Sefton Council

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Sefton Joint Intermediate Care Strategy 2021-2024

Master Version
Date: July 2021

Contents

1. Executive Summary

This strategy is the product of collaborative working with a range of professionals in both health and social care organisations from 2017 to date within the Integrated Community Reablement and Assessment Service (ICRAS). It is a combination of recommendations, values and beliefs, an understanding of what works well and what offers value for patients and these will shape the future development of an Intermediate Care Model for adults within Sefton, including ensuring that model implemented in Sefton is conversant with national discharge models and operating policies.

Intermediate Care is defined as a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living.

This strategy sets out work undertaken to date and will lead to the delivery of an updated model of service delivery, designed to rebalance hospital and community care, provide home based intermediate care, reablement, bed based intermediate care and crisis response. The aim of which is to encourage independence, avoid unnecessary admission to hospital and accelerate discharge from hospital, while ensuring that no long-term decisions about care and independence are taken in a hospital setting.

This strategy will be underpinned with associated action plans to ensure adequate and timely delivery, and as a result the strategy will be a working document, subject to regular review in order to ensure that it reflects action plan progress and any newly emerging themes, findings and objectives.

Both health and social services are committed to making a real difference to the way services are delivered and the quality of the patient's individual experience of health and social care provision in Sefton.

	
Fiona Taylor Chief Officer NHS Southport and Formby CCG NHS South Sefton CCG	Deborah Butcher Executive Director of Adult Social Care and Health

2. Vision

Both Sefton Clinical Commissioning Groups and Sefton Council envisage a seamless intermediate care service designed to enable and support people to remain in their own homes for as long as possible; living independently, increasing time spent with family and friends and reducing the need for longer term care provision.

3. Context

Sefton now has established an aligned strategic vision for the borough or the place of Sefton via the Health and Wellbeing Strategy, Sefton2together and the NHS 5-year delivery plan.

There is a clear ambition to grow its integration and build on the success of its established Better Care Fund, delivery of the services described in this strategy are key to this. Other interdependent strategies to be considered alongside this are described in section 3.3.

Governance oversight to this ultimately rests with the Health and Wellbeing Board and its delivery will be driven by Sefton's Integrated Commissioning Group.

The provision of Intermediate Care is defined as a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Sefton health and social care integrated team have committed to work collaboratively to develop the model and supporting infrastructure needed for effective and efficient delivery.

3.1 *Current and Future Demand*

The Sefton Population Projections[1] identifies the following key facts.

- The estimated population of Sefton in 2018 was 275,396. The latest 2018 based population projections suggest an increase in population year on year rising over 6% to 292,176 in 2043. The biggest percentage increase is estimated to be among residents aged 65 and over, with this age group expected to rise by a third from 64,032 in 2018 to 85,198 by 2043 (from 23% of the population to 29% of the population). Every quinary age group above 65 is projected to have a significant increase, in particular those aged 85-89 projected to increase by 61% and those aged 90 and over by 95%.

- Sefton's 65+ population is 64,032 accounting for 23% of the total population and largely accounts for the projected future increases in the total population.

- Sefton already has a sizeable population of older people. As this grows, it will have a large impact on services and their ability to cope.

- Sefton has the highest proportion of residents aged 65+ and 75+ than the other local authorities within Liverpool City Region.

[1] Sefton Population Projections – 2018, Business Intelligence & Performance on behalf of Sefton Council

- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls - 36% more by 2035[2].

- By 2035, it is projected that 38% more people aged 65 and over will have dementia. This will impact on their wider health and their care needs[2].

- In 2019, over 2,800 people are forecast to be living in a care home (with or without nursing) – there will be an increase of over 40% by 2035[2].

- Like most of the country Sefton has a growing and ageing demographic. By 2043 Sefton will have an overall forecast increase of 33% of residents who are 65+ and is set to account for 29% of Sefton's population

- Current statistics show Sefton having the largest cohort of residents 65+ within the Liverpool City Region[3].

Borough	**Sefton**	**Wirral**	**St Helens**	**Halton**	**Knowsley**	**Liverpool**
Age 65+	23.1%	21.3%	20.4%	17.9%	17.0%	14.6%

- A further analysis of the 23.1% of older Sefton residents by sub-areas is as follows;

Sefton	Southport	Formby	Maghull	Crosby	Bootle	Netherton
Age 65+	26.6%	31.4%	26.5%	21.7%	15.5%	17.5%

By way of summary, the Sefton Strategic Needs Assessment identifies Sefton as having a growing elderly population. Older people are more likely to develop complex and long term health conditions, which lead them to require increased health and social care.

