Placements

12.1 The need for more Intermediate Care places for patients who are too medically unstable or frail to be returned to home or admitted to a residential rehabilitation unit has been highlighted. The increasing use of 7-day assessment beds confirms the need for placements for patients requiring 24-hour nursing care. In addition, intermediate care type schemes have been piloted in which private sector Nursing (and Residential) Home beds have been spot purchased to facilitate the movement of patients through the health community.

12.2 In December 2000, Cornwall Social Services allocated £125,000 of Winter Pressures Funding to Derriford Hospital to this end. The scheme was based upon a similar project in Plymouth and was co-ordinated by the East Cornwall Community Resource Bed Management Project (Shacklady, 2001b). The following year, Social Services allocated £125,000 from the ‘Cash for Change’ Initiative via acute trusts in the county to undertake a similar remit. Again, the Community Resource Facilitator co-ordinated transfer of North and East Cornwall patients admitted to Derriford, in conjunction with the North Cornwall Discharge Co-ordinator (Shacklady, 2002b).

12.3 Within both schemes, Nursing or Residential Home care was individually purchased for patients who required convalescence or a different level of rehabilitation to that provided by a Community Hospital or Homeward Bound Unit. Beds were spot-purchased and individual agreements made by verbal and written contracts with each GP and Nursing Home. Patients were not means-tested for the scheme, and could be placed for a maximum of 8 weeks.

Process Issues

12.4 Appropriate intermediate care environment was assessed by the Scheme Co-ordinator and North Cornwall Patient Discharge Co-ordinator drawing upon their assessment skills as clinicians, based upon information provided by acute and community ward staff, Discharge Co-ordinators or District Nurses in the community.

12.5 GPs provided medical cover (generally the patients’ own GP), though where necessary the scheme co-ordinators arranged for ‘out of area’ GP cover.

12.6 Referral sources included Cornwall Social Services (both within Derriford Hospital and the community), Derriford Bed Management Team and patient co-ordinators, the North Cornwall Patient Discharge Co-ordinator, OTs, PTs, Ward Staff, Pre-operative assessment clinics, Discharge Liaison Team, Consultants, GPs, District Nurse teams, Community Hospital Staff and the Eldercare Specialist Nurse/RAS Co-ordinator in East Cornwall.

12.7 Some inappropriate referrals were initially received from ward staff who viewed the scheme as a solution to bed pressures. The scheme co-ordinators had to act with a strong advocacy role to ensure that patients accessed the correct environment with a planned discharge route and were not incorrectly placed. To this end, extensive liaison was required to raise awareness about the purpose of the initiative.

12.8 In her previous role as a Nursing Home trainer, the Community Resource Facilitator had personally visited Nursing Homes within East and North Cornwall. The North Cornwall Discharge Co-ordinator has also visited Homes receiving placements in order to assess quality and environmental context for rehabilitation.
12.9 Local differences in the way in which the scheme was co-ordinated led to some fragmentation in North Cornwall, where patients are referred to both Derriford and Treliske acute Hospitals. Whilst the Derriford scheme was wholly co-ordinated by the Bed Management Project for East and North Cornwall, Nursing Home placements were also purchased directly in North Cornwall by Treliske Hospital, often without the knowledge of the North Cornwall Co-ordinator. As a result, she was asked on occasions to problem-solve for complex patients of whom she had no prior knowledge. Fragmentation of scheme co-ordination worked against the development of a single point of contact.

12.10 Capacity within the independent sector remains an ongoing problem. At one point, for example, there was only one Nursing Home vacancy in the whole of East Cornwall. Patients could not always access home of choice. Patient expectations of receiving community hospital care also had to be carefully challenged when they did not require this level of rehabilitation.

12.11 Problems were encountered when one Nursing Home (the only home with vacancies) raised its charges above the Social Services rate. As a result, fees were negotiated individually for short-term contracts.

12.12 Delays were encountered in obtaining 48 hour response times to therapy assessments for patients who required therapist oversight to achieve discharge goals. The number of referrals created pressures on the Community Therapy Teams. Spot purchase of therapy staff was considered as a solution, but no therapists were available via bank or agency employment.

12.13 Part of the scheme’s budget was used to arrange transport for transfers. In 2000/01, £10,500 was allocated to contract with Westcounty Ambulance Services Trust for a short notice vehicle and two crew based at Liskeard Ambulance Station, providing an afternoon and evening service from Monday to Saturday. In 2001/02, Derriford Hospital contracted a short notice ambulance from a private provider. For most transfers to or from a Community Hospital or Intermediate Care setting, this vehicle was available to the Cornwall co-ordinators. Private transport was purchased when the vehicle was unavailable. The total cost of purchasing transport in the second year was £2,000.

Outcomes

12.14 In the 15 week pilot held in the winter of 2000, 92 patients accessed the scheme. The following winter, 144 patients accessed the scheme in 20 weeks.

