A Proposed New System for Health and Social Services

Integrated Community Services: Intermediate Care

Scheme-level Outline Business Case (OBC)

Version 2.0

13 June 2012

This document

Purpose of the Outline Business Case

The Green Paper, *'Caring for each other, caring for ourselves'*, was produced in May 2011. Following public consultation, eight service areas were selected for early service development in 2012 – 2015. Sustaining Acute Services was identified as being 'Business As Usual', and was removed from the OBC list, therefore, seven OBCs have been produced.

Each proposed service change has been developed robustly, with full involvement from stakeholders. Working groups have used an Outline Business Case (OBC) template when discussing and developing the service changes, in order to ensure that all relevant aspects have been considered. The template incorporates guidelines from the UK Government's website on Business Cases as well as the template on the Treasury & Resources website.

Once approved, each OBC will be progressed to Full Business Case (FBC) – this is anticipated to be by Autumn 2012. The FBC will provide detail on the service change, including detailed timescales and action plans for implementation. Service implementation commences once the FBC has been approved and fund secured from the Medium Term Financial Plan, which is due to be agreed in late Autumn 2012.

Structure of this document

This Outline Business Case presents the elements of service change that must be considered in order for plans to be robust, stakeholders to be fully engaged, and risks to be managed effectively.

The case for change for Intermediate Care services is presented, building from the case for change in the Green Paper. The linkage with the HSSD strategic principles and with the relevant services' strategies is clearly identified. The outcome of the Green Paper consultation, and in particular the views of stakeholders received during the consultation period have been presented where applicable, in recognition of the importance of these views.

The OBC then outlines the proposed service change, and the elements thereof, for example, the impact on workforce, on costs and on service delivery / quality.

Indicative costs and benefits are outlined. Some rounding adjustments have been made. All costs are presented at prices relevant to the each year, to ensure that the full cost of the proposals is understood. Costs and benefits which are quantitative and qualitative, short and long term and relevant to patients / service users / carers / families, clinicians and the public have been considered.

Implementation considerations are then presented, including stakeholder engagement and communication, key risks and issues for both the implementation period and for the full service delivery.

Revision history

Version	Date	Author	Description
0.01	01.11.11	KPMG	Working draft
0.02	30.11.11	KPMG	Generic update
0.03	21.03.12	John Cox	Final iteration
1.0	20.05.12	Rachel Williams	Final review and revision
1.1	12.06.12	John Cox	Final update
2.0	13.06.12	Rachel Williams	Finalisation

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Abbreviations and Definitions

Abbreviation	Definition
CSED	Care Services Efficiency Delivery Programme
FBC	Full Business Case
HSSD	Health And Social Services Department
MTFP	Medium Term Financial Plan
OBC	Outline Business Case
PSSRU	Personal Social Services Research Unit
QIPP	Quality, Innovation, Productivity and Performance

1 Executive Summary

1.1 Introduction and background

In common with jurisdictions and countries across the world, Jersey faces substantial current challenges in ensuring the availability of high quality health and social care for its citizens within a financially affordable sum. The KPMG technical document and the Green Paper, both published in May 2011, demonstrated that health and social care services in Jersey are at a crossroads. Existing capacity is due to be exceeded in some services in the near future, the elderly population is rising disproportionately and almost 60% of the medical workforce is due to retire in the next 10 years.

In early 2011 the vision for health and social care in Jersey was agreed. This clearly stated that services must be safe, sustainable and affordable.

The public consultation on the future of health and social services in Jersey concluded on 22 August 2011. Since that time, a Working Group has been considering the service changes that are required urgently; this Outline Business Case is a result of that process.

1.2 Strategic Context

The States of Jersey Strategic Plan 2009-2014 includes a number of priority areas for Health and Social Services, including:

- To develop a strategy that will draw together in a cohesive way all the action required to deal with the ageing population
- To enhance and improve healthcare provision and promote a healthy lifestyle
- To support those in need and increase social inclusion by helping people to help themselves

HSC2001/1: LAC (2001)[1] provided the baseline to understand the nature of Intermediate Care. Expectations with regard to the role of these services within the overall modernisation agenda have been detailed in the National Service Framework (NSF) for Older People. It set an aim “to provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living”, and characterized services as:

- Targeted at individuals who would otherwise face unnecessarily prolonged hospital stays or avoidable admission to acute in-patient care, long term residential care, or continuing NHS in-patient care
- Provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery
- A planned outcome of maximising independence and typically enabling patients/users to remain living at home
- Time limited, normally no longer than six weeks and frequently as little as 1-2 weeks or less

- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

1.3 The Case for Change

Jersey's population is rapidly ageing. The over 65 population is forecast to increase by 95% between 2010 and 2040. This will have significant impacts on demand for health and social care services. Currently, services face a number of challenges; if services do not develop, services will become unsustainable as demand increases:

Non-elective hospital admissions are driven by general medical patients, of which 53% are over 65 years old. Jersey has a high number of delayed hospital discharges, mainly caused by Care home placements and adults awaiting rehabilitation within Samares unit.