Managing such increased demand will necessitate a new approach to service planning, enabling people to maximise their independence and decrease reliance upon acute and social care services.

3.2 Strategic Aims and Objectives

This strategy has been informed by ongoing discussions with patients, carers, local residents and a wide range of stakeholders through the CCGs' "Big Chats", "Mini Chats" and other listening activities and is congruent with the CCGs' strategic priorities of:

3.2.1 Frail Elderly: to support the frail elderly, with long term conditions, to optimise self-care based in the community or home setting, while preventing unnecessary and unplanned admission to hospital;

[2] Projecting Older People Population Information System correct as 01/07/2020

[3] Mid-Year Estimates 2018

3.2.2 Unplanned Care: to support patients of all ages to manage their healthcare needs at home or in the community setting, while preventing unnecessary and unplanned admission to hospital;

3.2.3 Primary Care Transformation: to support the healthcare needs of the population through enhanced primary and community care services, supporting self-care and enabling appropriate intervention at home or in the community and preventing unnecessary and unplanned admission to hospital.

Further, as part of the Intermediate Care and Reablement Scheme of the Better Care Fund for Sefton, the main scope of this scheme is to reduce hospital admissions and readmissions, reduce the need for ongoing care and support and to reduce the number of admissions into long term residential and nursing care.

3.3 Linkage with Other Strategies and Priorities

This strategy will both link to, and be informed by associated strategies, plans and priorities, including, but not limited to;

3.3.1 **Sefton Care Home Strategy 2021/24** – this developing strategy outlines a 3-year approach to this sector of care, providing a direction of travel for existing care providers and a clear indication to new providers wishing to become part of the Sefton Care Home market. Essential to the success of this strategy is strong leadership at all levels and across all agencies. Success will revolve around a commitment to supporting and delivering high quality care and the development of trusting, committed partnerships. The strategy will enable us to develop and communicate the long-term commissioning intentions, of which Intermediate Care services will be a part of;

3.3.2 **Sefton2gether** – this joint Council and CCGs plan has a focus on Early Intervention, Self-Care and Prevention and having Integrated Care Teams to ensure targeted care coordination.
https://www.southportandformbyccg.nhs.uk/media/4044/sefton2gether-final-print-version-2020.pdf

3.3.3 **Seftons Health & Wellbeing Strategy 2020-25** – this identifies that the Sefton health and care system, including wider partners, works together to meet the needs of our entire population. This means focusing on the areas of greatest need and ensuring the best use of available resources.
https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf

3.3.4 **Sefton's Market Position Statement** – this is currently in draft and will be published shortly and sets out a direction of travel including strategic and legislative drivers that are influencing change. It provides information to the social care market on population needs, service demands, commissioning priorities and resource availability, to facilitate the effective planning and development of services and opportunities to meet the needs of our residents – both now and in the future, of which Intermediate Care type services will be a key element.

3.3.5 **Sefton's Dementia Strategy** – in development due to be published September 2020, this outlines that positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised. It outlines the intention to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

3.3.6 **Sefton Older People's Strategy** – a key element if this strategy is the identification of the need to ensure that Older People are supported to keep independent and that improving Health and Social Care services is one of the biggest things that Older People identified can help them. The aims and objectives outlined in this Intermediate Care strategy support these aims.

https://www.sefton.gov.uk/your-council/plans-policies/adults.aspx

3.3.7 Extra Care Housing – The development of extra care across the borough as an alternative housing option to other more costly and restrictive options such as residential and nursing care is a key driver for Sefton. Extra Care Housing offers a self-contained home of your own where social activities are easy to find, and help is on hand if you need it. It is intended to enable and support older and vulnerable people to live independently for as long as possible, but with the reassurance that care and support services are available should they need them, either now or in the future. Our goal is to deliver 1,306 extra care units by 2035 this will then have significant impacts on our reliance on other more costly services across the spectrum.

http://www.housingcare.org/jargon-extra-care-housing.aspx

4. The National Model and Operating Policy

Underpinning and driving the delivery of this strategy will be the need to ensure that it supports and delivers a model in line with the *"Hospital discharge and community support: policy and operating model"* (July 2021).

This document sets out the hospital discharge service operating model for all NHS trusts, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England.