- In 2000/01, 4% of patients were referred directly from the community. This increased to 24% in the following year. Referrals from Community Hospitals accounted for 25% and 17% in the two respective years. The majority of patients were referred from the acute hospitals trust and came from a range of specialties.

- There were no age restrictions for patients accessing the schemes. The average age of patients in 2001/02 was 81 (range 55-94 years).

- In 2000/01, 61% of patients accessing the scheme had identified nursing needs and a Nursing Home bed was spot purchased. 39% of the patients who accessed the scheme did not have identified nursing needs or had needs that a District Nurse could meet. Residential Beds were spot purchased for these patients. The respective proportions of Nursing and Residential beds purchased in 2001/02 were 71% and 29%.

- Length of stay in 2001/02 varied from 4 to 56 days with an average stay of 19 days.

- 25% of patients who accessed the scheme in 2000/01 were referred to Community Assessment and Rehabilitation Teams (41% in 2001/02). These patients did not require
the level of therapy offered within a Community Hospital or Homeward Bound Scheme, but did require therapist oversight to achieve discharge goals.

- 13% of patients in 2000/01 (11% in 2001/02) had elderly, mentally and infirm (EMI) health problems and were able to access a suitable intermediate care setting in one stop, to allow further discharge planning to take place with Community Psychiatric Nurse input.

- Equipment was hired or purchased for 12 patients in 2001/02 to speed transfer into and out of intermediate care and hospital settings.

- On discharge from the scheme, 52% of patients were discharged home in 2000/01 (59% in 2001/02). 1% transferred into a Homeward Bound Unit (4% in 2001/02). 33% were discharged into permanent care (7% in 2001/02). 2% were admitted to hospital (6% in 2001/02). 10% died (12% in 2001/02) and 2% accessed planned respite care. In 2001/02 11% patients were discharged into Community Hospitals and 1% accessed palliative care.

- The project estimates that 1123 hospital bed days were saved as a result of the scheme in 2000/01 (690 acute and 433 community). In 2001/02, 2728 hospital bed days were estimated to have been saved (1273 acute and 1455 community).

**Key Messages**

12.15 Nursing home placements have been used to transfer patients who have had identified nursing needs but who have not required the level of therapy offered within a Community Hospital or Homeward Bound Scheme. The Intermediate Care Co-ordinators in East Cornwall and North Cornwall have valued the fact that this scheme has extended the menu of services available to them. The flexibility associated with spot purchasing was also valued, though this has been constrained by the lack of capacity of Nursing Home beds.

12.16 The scheme undoubtedly benefitted from the experience of both the East and North Cornwall Co-ordinators in assessing need for Intermediate Care, liaising with professionals across disciplines and using their knowledge of capacity within the community to identify appropriate destinations for patients. Indeed, the wider the menu of available services, the greater the need for central co-ordination to ensure that the whole system of intermediate care can operate efficiently. Thus, whilst there is a perceived need to expand places in intermediate care settings that can provide nursing care, good systems of operational co-ordination must in place to support such expansion.
13 Intermediate Care in Cornwall: Assessment

13.1 As indicated in Section Two of this report, the potential benefits of intermediate care are assumed to be wide ranging. The provision of effective care closer to home is seen as a way of improving appropriateness, acceptability and choice. Intermediate care is also seen as a way of enabling a more effective use of acute capacity and capacity in long term health and social care. It is therefore important to consider evidence of the impact of intermediate care developments on both service quality and cost-effectiveness.

13.2 In so doing, it is helpful to reflect upon the factors that enable or constrain the realization of the potential benefits of intermediate care. These include the strength of local partnerships and, within the rural county of Cornwall, the significance of rurality to service developments.

Service Quality

13.3 Intermediate Care Co-ordinators in Cornwall are clearly motivated by a desire to seek more appropriate care for older people who want alternatives to hospital admission or admission to long-term care. They take a real pride in the service they provide and show imagination and persistence in facilitating transfers throughout the system. In describing their work, the value of service quality is emphasized above the drive to promote efficiency ("it’s all about quality and appropriateness"). The importance of catering for the needs of individual patients, regardless of the time that this may involve, is also strongly felt by the Intermediate Care Co-ordinators.

13.4 Liaising closely with acute and community ward nurses and Discharge Liaison staff to establish the needs of individual patients, and with good knowledge about daily capacity in the range of intermediate care settings, the Co-ordinators are well placed to direct patients to appropriate care settings. The main factor that limits their ability to do this is capacity within the system. The community hospitals are operating under considerable pressure, particularly during the Winter months. In January 2002, for example, the bed occupancy rate was 100% in four of the seven community hospitals in North and East Cornwall and 97% in a fifth. Capacity within the independent nursing sector remains an ongoing problem which affects the use of both 7-day assessment beds and longer nursing home placements. Community therapy teams are also stretched, with demand peaking in the winter months. In January 2002, the community therapy teams in North and East Cornwall handled 207 referrals (compared to an average monthly total of 150). Of the intermediate care services available in North and East Cornwall, only the residential rehabilitation units had any spare capacity in January 2002 and, by February 2002, the Homeward Bound Units in this area had bed occupancy rates of 93% and 100% respectively.

