

FLINTSHIRE COUNTY COUNCIL

REPORT TO: **CABINET**
DATE: **TUESDAY, 20 JANUARY 2015**
REPORT BY: **CHIEF OFFICER (SOCIAL SERVICES)**
SUBJECT: **INTERMEDIATE CARE FUND (ICF)**

1.00 **PURPOSE OF REPORT**

- 1.01 Members will be aware that Welsh Government developed a one year 'Intermediate Care Fund' (ICF) to encourage integrated working between local authorities, (including Housing and Social Care), Health and other partners.
- 1.02 This report provides Cabinet with an overview of the projects delivered by the Intermediate Care Fund and the opportunity to scrutinise the outcomes that have been delivered.

2.00 **BACKGROUND**

2.01 **What is Intermediate Care?**

"Intermediate care services are provided to patients – generally older – to help them avoid going into hospital unnecessarily, to help them be as independent as possible after discharge from hospital and to prevent them having to move into residential or nursing homes until they really need to. These services are generally time-limited, until the person has regained independence or medical stability, and are provided in people's own homes, in community hospitals or sometimes within local nursing homes" Kings Fund, 2013.

2.02 **The Intermediate Care Fund**

The ICF Fund was set up by Welsh Government to support older people, particularly the frail elderly, to maintain their independence and remain in their own home. Funding was allocated on a regional footprint with £1,926m allocated to Flintshire. This consists of £642k capital and £1,284m revenue funding.

Welsh Government were clear that the Fund could not be used to substitute existing funding streams and must be used to support new, or additional, provision of services and ways of working. The ICF was designed to be one year funding (2014/2015) and Welsh Government have confirmed that the Fund will cease on 31st March 2015.

2.03 Managing the Fund

The ICF was allocated on a regional footprint with Flintshire leading the management of the Fund on behalf of North Wales.

Each authority within the region developed their own bid for funding and the individual bids were pulled together to form a coherent regional bid. Flintshire's bid was developed with contributions from Social Services, Housing, BCUHB & Third Sector organisations.

The bid for Flintshire was based upon three key themes with a consistent focus on enhancing services for people with dementia:

Theme 1: Improving preventative care & avoiding unnecessary hospital admission and delayed discharge

Theme 2: Promoting and maximising independent living opportunities

Theme 3: Supporting recovery and recuperation by increasing the provision of reablement services

3.00 CONSIDERATIONS

3.01 The ICF has enabled the following projects to be delivered in Flintshire:

Provision of step up/step down beds in residential care homes	Funding has been used to purchase beds within 3 Care Homes in Flintshire (LLys Gwenffrwd, Marleyfield and Croes Atti) for people who are ready to come out of hospital but need some more support in the community before they can go home. Funding is also used to purchase additional beds across the County if there is a need. The project has facilitated timely hospital discharge and supported people to develop their independence in a safe environment with a view to enabling them to return to live in their own home.
Purchase of a dementia assessment bed	A bed is available at an EMI Residential Care Home where people with dementia can have their needs assessed over a period of time, enabling a fuller understanding of the person and their needs. This approach provides an effective alternative to people being assessed on a hospital ward when they can be confused and distressed.
Increasing staff resource	The Fund has enabled additional staffing across Health and social care to support intermediate care. There has been an increased in Occupational Therapy provision in Wrexham Maelor Hospital to support timely hospital discharge with plans to fund an additional 0.5 of post in Glan Clwyd over the winter months. Additional Social Worker and Occupational Therapy provision in the Reablement team and additional Nurse capacity into the