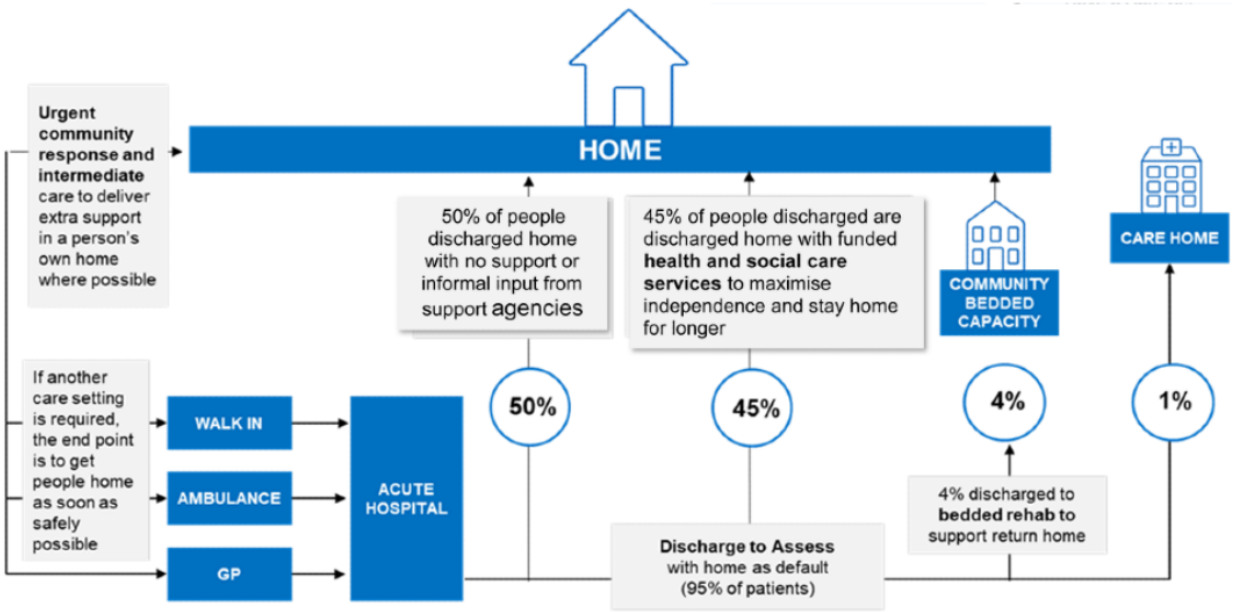
In summary, this model outlines the following four discharge pathways;

- **Pathway 0**
  - Likely to be minimum of 50% of people discharged:
  - simple discharge home
  - no new or additional support is required to get the person home or such support constitutes only:
  - informal input from support agencies

- a continuation of an existing health or social care support package that remained active while the person was in hospital

- **Pathway 1**
  - Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.
  - Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.
- **Pathway 2**
  - Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home
- **Pathway 3**
  - For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).
  - Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

The following diagram also summarises the model;



(Source: Hospital discharge and community support: policy and operating model - July 2021)

People with Mental Health conditions such as delirium or dementia will better recover in their own home/care home as this is an environment that is familiar to them. Additionally, it is far more likely that an accurate assessment of long-term health and social care needs will be possible once they have returned to their own home as opposed to an unfamiliar and often confusing environment.

It is our commitment to continue to embed some of the principles of the discharge to assess and home first adapted for mental health care pathways, such as;

- Assessment of long-term care and support needs in the most appropriate setting and at the right time for a person.
- Instigation of care packages as soon as a person is ready to leave hospital, doing what is right by them and crucially removing delays and disputes over funding and responsibilities (and if needed resolving these after the discharge support has started).

The first few days and especially nights following discharge home of someone with dementia or delirium are usually the most challenging and therefore we will endeavour to ensure that the package of care is tailored to individual need and that we utilise other resources to support independence such as assistive technology.

5. Supporting Infrastructure

At present Sefton has the following four schemes / services of intermediate care to support delivery of the overall model;

- Home-based intermediate care
- Reablement
- Bed-based intermediate care
- Crisis response

However, a key deliverable for this strategy will be to review these schemes / services to ensure that their individual operating models are in line with the national model and to ensure that they have sufficient capacity within them to meet demand.