13.5 Co-ordinators and providers of intermediate care are therefore working within a highly stretched system. Despite this, evidence suggests that the quality of services provided is high. Formal data relating to service quality are only available for two service elements (community therapy and residential-based rehabilitation) and, as noted in paragraph 8.24, the Social Service Department’s ‘snapshot’ evaluation of the work of community therapy teams is likely to have captured only a small proportion of overall activity. Nevertheless, the available data show high levels of user satisfaction with therapy services and of improvements to
functional status (see Table 2). In addition, user satisfaction with the Homeward Bound Units themselves (standard of accommodation, meals, helpfulness of staff and visiting arrangements) ranged from 94-100% of respondents.

Table 2: Social Services Monitoring Statistics for Community Therapy and Homeward Bound Units

<table>
<thead>
<tr>
<th></th>
<th>Community Therapy</th>
<th>Homeward Bound Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>% patients having an improvement in health, well-being and ability to cope with everyday living</td>
<td>66</td>
<td>78</td>
</tr>
<tr>
<td>% patients admitted to hospital</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>% patients admitted to nursing/residential care</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>% patients discharged with no package of care</td>
<td>33</td>
<td>40</td>
</tr>
<tr>
<td>% patients discharged with increased/new package of care</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>% patients who felt that they had received all the therapy services necessary to meet their needs</td>
<td>75</td>
<td>91</td>
</tr>
<tr>
<td>% patients who agreed that the therapy services they had received would allow them to resume their usual daily activities</td>
<td>49</td>
<td>78</td>
</tr>
<tr>
<td>% patients who agreed that the therapy services they had received had improved their confidence in being able to cope</td>
<td>64</td>
<td>88</td>
</tr>
<tr>
<td>% patients who felt involved in their therapy</td>
<td>64</td>
<td>79</td>
</tr>
<tr>
<td>% patients who agreed that information from the therapist was given clearly</td>
<td>86</td>
<td>93</td>
</tr>
<tr>
<td>% patients who felt that that therapist took account of their normal lifestyle</td>
<td>79</td>
<td>93</td>
</tr>
<tr>
<td>% patients who felt that the therapist took account of their family/caregivers’ needs</td>
<td>63</td>
<td>78</td>
</tr>
<tr>
<td>% patients who knew how to contact their therapist if they needed to</td>
<td>81</td>
<td>75</td>
</tr>
<tr>
<td>% patients who agreed that therapists kept to appointments</td>
<td>85</td>
<td>83</td>
</tr>
<tr>
<td>% patients who felt that the number and length of therapy sessions were sufficient to suit their needs</td>
<td>73</td>
<td>86</td>
</tr>
<tr>
<td>% patients who had confidence in their therapist</td>
<td>84</td>
<td>97</td>
</tr>
<tr>
<td>% of patients who expressed overall satisfaction with the service they had received from therapists</td>
<td>84</td>
<td>95</td>
</tr>
</tbody>
</table>

As well as formal data relating to service quality, a number of case studies have been included in the report that qualitatively demonstrate the ways in which intermediate care services are meeting a range of patients needs and making good use of available resources. In Box 6, a case study was provided of a rapid response assessment. In this example, the service...
responded to the patient and carer’s needs (to remain at home and to receive an enhanced package of nursing and social care). The speed and efficiency of the service was commented upon and a high level of satisfaction expressed by the service users. The case study also illustrates the value of multi-agency working and of reducing duplication. In Box 8, three case studies described the work of community therapists and rehabilitation care assistants. Again, the care and attention paid to responding not only to physical needs but to psychosocial needs (such as lack of confidence and motivation) are apparent. Box 9 similarly demonstrates the extent to which the individual needs of patients transferred from acute hospital are prioritized.

13.7 An important dimension of the quality of intermediate care services in Cornwall is the extent to which, in certain localities, the system operates as a whole system. The wide range of available service models is one factor here. Of equal importance is the way in which different parts of the system relate to each other. For example, community hospitals are increasingly expected to admit heavily dependent patients from the acute sector. In turn, Homeward Bound Units and Community Therapy Teams are supporting patients who, in the past, were more likely to be referred to a community hospital. The particular contribution made by different services within the system as a whole is not always fully appreciated. For example, frustration has been expressed by acute sector staff about the fact that many of their patients are too frail and/or unwell to meet the eligibility criteria for Homeward Bound Admission. This ignores the fact that Homeward Bound Units may more usefully play an indirect role in releasing acute capacity (by releasing community hospital capacity) than by directly accepting acute sector patients.