Jersey has a relatively high proportion of older adults in care homes, and there is currently a waiting list for States-funded access to nursing home beds. Anecdotal evidence indicates that the demand on care home usage is partly due to the lack of available intermediate care services. Furthemore, much of the current estate will not be fit for purpose and much will not meet the requirements of the new Regulation of Care Law.

The landscape of rehabilitation and community care services in Jersey is limited in variety and availability. Other than the Samares Rehabilitation Ward, there are no step-up/step-down facilities for patients who could be managed outside of a hospital environment, and the capacity of other existing services for older adults will be exceeded within two years. This, along with the lack of 24 hour community services and waiting lists for nursing homes creates both an immediate impact on secondary care and a longer term impact on health and social care system.

Services are not integrated and locally, and services are arranged across various tiers resulting in inefficient use of resources.

Recruitment and retention of suitable numbers of essential health and social care staff remains a challenge. It is envisaged that the development of "generic" support staff and enhanced roles for professional staff will help, as will a policy of "growing our own" in line with the current systems for nurses and social workers.

The way in which services are commissioned and provided needs to be fundamentally changed, requiring health and social care services to engage in a different approach to better serve the community. HSSD need to work in partnership with a range of providers, including the Third Sector and Primary Care, to support people outside institutional care, ideally in their own homes.

1.4 Service Objectives for Intermediate Care

An integrated Intermediate Care service (across health and social care) for adults will promote faster recovery from illness and will reduce unnecessary acute hospital admission and premature admission to long-term residential care. This will be

achieved through by supporting timely discharge from hospital and maximising independent living.

1.5 Intermediate Care by 2015

The redesigned health and social care system aims to support and enable service users and their carers to live productive and independent lives in their own homes for as long as possible. The Intermediate Care service will provide care for all services users, including those with dementia, long term conditions and end of life care for 6 – 8 weeks. The service will work closely with all other aspects of the system to ensure individuals are identified early, their care is co-ordinated, and the transition to longer terms services, where necessary, is timely and smooth.

The Intermediate Care service will comprise co-located physical, mental health, therapy and social care professionals, working within an Intermediate Care Resource Centre, providing:

- Access to **24/7 Nursing and home care**, including night sitting, falls management and prevention and emergency social care
- Short term community beds providing admission avoidance (**Step-up Unit**) and rehabilitation and recovery (**Step-down Unit**) from inpatient settings
- **Telehealth and telecare**

The Intermediate Care service will be delivered in partnership between HSS, independent providers, the Third Sector, Parishes and Primary Care.

It will link with the Single Point of Access (SPA), which co-ordinates all referrals, provides appropriate responses to service user need, coordinates care and monitors the service user's progress through the care pathway.

Risk stratification will be undertaken to identify those patients who are at risk of presentation at the Emergency Department, either through an exacerbation of a chronic disease or with a high risk of developing the first signs of one.

Care co-ordinators will support the individual, ensuring needs assessments are completed and individual care plans are produced.

The majority of care will be provided in individual's homes (otherwise known as a 'virtual ward'), with a small number of community-based beds in Step-up and Step-down Units for admission avoidance and rehabilitation.

Benefits include:

- Improved transition for service users between acute and community services
- Reduced Emergency Department presentations and unnecessary admissions
- Integration, providing a coordinated service operating for the benefit of patients / service users and carers

- Increased independent living by supporting people in their own homes where possible and supporting them "to do" rather than be "done to."
- Cost deferment of £8.5m for the period 2013 – 2015
- A more attractive career path

1.5.1 The Financial Case

A recurring additional revenue investment of £1.3m in 2013, £2.3m in 2014 and £2.9m in 2015 is required.

Non-recurring implementation costs are estimated at £199k in 2013, £58k in 2014 and £27k in 2015.

