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# Intermediate Care Co-ordination

## The function

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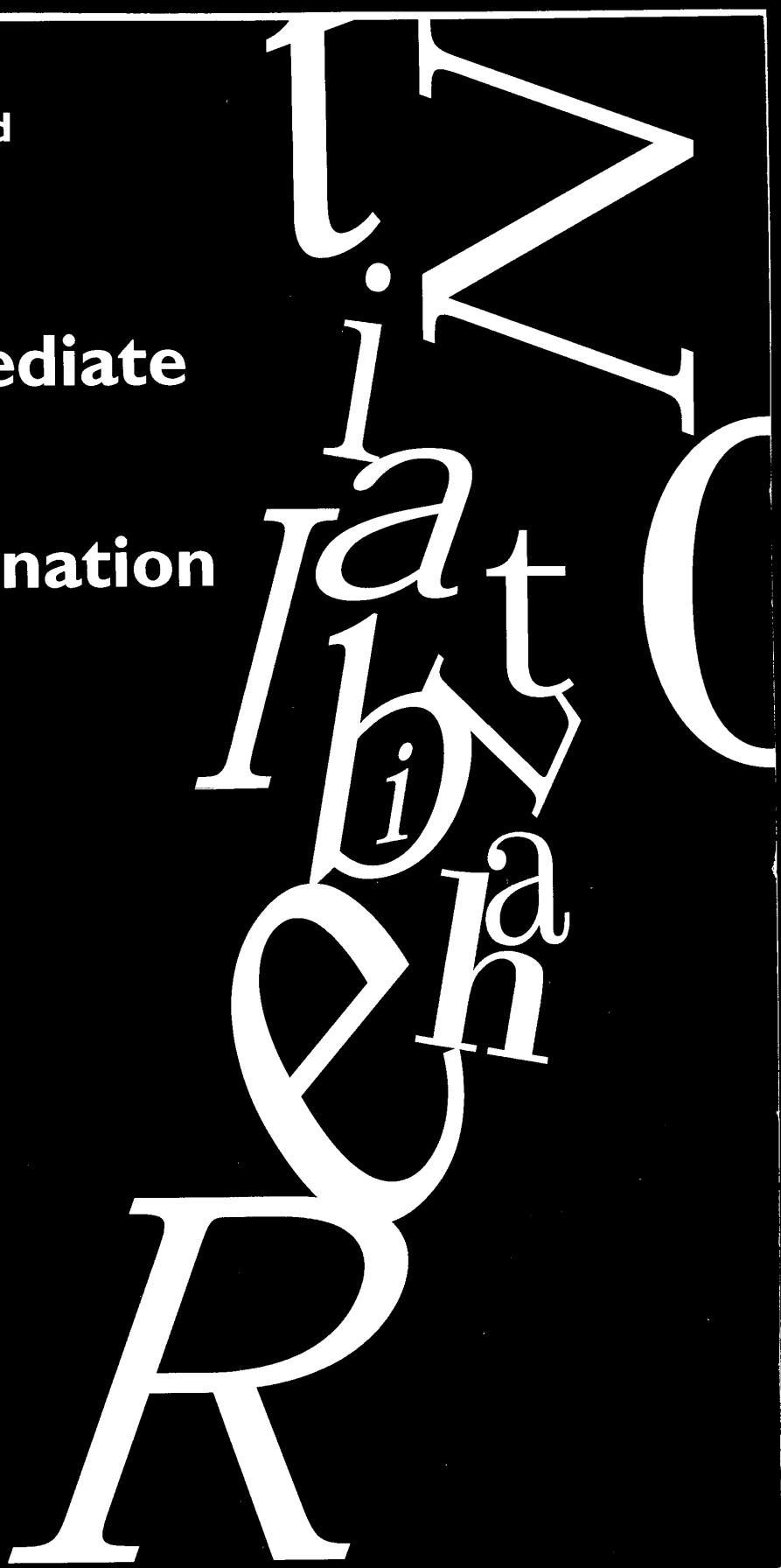

# Intermediate Care Co-ordination – the function

Paper prepared for the workshop
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## Background

In the guidance on intermediate care, the Department of Health advised 'the NHS and councils to appoint jointly an intermediate care co-ordinator in each Health Authority area initially' (p.8, para.15). In the National Service Framework for Older People, one of the first milestones is that 'local health and social care systems are to have designated a jointly appointed intermediate care co-ordinator in at least each health authority area' by July (p.49).