Cost-Effectiveness

13.8 Cost effectiveness of intermediate care schemes is a difficult area to formally evaluate. Costs of inputs are difficult to quantify due to the complex system of arrangements that are required to support intermediate care. If the expansion of intermediate care services results in service duplication, this would also increase costs. However, this is only the case if there is spare capacity and evidence suggests that the local acute hospitals are operating with no spare capacity most of the time. The possibility that, rather than reducing overall demand for hospital services, the expansion of intermediate care has precipitated a general increase in demand presents a more complex problem for the assessment of cost-effectiveness. This may be the case if patients are being offered treatment and rehabilitation who would in the past have remained or have been discharged home with an inadequate package of support. In this case, the different schemes that have been developed in Cornwall may well be appropriate, effective, and indeed cost-effective. However, they will not necessarily lead to savings in the acute sector.

13.9 For most of the Intermediate Care services that have been developed in Cornwall, it has been possible to estimate the percentage of placements that are used to prevent inappropriate admission or long-term care or to facilitate early discharge. It is important to note, however, that these estimates reflect the judgements made by service professionals about individual patient outcomes and may thus be subject to bias. In the case of community therapy, for example, a significantly higher percentage of referrals are flagged in the Carrick Intermediate Care Facilitator’s database as having prevented an acute admission or an admission to long-term care than indicated in the Social Services Snapshot Evaluation. Percentages of patients who were supported to facilitate hospital discharge were comparable. Differences in proportions of prevented admissions may in part reflect differences in the way in which
responses have been coded (community therapists in the Snapshot Evaluation tending to describe referrals according to clinical rather than intermediate care criteria). It would nevertheless be useful to carry out some further work to validate cases that are flagged as prevented admissions.

13.10 In addition to estimating the proportions of patients that are diverted from acute care, in order to calculate savings made to the acute sector, certain assumptions must be made regarding hospital lengths of stay. The approach developed by East Cornwall’s Intermediate Care Team Leader has now been rolled out across the county. This makes estimates of the number of bed days saved per patient on the basis of condition-specific average lengths of stay in each of the acute hospitals (accepting that the casemix in Derriford is somewhat different to that of Treliske). For example, if a fractured neck of femur patient is discharged after four days and the usual length of stay is seven days, it is assumed that three bed days have been saved. This system is both transparent and pragmatic. However, if intermediate care placements are being targeted at patients who would otherwise face prolonged hospital stays, the use of average lengths of stay may underestimate the contribution made by early discharge. Again, the validity of this system could usefully be tested through comparison with multi-disciplinary clinical assessments of individual outcomes.

13.11 Taking these qualifications into account, the evidence presented in this report suggests that intermediate care services in Cornwall are cost-effective. To summarise:

**Rapid Response Assessments**

- Estimated average monthly costs per G-Grade Nurse assessor in Carrick and North Cornwall were respectively £147 and £368 in 2001/2002. This implies that, in order to make savings to the acute sector, each Nurse Assessor would have to save an average of 0.58 bed days per month in Carrick and 1.29 bed days in North Cornwall.
- Assuming an average length of stay of around 5 days in Cornwall for Falls and Stroke patients, activity data in Carrick suggests that an average monthly saving of 2.2 bed days was achieved per district nurse between January and September 2002.
- In North Cornwall, local data are only available for G-Grade Nurse Assessments that have prevented a hospital admission and resulted in an admission to a 7-day designated home. On the basis of this activity alone, district nurses achieved an average monthly saving of 1.9 bed days between April and September 2002.
- In East Cornwall, where the costs of supporting Rapid Response have been largely absorbed by the existing District Nursing Service, each of the 9 G-Grade Nurse Assessors achieved an average monthly saving of 7 bed days between February and July 2002.
- Thus, in all three areas, estimated savings to the acute sector outweigh the investment made to support rapid response schemes.

**7-Day Designated Nursing or Residential Homes**

- The current cost per bed night of a stay in a designated care home is £53.64. The current costs per acute bed are £285 per day.
- Taking into account both the costs per bed night of stays in designated care homes and the investment made to support G-Grade Nurse Assessors (who are the major referrers to these homes but who also refer to other intermediate care services), placements to 7-
day assessment beds make overall savings to the acute sector providing that they involve a minimum of 2 days stay in Carrick and 5 days stay in North Cornwall.

Rehabilitation at Home

- Activity data were only available for Occupational Therapists in Cornwall, who handled an average of 88 referrals per therapist per annum in 2001/2002.
- Extrapolating the figures yielded by the Social Services snapshot evaluation, if only 20% of referrals have prevented a hospital admission or facilitated hospital discharge, an average of 88 acute bed days (17.6 patients x 5 days) will have been saved per Occupational Therapist in 2001/2002. At £285 per acute bed day, this amounts to a saving of £25,080.
- To cover therapy staffing costs, each therapist would have had to have saved an additional 139 days to long-term residential care. This equates to the prevention or delay of admission of 4.6 patients for one month, 1.5 patients for 3 months or 0.76 patients for 6 months. Extrapolating the figures yielded by the snapshot evaluation, each occupational therapist has prevented an average of 6.2 admissions to long-term care. Thus, each admission would only have to be delayed by an average of 23 days to make community therapy cost-neutral in overall terms. As it is likely that this break-even point is being exceeded, the analysis suggests that community therapy is cost-effective.