The service will require an additional 63.5 FTE Nurses, Health Care Assistants and other professionals in the period to the end of 2015. Further significant investment in staff will be required in later periods as the Rapid Response and Reablement teams are introduced (from 2016). In addition there will need to be an additional sessions from a range of clinicians including podiatry, speech and language therapy, psychiatric nursing and dietetics.

The cost of overall investment is offset by an estimated annual cost containment of £3.3m (by 2015), which comprises (by Q2, 2015):

The cost containment figure is based on an estimate of the number of bed days which could be released and reused. This has been estimated at 24 hospital beds and 1 nursing home bed. The cost containments comprise:

- 6 Step down Beds – 6 hospital beds
- 4 Step up Beds – 4 hospital beds
- 4 Spot purchase residential beds – 4 hospital beds
- Step up/down Beds – 1 nursing home bed
- Impact of 24/7 Community Services – 10 hospital beds

1.5.2 Implementation Actions and Timescales

		2012				2013				2014				20	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
24/7 Nursing and home care	Funding agreement for new model														
	Recruitment and training of additional staff														
	Establishment of initial community team														
	Service commences Second phase of recruitment														

Single care pathway	Review current service provision across health, social care and the Third Sector															
	Procurement of an IT package to develop the information hub															
	Redesign the pathway with Single Point of Access and Care Coordinators															
	Consultation and training on new assessment and Care Coordination process															
	Development and implementation of redesigned assessment and Care Coordination process															
Intermediate Care Resource Centre and Step-up/ Step-down Unit(s)	Business planning for the development of the site for the Intermediate Care Resource Centre															
	Capital investment agreed															
	Recruitment of additional staff for Step-up/Step-down Unit(s) commences (if relevant)															
	Training of new staff commences															
	Partial start-up of service															
	Recruitment begins for the full complement of staff															
	Full service goes live															
Telehealth and telecare	Scoping and service specification															
	Tendering of service															
	Review and design of operational procedures															
	Training															
	Service available															

1.6 Stakeholders, risks, issues, dependencies and enablers

1.6.1 Stakeholders

The OBC was produced by a Working Group comprising:

- Professional H&SS Staff
- Professional other staff
- Voluntary sector
- Provider Sector

These Stakeholders will continue to be engaged as the OBC develops into a Full Business Case.

1.6.2 Risks and Issues

- Unrealistic expectation from service users, communities and professionals
- Recruitment and retention of appropriate staff
- Staff willingness to develop new models of care
- Ageing workforce / retirement
- Accommodation availability for Intermediate Care Resource Centre
- Operating an integrated IT system

1.6.3 Dependencies

- States Strategic Plan
- Regulation of Care Law
- Approved Providers List
- Hospital Charges Law
- Long term Care Benefit

1.6.4 Enablers

The development of intermediate care will require workforce development, as new ways of working will be required, both in terms of skills, locations and care delivery.

IT and informatics will be critical to the service's success, as these will support multidisciplinary community working, support individuals in their own homes and provide visibility of outcomes, activity and benefits

1.7 Next steps

- Identify potential demand
- Explore and develop indicators and outcome measures
- Identify key challenges of workforce development
- Ensure OBC is endorsed by the Older People's Policy Group
- Continue engaging with stakeholders
- Complete the Full Business Case, including developing detailed service design.

2 Introduction and background

2.1 A Global challenge

Every health and social care system is experiencing similar challenges:

- Demographic change is dramatically increasing demand on all health and social care systems.
- Technological advances are allowing efficiency and quality improvements but also creating major new costs.
- Societal change is altering the relationship between services and service users, professionals and the public and between the state and individuals.
- Increasing regulation in health and social care is increasing quality but also reducing freedom to act atypically.
- Service ethos is shifting from treatment to prevention and promoting independence.

Health, social care and Third Sector partners and multi-agency teams need to work closely with one another and with patients, service users and carers to provide tools and evidence-based services aimed at managing demand, promoting health and wellbeing, ensuring equality of access and protecting / safeguarding vulnerable people. Our aspiration is to enable people to be cared for in the most appropriate place, living as productive and independent lives as possible.

2.2 The Challenge for Health and Social Care in Jersey

Jersey is experiencing many of the same challenges as all other health and social care systems internationally, but it also has some unique challenges.