We are committed to implementing a Discharge to Recover model and ensuring that long-term care needs assessments not being performed in an acute hospital setting as such assessments will not reflect the abilities of a person and may lead to an over-prescription of care and support, persons should be allowed a period of recovery to give an accurate picture of their future needs.

These services will be delivered in an integrated way so that people can move easily between them, depending on their changing support needs. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team and most commonly by healthcare professionals and/or care staff.

4.1 Intermediate Care

Intermediate Care is defined as a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living.

(https://www.nice.org.uk/guidance/ng74/chapter/recommendations#intermediate-care, 2017)

Intermediate care services are usually delivered for no longer that 6 weeks and can be as little as 1 to 2 weeks in duration. Four service models of intermediate care are available: bed based intermediate care, crisis response; home based intermediate care and reablement.

4.2 Core principles of intermediate care, including reablement

Collaborative working to develop goals which optimise independence and well being
Person centred approach, taking into account cultural differences and preferences

Ensure good communication at all stages of assessment and delivery between intermediate care practitioners, other agencies, people using the service and their families and carers.

Intermediate care practitioners should

- Work in partnership with the person to find out what they want to achieve and understand what motivates them
- Focus on the person's own strengths and help them realise their potential to regain independence
- Build the persons knowledge, skills, resilience and confidence
- Learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as independent dressing and meal preparation.
- Support positive risk taking

Ensure that the service user and or their family or carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- Verbally
- In written format
- In other accessible formats, such as braille or Easy Read
- Provided by a trained, qualified interpreter

4.3 Assessment of need for intermediate 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 patients and service users to resume living at home
- be time-limited, normally no longer than six weeks and frequently as little as a few days;

- involve cross-professional working, with a single assessment framework, single professional records and shared protocols;
- Inclusive of older people with mental health needs, either as a primary or secondary diagnosis.
- Intermediate Care services may also:
- form part of the pathway for end of life care, if there are specific goals for the individual or carer that could be addressed in a limited time; or
- link with longer term plans for support.

6. The Models of Care

The four models of care within the pathway will ensure a flow through intermediate care for the patient at a time and level as their need dictates. To be effective, the pathway relies on the interdependence and close alignment of health and community services, together with third sector services to ensure there all gaps in services are bridged and there are no delays in transfers of care.

Home based intermediate care

Home based intermediate care are community-based services that provide assessment and interventions for people in their own home or a care home setting, whether that is an older person or someone with a learning difficulty or other assessed needs. The aim is to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. Care will be provided through a multidisciplinary health and social care approach with agreed goals and support tailored to individual need.

There will be access to and the further development of assistive technology to promote independence at home e.g. telecare (such as pendant alarms and falls detectors), community equipment (such as beds, hoists and walking trolleys), and minor and major adaptations to the home (such as hand rails and ramps). The introduction of other forms of digital assistive technology such as telehealth and teletriage will be explored to support people to remain in their chosen place of home for as long as possible.

The Sefton Integrated Commissioning Group will ensure that the home-based intermediate care offer will allow professionals to build a package of care and support around individual needs therefore enabling independence. In addition, we will work with the voluntary, community and faith sector in the development of community centred models of support which can be utilised by individuals in the longer term to enable transition from intermediate care.

Reablement

Fundamental to the objective of this service is the principle of helping people to support them rather than 'doing it for them' or 'doing it to them'. Evidence shows that timely bursts of Reablement, focusing on skills for daily living in people's own homes, can enable people to live more independently and, in most cases, appropriately reduce their need for ongoing longer-term services.

As a result, the Sefton Integrated Commissioning Group will seek to expand the provision of such services so that they become the default pathway for people, thereby ensuring that when people do receive services, in the first instance they are supported to regain their independence as much as possible.

Bed Based Intermediate Care

Bed based intermediate care is designed to help people avoid hospital or get home sooner, recover from illness, and plan their future care. It is a model of care which sits at the heart of Sefton's vision for an integrated health and social care system.

Assessment and interventions provided in a bed-based setting are designed to reduce the risk of further deterioration in the person's condition which can lead to reduced independence.

Sefton integrated commissioning group will ensure bed based intermediate care services are provided in a range of appropriate environments to meet the needs of the individual. We aim to ensure sufficient capacity to ensure that adults can start the service within 2 days of referral from hospital or the community setting. The aim of this is to maximise outcomes, prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and support timely discharge from hospital.