Residential-based Rehabilitation

- Weekly residential care in Homeward Bounds costs in the region of £371. The total cost of purchasing 36 beds during the year is £694,512. Approximately 18 hours per week of senior OT/PT time is dedicated to providing rehabilitation in each residential unit. 6 half-time posts throughout the county will cost around £100,900. The total estimated costs of residential rehabilitation in 2001/2002 were thus £795,412. This excludes the costs of managerial support.
- If the 294 patients attending Homeward Bound Units had received a spell of rehabilitation (at the national average length of 20 days) in a NHS Trust (at the national average cost of £3586), this would have cost £1,054,284. Using local costs, a 20-day spell within an acute bed would have cost £1,675,800 and in community hospital bed £705,600. If patients had received rehabilitation in community hospitals at the same average length of stay of HBU provision (28 days), this would have cost £987,840. This implies that residential rehabilitation is more cost-effective than providing rehabilitation in a hospital environment - acute or community - for the same given length of treatment.
- With current pressures on local capacity, it is of course doubtful that patients admitted to HBUs would have received a full course of rehabilitation in either an acute or community hospital setting. If, as suggested by research sponsored by the Centre for Evidence-based Social Services, each admission to a Homeward Bound Unit saves an average of 6 days in hospital, and 72% of admissions to HBUs facilitated early hospital discharge, £361,793 was saved by the acute sector alone between April 2001 and March 2002. This exceeds the NHS contribution to the Homeward Bound Scheme (12 beds at £231,504 per year).
- The potential savings made to the funding of long-term placements to nursing and residential care homes should be added to this figure. If, as suggested by therapists working in HBUs, the provision of residential rehabilitation increases independence
and prevents/delays admission to nursing and residential care, HBUs would have had to have prevented/delayed an average of 42 days per patient in residential care to be cost-neutral in overall terms (i.e. factoring in the savings made to the acute sector). The break-even point for Social Services (which contributes £463,008 annually to the schemes) occurs after 44 days. If the longer term outcomes for HBU patients are comparable to those of Broom Hayes Residential Unit, where over four fifths of those discharged home were still there six months after discharge, it is likely that this break-even point is being exceeded.

- The immediate savings made to the acute sector and the estimated savings of preventing/delaying admission to long-term residential and nursing care thus suggest that Homeward Bound Units are cost-effective for both the NHS and Social Services.

13.12 For the services discussed above, conclusions about cost-effectiveness depend upon certain assumptions about (a) the proportions of service users who have been genuinely diverted from acute or long-term care and (b) the lengths of stay in acute or long-term care that have been saved. For Community Hospital-based Rehabilitation, the assessment of cost-effectiveness is more straightforward. As evidence suggests that active discharge to community hospitals is now directing heavily dependent patients who would, in the past, have had prolonged stays within the acute sector to the community hospital sector, there is good justification for using straight cost comparisons. The current costs per acute bed in Cornwall are £285 per day and for community hospitals £120 per day. Even factoring in the costs of those Intermediate Care Co-ordinators who are carrying out active inreach and/or managing Community Hospital waiting lists, given the numbers of patients whose early transfer from acute hospital is being facilitated, Community Hospital-based rehabilitation is undoubtedly cost-effective.

13.13 On the evidence presented above, there are strong grounds for proposing that all of the various schemes described in this report are cost-effective in terms of the savings made to acute capacity.

**Partnership Working**

13.14 The fact that such a wide menu of intermediate care services has been established in at least three localities within Cornwall owes much to the strength of strategic-level partnership working and to the influence of key players working within both Health and Social Services. The leadership role provided by HAZ is of significance here. This not only provided strategic vision and direction, key HAZ managers playing a critical role in developing the necessary overview to identify potential improvements in service configuration and engaging senior managers from partner organizations in their forward-thinking strategies. The HAZ Eldercare Programme acted as a springboard for and, in key respects, evolved into the National Service Framework for Older People Local Implementation Team (NSF LIT), a group tasked with carrying forward specific components of the NSF. HAZ also provided the local health sector with an important opportunity to invest in partnership with SSD (which has received substantial funding for intermediate care/community rehabilitation from the Promoting Independence Grant, and which also assumed a strategic co-ordination role for key intermediate care components such as residential rehabilitation).

13.15 Partnership working has also been a real strength at the level of operational management. This owes much to the work of Intermediate Care Co-ordinators who have established widespread linkages with professional and managerial staff in Hospital and Community...
Health Services, primary care, Social Services and the independent sector. Intermediate Care Co-ordinators are also starting to meet up together on a regular basis to explore areas where more consistent systems can be developed across the county. The operational co-ordinators have played a key role in the developmental work required to ensure that arrangements are in place to transfer patients through the intermediate care system. Thus, like many other partnership projects in Cornwall, intermediate care systems have been developed, in a very real sense, from the 'bottom-up'.