To help people to explore the intermediate care co-ordinators' role and promote a common understanding of the expectations placed upon them, the Department of Health asked the team from the King's Fund Programme 'Developing Rehabilitation Opportunities for Older People' to jointly organise a workshop with them in June 2001. This workshop brought together some early post-holders and other stakeholders with responsibility for putting a system of co-ordination in place.

During the workshop, consensus emerged that the co-ordination function must operate at both strategic and operational level in care communities. There was a sense that in complex communities it would not be possible for one person to manage both.

The Department of Health and the King's Fund organised a second workshop on the topic. This took place in July 2001.

As a resource for delegates at the workshops, Jan Stevenson, Programme Manager, 'Developing Rehabilitation Opportunities for Older People', and Professor Keith Wilson, Head of NSF Implementation, produced a briefing paper setting out the range of functions of intermediate care co-ordination and their context within the overall implementation framework of the National Service Framework for Older People.

This Briefing Paper has been refined in the light of comments and discussions at the second workshop. It contains a comprehensive list of functions and tasks that need to be carried out in each care community to ensure an effective and efficient intermediate care system. Some are clearly strategic and, as such, could fall within the remit of a

strategic level planning group and/or one senior individual. Many are clearly operational tasks, and will require detailed day-to-day operational management to ensure a high-quality and efficient programme of care for patients.

It seems clear from the discussions that the way in which these functions and tasks are managed will depend very much on what services are already in place locally, the degree to which they are integrated, and the numbers, skills and experience of staff. In areas of high organisational complexity, a number of people may be needed to ensure that all tasks are performed; in relatively simple systems, one person may be able to perform all the tasks effectively.

Some potential challenges faced by those developing the role and service system were identified:

- Organisational change in care communities (e.g. health authority and primary care developments) may in turn necessitate changes in the way that intermediate care is co-ordinated.

- The focus on co-ordination of the current service system must not be allowed to inhibit the identification of further opportunities to develop new service responses or change to current working practices and the way current resources are used.

We are grateful to all those people who contributed to the debates at the two workshops, including Gareth Jones, Department of Health Policy Lead on Intermediate Care, and Linda Spencer of the King's Fund. We are also grateful to those members of the Rehabilitation Development Network who shared their documentation with us. We hope this paper will now help them and others to decide on the most appropriate way to manage the intermediate care co-ordination role to suit their local care communities.

Jan Stevenson
King's Fund
July 2001

Keith Wilson
Department of Health
July 2001

# Intermediate care co-ordination – the function

The co-ordination function spans a broad strategic-operational spectrum.

Co-ordinating the effective and efficient delivery of services to individuals through a variety of case managers in a variety of settings, the function includes:

- promoting and providing information about intermediate care services
- developing care pathways and protocols for access to services
- ensuring intermediate care is integrated across the statutory and independent sectors, and across primary care, community health services, social care, housing and the acute sector
- securing agreement on the use of Health Act flexibilities and arrangements for financial management.

## *Local arrangements*

The responsibility for ensuring that the function is undertaken in a local system may fall to one or more individuals. The way in which responsibility is allocated will depend on a number of factors at a local level. These factors will include:

- the size, demography, complexity and maturity of the local health and social care systems and associated intermediate care system
- the skills, experience, capability and capacity of individuals available to ensure that the function of co-ordination is carried out
- the style of management locally – in terms of how management roles generally combine or separate operational and strategic roles.

Local systems will need to decide how much of the full spectrum is included in the role of the local co-ordinator – this will need to fit local arrangements overall.

Where the role of the co-ordinator is clearly focused on operational functions only, then clear and definite arrangements will need to be put in place to ensure that the strategic function is effectively discharged by some other(s). At the very least it would be good practice to ensure that the co-ordinator has a major advisory input into the strategic process.

In some circumstances, the co-ordinator will have responsibility for the operational function, together with some, but not all, aspects of strategy. In such cases, it will need to be made clear where the responsibility rests for strategic intermediate care development overall.

Specific roles, areas of responsibility/accountability will all need to be stated clearly in job descriptions, which will therefore differ to reflect local arrangements.

### *The context for strategic development*

- The organisational context for the strategic development of intermediate care will be the NSF Local Implementation Team.
- Overall responsibility for implementation of intermediate care as an NSF Standard will rest with the Chief Officer who has the local mandate for co-ordination of NSF implementation, as required in the NSF.
- The NSF implies that each standard itself should be led by a nominated local Chief Officer; by implication this includes intermediate care.
- Local implementation plans, including plans for development and implementation of intermediate care, will be part of the annual Joint Investment Plan, alongside other plans for older people's services.