	Crisis Intervention Team. This additional capacity has helped ensure people are supported to live independently and to provide intensive in reach support to people in Step Up/Down provision to help them return to the community.
Extending Specialist Dementia Care in the Community	A range of initiatives have been funded including plans to roll out the "Living Well" service model. This service provides an outcome focussed approach to supporting people with dementia living to in their own homes. Work has been undertaken to promote the development of dementia friendly communities and, working with NEWCIS, to deliver dementia awareness to carers – including e-learning opportunities.
End of Life Care	BCUHB Macmillan End of Life Care Facilitation team are piloting the "Six Steps to Success Programme for Palliative Care" in Nursing Homes. The aim is to ensure people have improved end of life care with choice and control over their end of life care plans whilst increasing staff confidence and understanding of end of life care. The pilot also aims to reduce inappropriate hospital admissions and delayed transfers of care for those who are at end stage palliative care. A number of Residential Homes have also indicated that they would like to introduce this programme.
Equipment, aids and adaptations	A range of projects to extend the availability of assistive technology, aids and adaptations to people living at home to maintain their independence and wellbeing. Also included are additional adjustable beds, available to loan through the Red Cross.
Enhanced Pharmacy Support within the community	Funding has been used for a Pharmacist and Pharmacy Technician to provide more direct support to Residential Care Homes and to GP's for example to make targeted visits to people in their own home to review medication use.
Falls Prevention	Two staff members from the Therapies Team in BCUHB have been funded to conduct in depth assessments with older people identified as being at risk of falls to find ways that their risk can be reduced.
Dementia Community Support Service – Alzheimer's Society	The Alzheimer's Society has been funded to provide one to one personalised support for people living with dementia in their own homes. The focus of the work is to enable people with dementia to continue with personal hobbies and interests, try new experiences and continue with daily living and other activities that are important to them. The support is time limited and focuses on supporting people to access activities themselves.
Intermediate Care Support Service – British Red Cross	British Red Cross has been funded to provide a rapid response, low level support service through volunteers to people who are in receipt or leaving other Intermediate Care Services. For up to three hours a week, for up to 6 weeks, low level practical and emotional support is provided to help individuals feel confident and independent at home.

Healthy Homes for Discharge Project – Flintshire Care & Repair	Flintshire Care & Repair have been funded to work with individuals to address concerns that could be preventing a safe discharge from hospital. Team members carry out a full assessment of the person and their property and then make the appropriate links to a wide range of services and organisations that can provide any assistance that is needed.
Hoarding Tendencies Support Project – Flintshire Care & Repair	Flintshire Care and Repair will use specially trained staff to assist individuals with hoarding tendencies to provide practical help and support in order to address any immediate issues preventing an individual from returning home safely after a hospital stay and to address the causes and consequences of their hoarding behaviour to prevent further ill health, reduction in independence. There has been a high demand for this services and additional ICF money has been reallocated to help meet demand.
Neurotherapy Centre	To provide additional Counselling, Occupational Therapy and fatigue management support for older people with a neurological condition and their Carers, many of whom will be spouses of a similar age, in order to promote wellbeing, increase independence and reduce the need to access statutory services.
Support at Night	Working to transform the way we support some of our service users at night through improved technologies and having staff available to offer support to a cluster of people living in the community. The service will be trialled in the new year and evaluated.
Conversion of a property for short term intermediate care accommodation	A property is being converted to provide accommodation for an individual to live on a short term basis whilst they regain their independence. The property will be equipped with telecare equipment and where appropriate a package of health and/or social care will be provided to meet their needs to facilitate their return home.
Development of Extra Care	A significant element of the capital element of the ICF (£550k) is being used to support the development of additional Extra Care Facilities. Capital funding has provided leverage for investment in the development two additional Extra Care provisions. Plans are underway to develop Extra Care at Flint and Holywell.

3.02 Achievements to date

3.03 During the first 6 months of the project (April – September 2014)

- 25 people were supported through ICF step down beds for a total of 396 nights. The average length of stay was 16 nights for each patient.

The following case study provides a real life example of how the ICF step up/step down beds have made a real difference to the lives of vulnerable older people:

Case Study

Mr G is 90 and lives alone in a flat on the eleventh floor of a large building. Mr G was admitted to hospital in February 2014 for neurology investigations, following a period of ill health, confusion and poor mobility.

In May 2014, Mr G was able to be discharged to an ICF step down bed. Mr G was concerned about returning home, stating he did not feel safe and expressed a desire to enter 24 hour care, which was supported by his family.

The Intermediate Care and Reablement teams engaged with Mr G and his family, carrying out multi-disciplinary assessments, including a Carers Assessment. Working with Mr G and his family, a range of personal outcomes were identified and a program of interventions put in place. Through this fully supported process, Mr G was able to regain his confidence and some independent skills resulting in his decision to return home.

Mr G returned home after a period of 12 days in the step down bed and a week after doing so said "he was happy he had returned home".

His return home was facilitated by the implementation of a Reablement package providing ongoing support, including Telecare equipment and equipment to aid his mobility, three home care calls a day from care services and family support at lunch time.