13.16 Against such successes, there have been barriers to partnership working in relation to intermediate care. The early emphasis placed on the need to develop locality sensitive strategies within each of the Primary Care Organizations (despite the fact that the resultant schemes did not differ significantly in content) stretched the capacity of countywide agencies. Local versus countywide tensions emerged around issues of power, ownership and accountability, undermining the extent to which progress in strategic planning was supported by strategic co-ordination and management. For example, the failure to appoint a dedicated intermediate care co-ordinator at countywide level led to early gaps in both strategic and operational co-ordination. Whilst these were acknowledged and addressed in some localities (notably North Cornwall and Carrick, both of which pursued a whole systems approach), in other areas strong strategic direction in driving forward developments was not sustained. There have been difficulties in fully engaging RCHT and, whilst linkages with the independent sector have been unusually strong, the voluntary sector has not always been engaged on equal terms.

13.17 Difficulties of involving front-line staff in joint working initiatives also emerged in the development of intermediate care schemes. For example, there have been procedural difficulties in transfers from the acute hospitals to Homeward Bound Units, in part because of a lack of clarity about roles, responsibilities and information required. Concerns about the implications of transferring responsibility (but not necessarily accountability) for care may also explain a reluctance on the part of primary care and hospital discharge teams to refer patients to residential rehabilitation units and on the part of therapy teams to use rehabilitation care assistants (RCAs). It is perhaps to be expected that new ways of working take time to embed in practice. However, the scope for more actively facilitating change in multi-professional relationships and thinking could be usefully explored.

13.18 As the Cornish health sector emerges from a period of considerable organizational turbulence, many of the barriers to effective partnership working are breaking down and there is a widespread perception that 'change is really happening in 2002'. The interface with RCHT is improving as the Trust has begun to review its own processes for improving the patient journey through the emergency admissions process. Since April 2002, the countywide Promoting Independence Group (originally established by Social Services) has been hosted by Central PCT. It is hoped that this will encourage more regular attendance by PCT representatives at a meeting designed to bring strategic leads and professional representatives (from Social Services, RCHT, community hospitals, PCTs and the independent sector) together.

13.19 For operational managers and front-line staff, growing familiarity with alternative service options owes much to the work of Intermediate Care Co-ordinators who have ensured that a wide range of potential referrers are engaged in the intermediate care system and understand the potential to refer people to more appropriate settings. Links are also being forged with related services such as sheltered housing and Care and Repair. In Carrick, for example, the use of sheltered schemes as a potential source of intermediate care is currently under
consideration as is the need to ensure that housing improvements are considered as part of overall care plans. A central concept of intermediate care is that it is part of a whole system, that not only links primary care, community health services, social care and acute hospital care, but that requires support from health promotion and preventative services. Thus, the emergence of such linkages is a significant outcome in its own right.

The Significance of Rurality to Intermediate Care Development

13.20 A number of factors make rurality of key significance to the development of intermediate care systems. These include demography and the additional costs of providing rural services and the need for rural proofing.

Demography

13.21 Rural areas tend to have older demographic profiles than urban areas. In 1999, the proportion of the population at or above retirement age was 20% or more in all of the ‘coast and country’ rural health authorities (including Cornwall and the Isles of Scilly) compared to less than 16% in Inner London. In Carrick and Penwith, 22% of the population are aged 65+. Thus, there is particular pressure on rural authorities to achieve service improvements as set out in the NSF for Older People.

13.22 In recognition of this, CIoS HAZ provided both strategic direction and significant resources for the development of intermediate care, investing in the order of £1,400,000 to local schemes. In the same period, Cornwall Social Services Department has invested more than £2.2 million directly into the development of HAZ-funded Intermediate Care schemes.

13.23 Whilst the particular demographic structure of rural areas such as Cornwall has meant that intermediate care has been high on the local agenda, Cornwall’s demographic profile may also account for the fact that the local health sector is under severe financial constraint. Evidence suggests that, although the age-cost curves that are used in all three components of the English NHS resource allocation formula acknowledge the rising costs of care for older age groups, the per capita allocations for older age bands are nevertheless conservative. Bias against rural areas serving demographically older populations is compounded by the fact that the measures that make up the additional needs indices of formula may not adequately capture disadvantage in rural areas. Finally, the current resource allocation system takes no account of the additional costs associated with rural service provision. Taken in combination, this means that the current weighted capitation formula is likely to discriminate against rural areas (Asthana et al, 2002).

13.24 The suggestion that, due to both its demography and rurality, the health sector in Cornwall is under-funded marries with local evidence that co-ordinators and providers of intermediate care are working within a highly stretched system. Local acute hospitals, community hospitals, homeward bound units and nursing homes are operating under considerable pressure. During the winter months in particular, bed occupancy rates are exceeding levels at which risks of crisis occur. Limited capacity within the system not only limits the extent to which patients can be directed to the most appropriate location of care. High turnover of patients places individual staff under considerable pressure.