Crisis / Rapid Response

Such services build on other existing short-term intervention services by also offering another mechanism to provide Domiciliary Care, Reablement tasks and practical support to enable Service Users who are medically stable, to remain safe and secure in their own homes when an acute situation occurs and who, without such support, may normally be admitted to Hospital or access other services such as longer-term care at home or in a care home setting.

As part of the implementation of this strategy, opportunities to develop such services will be considered, which will also encompass how such services can link with other services and provide timely interventions to people, thus reducing the need for an acute hospital admission and/or longer-term service.

5.1 WHO will deliver the care?

The intermediate care offer within Sefton will be provided through multidisciplinary teams and services working through an integrated model of service delivery to provide holistic short-term care interventions and rehabilitation. Key to the delivery of this model will be a single point of access for those referring into the service and a single assessment and care planning process approach. There is a need for further review and consideration of these enabling processes as part of the implementation of this strategy.

The intermediate care model will comprise:

- Nurses and health care assistants
- Allied health professionals e.g. occupational therapist, physiotherapist
- GP or Geriatrician
- Social workers
- Care workers e.g. within reablement and crisis response

There will be clear routes of referral and engagement with commonly used services, for example:

- General practice, pharmacy, podiatry
- Mental health and dementia services
- Housing services
- Voluntary, community and faith services

The intermediate care model will encompass a broad range of disciplines and skills and competencies to support effective service delivery. There will be flexible utilisation of the intermediate care workers between community and bed-based care; and greater interaction of

health and social care to enable education and development opportunities for care workers to create a robust workforce to support reablement and crisis response.

The intermediate care model will link closely with other developments within Sefton. This will include the integrated care teams which are delivered at a local level and whose remit is to proactively support service users and avoid reactive interaction with the urgent primary and secondary care systems. The integrated care teams will identify and refer individuals to intermediate care where required and will also provide follow on support after intermediate care. The intermediate care model will also establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services, together with Continuing Health Care Teams, to ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

5.2 WHERE care will be provided

Intermediate care will largely be provided in the person's own home, but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting, or with some nursing care may be the only viable option to avoid hospital admission.

5.3 WHEN care will be provided

Step up: the service will provide a proactive "rapid response" assessment within two hours of referral, providing an intervention in people's homes (or place of residence) with a view to avoiding admission to hospital.

Step down: the service will also 'in reach' into local acute services with a view to facilitating early discharge. Decisions relating to long term care will not be made in a hospital environment, but in the patient's home environment to promote and sustain independence and wellbeing.

5.4 How long will care be provided for?

Intermediate care should last no longer than 6 weeks and is a time-limited service with the intention of preventing unnecessary hospital admission, reducing lengths of stay in hospital and enabling patients to return home quickly by providing support in the community for a short period while on-going packages of care are commissioned from Adult Social Care.

It is goal-focussed and provides time for assessment and intervention based on specific, agreed outcomes to be achieved within days and weeks, supporting people to return to self-care.

5.5 Transition of Care

Transition of care will be effectively planned within the 6 weeks service duration and will run parallel with intermediate care interventions. This will enable the service user to exit the service smoothly and transition into any ongoing service provision, the aim of which is to enable and maximise independence at home.

Persons needing ongoing support will have had an equal partnership with the multidisciplinary team to enable them to make choices about their own care. They will be treated with dignity and respect throughout their transition.

A clear plan will be provided to the service user on transition with good communication between intermediate care teams and other agencies and on other types of support available.

A contingency plan will be agreed equally between parties with Information readily available about how to self-refer back to the service and how to contact the team if needed.

6 Outcomes

6.1 Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission and manage the projected increase in demand

- We will agree a model across Sefton, in partnership between health and social care, independent sector and the third sector to agree a single model for intermediate care.

- We will review and develop team capacity in the community, together with community bed provision to take account of the projected increase in the elderly and frail population, while demonstrating value for money and effectiveness in reducing hospital admission.

- Organisational boundaries will not be allowed to obstruct or delay operation of the system. A cohesive team will ensure effective co-ordination and accountability for all members of the intermediate care teams.

- Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.

- The strategy will be delivered through a patient-centred approach and implemented through working in a collaborative manner.

6.2 Ensuring decisions about long term care are made only when individuals have had an opportunity for rehabilitation and recovery

- We will ensure that patients are not transferred directly from a hospital ward to residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement.

- We will ensure that individuals with complex health needs are treated fairly and offered rehabilitation prior to any decision being made about their long-term needs.