A small island

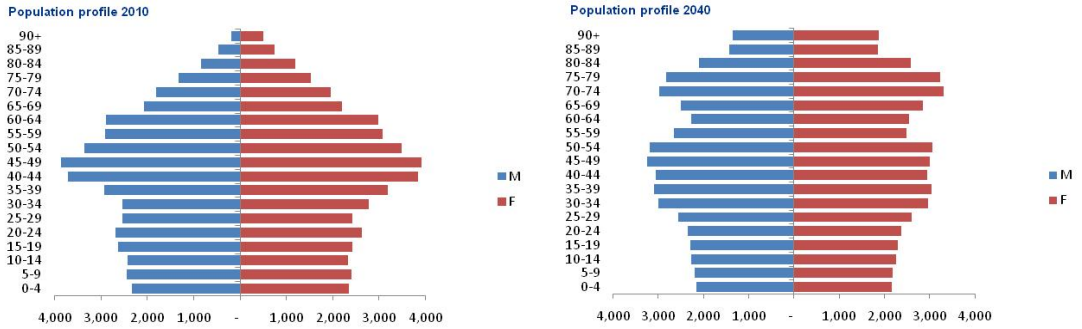
In normal circumstances our population of just under 100,000 would be considered too small to support comprehensive acute hospital services and very specialist social care services – this would normally be provided for a population of over 250,000. However, geographical isolation and infrequent but material travel difficulties mean that providing a significant level of acute and emergency services locally is essential, and that it is desirable to provide local care packages for people with complex needs.

Accordingly, the unit cost of delivering hospital and social services in Jersey is higher compared with systems serving larger populations. This is because the fixed costs of key services such as Accident and Emergency, intensive care, and secure residential accommodation, which are still necessary to support relatively low levels of activity. This, along with the cost of living (including the cost of land and buildings) in Jersey leads to an additional funding “premium”, which increases unit costs. Secondly, it can produce vulnerable services due to workforce models, particularly in the medical workforce, which are relatively light, highly reliant on very small numbers of individuals and where the achievement and maintenance of specialist skills is difficult given relatively low patient numbers.

2.2.1 Demography

Given immigration controls the population of Jersey is rising only slowly. But it is ageing rapidly. Over the 30 years from 2010 to 2040 the numbers of residents over 65 is projected to rise by 95%; in the period to 2020 the increase is projected to be 35%. This demographic change will create a huge surge in demand for health and social care services which will overwhelm the current capacity of the existing services.

Fig 1. Demographic change in Jersey



Within 5 years, the current numbers of hospital beds, operating theatres, residential and nursing care beds and other key community services will be inadequate to meet demand. These services therefore need to be expanded, supplemented and/or changed urgently to ensure that services can be safely and sustainably provided for the growing elderly population.

2.3 Strategic Principles

The vision of services which are safe, sustainable and affordable was distilled into a set of strategic design principles in late 2010. These were developed by stakeholders across health and social care, and ratified by Ministers:

- Create a sustainable service model – efficient, effective, engaging the public in self-management and with consistent access and thresholds
- Ensure clinical/service viability – overcome the challenges of low patient volumes, delivering high quality care and minimising risk
- Ensure financial viability – reduce the impact of diseconomies of scale, with value for money, an understanding of the costs of care in Jersey and robust procurement
- How should we fund health and social care? – establishing a charging model that incentivises care and cooperation
- Optimising estate utilisation – ensuring the estate is fit for purpose and utilised to maximum efficiency
- Workforce utilisation and development – supporting and utilising the workforce to the best of their abilities

- Clinical governance – sustaining a culture of safety, learning and transparency
- Use of business intelligence - with robust data to support decision making based on fact, and including patients and the public in service design and decision making

Service principles and assertions:

- Social care and health should be integrated as seamlessly as possible on a service user's/patient's life journey, with teams of social care, home care, medical, nursing, occupational therapy, psychology and other staff working together, working with the third sector and private sector providers
- Integration will be supported by an organisational and professional mindset that puts people first and at the centre of decision making about their care package, and ensures that needs drive services and not the reverse, to improve emotional, social and health wellbeing.
- Single, integrated care pathways, single assessment and a move towards personalisation and needs driven care will provide choice and empowerment. At present, complex services are provided by a multiplicity of providers, teams and professionals with different referral and access points, assessment frameworks, eligibility criteria and pathways. Simplifying and standardising the current range of approaches would improve co-ordination, providing a holistic, streamlined service which provides support, enablement and choice of care setting for older people and support for their carers.
- Services should be planned and delivered within partnerships bringing together all sectors of our Islands community and economy
- Where appropriate, service provision should move away from residential care and institutionalisation within social care towards an increase in community provision to allow service users to integrate and lead independent and productive lives as much as possible.