The Additional Costs of Providing Services in Rural Areas

13.25 In the delivery of heath services in rural areas a number of factors work to increase the costs of provision. Greater distances combined with small and dispersed populations can make it
more difficult and costly to provide services to rural clients. The travel time required to deliver services within the community places an increased burden on rural health budgets, leaving less of the budget for the actual care element. Clinical governance and associated training, the need for multi-skilling and the need for a higher proportion of more senior staff in rural locations where supervision is an issue have implications for staff costs. There are also less obvious increased rural cost issues associated with aspects such as inter-agency working and low institutional capacity where private, public and voluntary sector bodies often struggle to release staff to attend partnership meetings.

13.26 All of these factors have a bearing on the provision of intermediate care in Cornwall. For example:

- Residential rehabilitation has been provided in small units based in independent sector residential homes. Although one centralized unit may have achieved greater economies of scale, this would have proved inaccessible to the vast majority of the population.
- Given the distances to be travelled, multi-disciplinary assessments (a core criteria in intermediate care guidance) can be difficult to set up in dispersed rural areas.
- Therapists appointed to community teams have had to adjust to a change in balance between ‘productive’ therapy time and ‘unproductive time’ due to travel, particularly in the more rural localities.
- Problems have been experienced in accessing Rehabilitation Care Assistants in more rural districts where their place of employment may be geographically distant from either the Therapist’s base or clients’ homes.
- Transportation has been identified as an important barrier to the transfer of patients through the intermediate care system.
- Extending consultant geriatrician cover to a wider range of intermediate care settings may not be practically feasible given the geographical size of local community hospital catchment areas.
- Independent action by nurses (e.g. the use of nurse-led community hospital beds) can make a critical difference where medical capacity is stretched. Nursing staff who are sufficiently qualified to work with flexibility (e.g. to substitute for other professionals) and autonomy, tend to be at the top of their pay scales.

**Key Messages**

13.27 An important dimension of the quality of intermediate care services in Cornwall is the extent to which, in certain localities, the system operates as a *whole system*. Thus, individual services should not only be evaluated in isolation, but with regard to their role in the system as a whole.

13.28 The evaluation of cost-effectiveness of intermediate care schemes depends upon certain assumptions about (a) the proportions of service users who have been genuinely diverted from acute or long-term care and (b) the lengths of stay in acute or long-term care that have been saved. The validity of estimates made about both of these factors could usefully be tested through comparison with multi-disciplinary clinical assessments of individual outcomes.

13.29 The work of Intermediate Care Co-ordinators has ensured that a wide range of direct referrers are engaged in the intermediate care system and understand the potential to refer people to
more appropriate settings. Future work should usefully focus on the strengthening of links with related services such as housing, social support etc.

13.30 The significance of rurality to the development and implementation of intermediate care schemes suggests that policy guidelines around national standards should be more sensitive to differences in the way in which services may need to be organised and delivered in different contexts.
14 Recommendations

General Recommendations

14.1 More reference should be made to Government Guidance as to what services do and do not constitute intermediate care services. At present, some activity that fulfils the Government criteria is not being described as Intermediate Care. This should be addressed.

14.2 Although strategic co-ordination in the different localities has strengthened significantly, there remains a role for a countywide perspective, not least to monitor and address local variations in service access, ways of working and service outcomes.

14.3 The lack of out-of-hours cover for a range of professionals (Intermediate Care Co-ordinators, District Nurses, Community Therapists) presents a blockage to the transfer of patients through the system. Whilst the provision of full out-of-hours services may not be cost-effective, the development of more limited schemes to provide cover could be explored.

14.4 Capacity with the system as a whole is extremely stretched. Thus, most components of the Intermediate Care system could make a legitimate claim for further investment. If this is not feasible (given the current financial climate), then limits to further increasing throughout should at least be acknowledged.

14.5 The monitoring of intermediate care is extremely variable. There is a lack of readily available information about rates of activity and, in particular, outcomes. If Cornwall wants to demonstrate its progress and impact, Intermediate Care monitoring systems need to be strengthened.

14.6 Estimates of the proportions of intermediate care referrals that have prevented an admission to acute hospital or long-term care or facilitated an early discharge need to validated. The validity of using condition-specific average lengths of stay to estimate savings to the acute sector should also be tested.

14.7 The significance of rurality to provision of intermediate care in Cornwall should be explicitly acknowledged and factored into service planning and development.

Intermediate Care Co-Ordination

14.8 Dedicated Intermediate Care Co-ordinators are essential for the successful development and maintenance of service structures, processes and linkages. West of Cornwall has recently appointed an Intermediate Care Co-ordinator. The scope for rolling out an Intermediate Care Co-ordination role in Restormel should be explored. Intermediate Care in North Cornwall, which provides a single point of contact, has been identified as a local model of good practice.