### *Strategic level functions*

Purpose:

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.

Tasks:

- 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.
- To ensure that financial resources are clearly identified for intermediate care services and supported with efficient systems of financial management.
- To develop shared/pooled budgets for intermediate care across health and social services.
- 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 area.
- To map existing intermediate care provision, and check that criteria, transfer protocols and care pathways are agreed by local stakeholders and are in place.
- To ensure that arrangements are in place for monitoring, auditing and evaluating the quality and effectiveness of intermediate care.
- 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.
- 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.
- To develop joint protocols and decision-making and information-sharing processes within the area, across professional and organisational boundaries, where these are not yet agreed and in place, with particular emphasis on linkages with mainstream services.
- To develop data systems and evaluation measures to provide information on service performance/trends, identify gaps and outcomes for individuals.

- To evaluate the effectiveness of the overall intermediate care system, and the services within it, against agreed performance criteria.
- To develop service models/change working practices to improve the quality of existing services or to meet unmet need for intermediate care.
- To gather information from a wide network regarding research and innovation on intermediate care, and act as an expert point of reference for commissioners and service providers locally.
- To liaise with stakeholders in neighbouring localities to ensure the effective management of cross-boundary patient flow in respect of intermediate care.
- To ensure that developments in intermediate care are effectively communicated to local stakeholder organisations, staff and the public.

### *Operational level functions*

Purpose:

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.

Tasks:

To ensure the efficient organisation and management of the referral, assessment, case management, admission and discharge arrangements by:

- Providing advice to the NSF Local Implementation Team on the strategic development of intermediate care services.
- Reviewing and developing clear admission criteria for each scheme within the locality and ensuring that there is no duplication.
- Promoting awareness of the intermediate care system, admission criteria and access point(s) with potential referrers.
- Ensuring 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.

- Making sure clients enter services at the most appropriate point on an agreed care pathway, with a named case manager and individual care plan and review date, building on local assessment and care management arrangements.
- Either negotiating placements and discharges into and out of intermediate care, or authorising patient transfers arranged by appropriately designated case managers.
- Ensuring that appropriate service specifications are in place for all intermediate care settings.
- Monitoring 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.
- Ensuring that appropriate medical cover is arranged either via a GP or a hospital specialist, in accordance with arrangements established by the commissioners of intermediate care.
- Undertaking regular planned reviews of client outcomes for each intermediate care setting.
- Reporting data on capacity, throughput and outcomes to the commissioner on a regular basis.
- Instigating and co-ordinating audit of intermediate care services.
- Identifying training needs of intermediate care staff and developing ways to meet these needs.
- Monitoring costs of services and managing a budget for problem solving.

To ensure the efficient use of the intermediate care system by:

- Identifying clients who would benefit from intermediate care and ensuring their smooth transfer in accordance with an agreed care plan.
- Making plans prior to admission for those elective patients admitted to acute hospital care with an anticipated discharge pathway through intermediate care.
- Making plans for non-elective patients as soon as they are transferred.
- Monitoring progress against care plans, ensuring that care is available as agreed and that clients achieve their personal outcomes.

- Setting 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).
- Ensuring non-old age hospital consultants are engaged in the intermediate care system and the potential to refer people to more appropriate settings.
- Agreeing access to intermediate care out-of-office hours and at weekends (e.g. via GP co-ops) with key partners and service providers.
- Assisting 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.
- Identifying and speedily resolving problems and blockages in the system in order to ensure that other services can operate efficiently.
- Ensuring that systems are in place and agreed for the client's records/care plans to be transferred through the system with them.
- Ensuring that equipment needs are identified and swiftly met, and that equipment is retrieved when a client no longer needs it.
- Ensuring that systems are in place to trigger other actions whilst the client is in intermediate care, e.g. home adaptations, putting together domiciliary care packages.

## Source documents


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- Department of Health. *National Service Framework for Older People.* 27 March 2001.
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- Report prepared for Keith Wilson by Sally Burton (Older People lead, West Midlands Region), Trish Bennett (Nurse Consultant/National Older People Task Force Member), Pauline Riley (CARATS Co-ordinator), Rotherham Priority Health Services NHS Trust. *Job Role and Specification for Intermediate Care Co-ordinator (Management Post) and Intermediate Care Manager (Senior Practitioner).* West Midlands Regional Office, July 2000.
- A number of local intermediate care co-ordinator job descriptions.