The Intermediate Care intervention enabled Mr G to be discharged from hospital to a safe environment for assessment, and prevented an unsafe discharge home/or admission to a care home. Through the collaborative efforts of Health, Flintshire Council, Mr G's carers and third sector involvement, Mr G was able to return home with support to live independently.

3.04 Further case studies are included in Appendix 1 of this report. Other achievements during the first 6 months of the ICF include:

- 18 people supported through the Care and Repair 'Healthy Homes for Discharge Project' which works with vulnerable older people in hospital to help ensure they return to secure, safe and warm homes.
- 8 people with dementia supported by the Alzheimer's Society, to access and engage in activities that interest them. The people supported, and their carers, have reported:
 - Reduced social isolation
 - Increased motivation and now engaging in daily tasks
 - Carer feeling more relaxed
 - Person with dementia reporting feeling happier
- 12 people referred to the Care and Repair Hoarding Tendencies Project

which supports vulnerable people who hoard and are at risk of falling in their home. 5 of the people referred were in hospital at the time of referral.

The ICF will be evaluated in Spring 2015 both at a regional and local level.

3.05 Challenges

There have been some challenges with the programme particularly relating to the one year, short term nature of developing additional/new services which involve a range of organisations. The most significant challenge has been recruiting staff as there can be long lead in times and, at times, specific skills have been needed. One particular example was a project which looked to bring additional CPN capacity to Flintshire. The capacity was intended to provide particular out of hours support for Care Homes to minimise hospital admission and enable support/treatment in the Care Home setting. Unfortunately BCUHB were unable to attract appropriate staff and the project did not proceed. Arrangements are in place for agreeing processes and priorities for any slippage in the Fund.

3.06 Governance arrangements

The regional ICF allocation has been overseen by North Wales Integrated Services Programme Board. The Board has representation from all 6 local authorities, Health and Housing with arrangements to co-op independent and 3rd sectors where appropriate. The Board forms part of the governance arrangements that feed into the North Wales Regional Leadership Board. The Board is chaired by Flintshire's Chief Officer, Social Services. This forms part of reciprocal arrangements across North Wales for leading on regional initiatives.

The Board has received regular reports on progress and outcomes delivered. Welsh Government have attend the meetings on two occasions and at their visit in December described North Wales' approach to managing the ICF as being an 'exemplar'.

3.07 Exit Strategies

Welsh Government have confirmed that the ICF fund will cease on the 31st March 2015. We have been advised that there is a degree of flexibility in funding projects until the end of April to ensure that projects are appropriately closed and to finalise support for people who have already started a short term service.

As a region we are working to identify critical ICF projects where it is considered that the end of the project will have a significant adverse impact on the delivery of effective intermediate care. In Flintshire the critical projects have been identified as:

- Step up/Step down provision and the associated investment in in-reach support staff to enable people to return back to the community
- The falls prevention project
- The palliative support project and associated nursing support
- A regional project for minor adaptation and equipment

We have communicated these priorities to BCUHB so there is an opportunity for dialogue aligned to the development of their 3 year plan. In addition we will continue to explore any potential funding opportunities from the Welsh Government.

4.00 RECOMMENDATIONS

4.01 Cabinet are asked to note the report including the progress made with the effective use of the Intermediate Care Fund.

4.02 Given the importance and early success of the priority services which have been recognised by BCUHB, other partners and Flintshire County Council, the case should be made to Welsh Government for continuing financial support when new funding possibilities arise.

5.00 FINANCIAL IMPLICATIONS

5.01 The end of the Fund will mean that successful projects will no longer have funding streams. Work is taking place to look at how critical projects could be supported (see 3.07 above).

6.00 ANTI POVERTY IMPACT

6.01 None.

7.00 ENVIRONMENTAL IMPACT

7.01 None.

8.00 EQUALITIES IMPACT

8.01 The end of projects will have an adverse impact for older people. However, this is a one year Fund.

9.00 PERSONNEL IMPLICATIONS

9.01 None.

10.00 CONSULTATION REQUIRED

10.01 None.

11.00 CONSULTATION UNDERTAKEN

11.01 None.

12.00 APPENDICES

12.01 Appendix 1 – Case Studies

LOCAL GOVERNMENT (ACCESS TO INFORMATION ACT) 1985
BACKGROUND DOCUMENTS

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