14.9 Despite the work of Intermediate Care Co-ordinators, some acute hospital staff continue to underestimate the role of community services in actively managing complex patients. Continued difficulties with the secondary/community interface partly reflect legitimate concerns about the danger of duplicating the work of Discharge Liaison Teams. The fact that discharge processes differ between localities also causes confusion and frustration. Useful work could nevertheless be done to improve the awareness and understanding of acute staff of the role of community placements.

14.10 Intermediate Care Co-ordinators benefit from holding a nominated budget for troubleshooting. Holding the community hospital waiting lists has been identified as a key
factor in enabling the Intermediate Care Co-ordinators’ role. Accountability relationships also need to be clarified.

**Rapid Response Assessment**

14.11 Local variations in District Nursing Provision have determined the extent to which rapid resource nurse assessment has been embedded across the county. There are differences in the county regarding the role of GP assessment in rapid response. These should be reviewed. The potential for providing access to specialist diagnosis within the community should also be explored.

14.12 Co-location of nurses and Social Services Case Co-ordinators in general practices in Carrick appears to have promoted a proactive and more autonomous approach to Nurse Assessment. This may provide a good model to be rolled out in other parts of Cornwall.

14.13 There is a perception of a declining use of nurse assessors to access intermediate care schemes as GPs return to traditional routes such as Case Co-ordinators. Ways of sustaining awareness of rapid response assessment should be considered.

14.14 Activity by Nurse Assessors is not being adequately captured by routine monitoring systems. The recording of assessments that result in the direct provision of an enhanced package of nursing/social care and that result in an acute admission are particularly problematic. Whilst these problems are being addressed, consideration should also be given to how data entry to the ICS system can be improved.

**Holding Services**

14.15 In order to hold a crisis that would otherwise result in a hospital admission, more specialist support may be required than that provided by a trained volunteer or Social Services Care Assistant. 7-day assessment beds are strongly supported by Intermediate Care Co-ordinators and G-Grade Nurses. However, capacity in this sector has been identified as being a major barrier to use. Capacity in the Independent Nursing Home sector also limits the use of longer term Nursing Home placements and has an impact on Community Hospital capacity (by reducing the scope for discharging patients). Thus, ways of promoting provision within this sector (e.g. through private-public partnerships) should be explored.

**Community Therapy**

14.16 Community therapy capacity impacts upon both the number of referrals and the balance of step-up and step-down referrals (for example, by limiting the extent to which the system is catering for people on the threshold of admission to long-term care). Thus, this is another priority area for investment.

14.17 There may be grounds for exploring whether Social Services procedures regarding the input of community therapists could be rationalized.

14.18 As NHS and Social Services Occupational Therapists are now both working in the community, some consideration could be given to the scope for integrating OT provision.

14.19 Most of the work undertaken by Community Therapy Teams is not labelled ‘Intermediate Care’ for monitoring purposes. This should be addressed. The collection of outcome data is also poor.
Rehabilitation Care Assistants

14.20 Whilst the views of local stakeholders about Rehabilitation Care Assistants are mixed, the use of RCAs is widely perceived to be very successful in Homeward Bound Units. In addition to testing the recruitment and deployment of Social Services care assistants to the training programme, the pros and cons of restricting the use of RCAs to institutional settings, and expanding the use of therapy technical assistants with home settings could be considered.

Residential-based Rehabilitation

14.21 There may be grounds for re-examining some of the eligibility criteria (e.g. cognitive ability, continence, need to transfer with one) for admission to Homeward Bound Units. Before doing so, however, it is important that clarity is reached about the optimal role of residential-based rehabilitation. The extent to which HBUs are catering sufficiently for people on the threshold of admission to long-term care should be reviewed.

14.22 Discharge processes from acute hospitals to Homeward Bound Units need to be rationalized. Local variation in referral processes together with a lack of awareness of HBUs amongst potential referrers could be addressed.

Community Hospital-Based Rehabilitation

14.23 The model pioneered by the East Cornwall Community Resource Bed Management Project has emerged as a local model of good practice.

14.24 In replicating this role, key areas for consideration include the pros and cons of undertaking proactive hospital in-reach; location (acute vs community); and the need for a dedicated budget.

14.25 Bed occupancy rates amongst community hospitals in North and East Cornwall are so high that it is difficult to see how they can create additional capacity for intermediate care. The fact that throughput has remained fairly steady in Community Hospitals in the West of Cornwall and, to a lesser extent, Central Cornwall, suggests that there may be scope to strengthen the role of community hospitals in intermediate care in these localities.

14.26 The example of North Cornwall suggests that giving nurses greater responsibility (e.g. for admitting and discharging patients) in community hospitals can be very effective.

Nursing Home Placements

14.27 Nursing home placements can play a valuable role in the system of intermediate care, particularly given the large proportion of patients who are too frail or unwell to be eligible for rehabilitation at home or residential-based rehabilitation. As noted above, lack of capacity is a real problem here.
References