- In Sefton we will work to ensure access to high quality Care at a Fair cost of care that allows people to remain in their own home wherever possible, utilising the resource of residential or nursing home by those whose needs require it most.

6.3 Increase individual satisfaction and maximise independent living

- We will continue to monitor and review the pathway to ensure a fully integrated service.
- We will ensure our services are individual centred.
- We will introduce a new series of measures to performance manage the operation and delivery of the service, which will include continuous assessment of the individual experience.
- We will ensure individuals do not become delayed in the system or access intermediate care services for longer than necessary.

6.4 Ensuring that models and services work for people with mental health problems, dementia and delirium

- We will deliver services that reflect that an accurate assessment of long-term health and/or social care needs will be possible once someone with dementia or someone recovering from delirium is back in their own home/care home and very unlikely if undertaken in the unfamiliar and confusing environment of a hospital.
- We will ensure that when following the principles of Discharge to Assess and Home First for people with mental health conditions on mental health care pathways, there will be in place the delivery of more supportive care packages than usual, which will be person-centred and planned in conjunction with the person and any identified carers, family and/or friends.
- Care coordinator or relevant mental health clinician will be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered as part of duties under the Mental Capacity Act (2005). For people where new mental health concerns are considered in light of discharge psychiatric liaison teams should be contacted by Case Managers in the first instance to review and assess as appropriate

7 Commissioning Approaches

7.1 A key element of this strategy is the service models for Intermediate Care services, and as a result Commissioners will need to ensure that services commissioned reflect these models, meet the desired outcomes and have sufficient capacity within them to meet demand.

7.2 Commissioning intentions and options will be outlined as part of the ongoing development of this strategy and the associated action plans, however it is important to initially highlight that these options could include;

7.2.1 Reconfiguring existing contractual arrangements to ensure that services are aligned to multi-disciplinary Teams in order to ensure that efficiencies are achieved and that there is the best use of available resources; and

7.2.2 Reviewing existing services in place to ascertain whether they can be expanded and/or remodelled in order to better meet the required models of service.

7.3 When commissioning proposals are formulated, both the CCGs and Council will ensure that the appropriate approval and procurement processes are adhered to, and that these intentions are outlined to all stakeholders.

8 Consultation & Engagement

8.1 Through the life of this strategy, all stakeholders will be consulted and engaged with to ensure that the strategy continues to identify emerging needs and remain aligned to other associated strategies and plans.

8.2 In addition, as part of the implementation of associated action plans, consultation and engagement will take place, for example with Service Users and Care Providers to ensure that commissioning activities take into account identified needs, desired outcomes, feedback on current services being delivered and Provider market factors.

9 Governance

9.1 As outlined earlier, oversight of this strategy ultimately rests with the Health and Wellbeing Board, however oversight will be conducted by the Programme Delivery Group.

9.2 As part of the implementation and delivery of the strategy an Operational Group will ensure that action plans and individual projects are managed, with this group including Providers delivering services.

9.3 Oversight and governance will also take place through other mechanisms such as the Better Care Fund and internal CCGs and Council bodies, for example when procurement activities are proposed.

9.4 The quality of the services provided will be monitored via contractual arrangements and regulated by the care quality commission who monitor, inspect and regulate service to ensure they meet fundamental standards of quality and safety.

10 Conclusion

10.1 Delivery of this Intermediate Care Strategy will be crucial in supporting the delivery of the CCGs and Councils aligned strategic aims. The strategy also represents key deliverables of the Health and Wellbeing Board and takes into account that the elderly and frail population is projected to rise significantly and there are an increased number of people living longer with more complex health needs.

10.2 Our challenge is to commission services upon which there will be growing demand, which offer a high standard of care within the current financial constraints.

10.3 The benefits for the Sefton population will be an increased quality of care and an environment where they are not admitted to hospital unless it is absolutely necessary and if admitted to hospital, ensuring that they are discharged quickly with services put in place to support them to resume independent living.

Appendix 1 - Terms used in this Strategy

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Home care

Care provided in a person's own home by paid care workers which helps them with their daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by the local council or by the person receiving home care (or someone acting on their behalf).

Intermediate care

A range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Person-centred approach

An approach that puts the person at the centre of their support and goal planning. It is based around the person's strengths, needs, preferences and priorities. It involves treating them as an equal partner and considering whether they may benefit from intermediate care, regardless of their living arrangements, socioeconomic status or health conditions.

Positive risk taking

This involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.

Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.