2.4 Stakeholders and public opinion

Between November 2010 and April 2011 a number of stakeholders were interviewed to ascertain their views on the future for health and social care. The key themes were:

- The development of an overall strategic plan as an overarching context for the development of the above is essential. This should address any changes required in the structure of services and relationships between them, as well as future funding mechanism to ensure the changes in service provision required will be delivered
- There is a groundswell of appetite for change
- Considerable scope exists for improvement in the coordination, collaboration and communication between different services and service providers
- Some gaps in service provision exist

- Elements of the operational infrastructure would benefit from strengthening. This includes improved mechanisms for data collection and distribution, recruitment and retention of key staff, and improvement and better use of estate

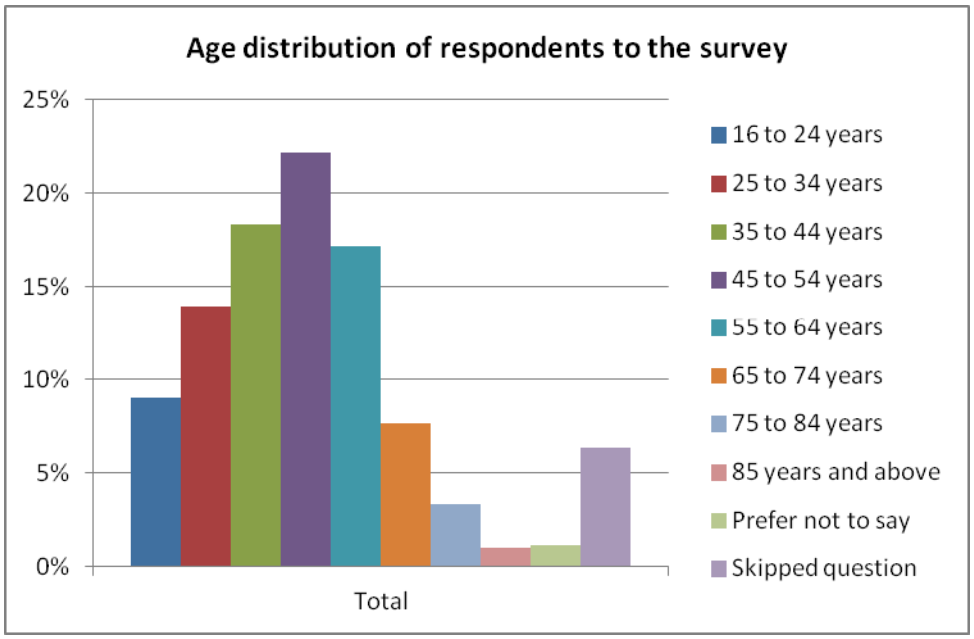
2.5 Results of the Green Paper consultation

Between May and August 2010 HSSD consulted on the Green Paper 'Caring for each other, Caring for ourselves'. More than 1,300 Islanders responded to the consultation. The response was overwhelmingly in favour of redesigning health and social services so that they continue to be safe and affordable for the future (86%), and many respondents included detailed comments and viewpoints.

The Green Paper sought views on three scenarios for the future of health and social care:

- Scenario One: "Business as usual" – services continue to be provided in the same way and through the same structures as in 2010; spending increases to meet growing demand.
- Scenario Two: "A small increase in funding" – the funding allocation does not increase. Services have to be prioritised within this budget and many services will be subject to 'means testing' or will be stopped.
- Scenario Three: "A new model for health and social care" – prioritised changes to service delivery, to ensure health and social services are safe, sustainable and affordable and are able to meet projected increases in demand.

Responses were received from across all age groups. 69% of responses were received from individuals; 17% from organisations, such as Family Nursing and Home Care, dDeaf Awareness Group and Mind Jersey. More women than men responded.



Responses

The overwhelming message from the consultation was the positive views of Islanders about their health and social services. The majority of the respondents believe it is very (81%) or fairly important (16%) to continue providing a wide range of health and social care services on island. The remaining questions elicited the following responses:

- The majority find it very important (82%) or fairly important (16%) that in future these services are free, or affordable, and available to all.
- The vast majority of people (90%) agreed that "The States should ensure that preventing ill health is as important as curing ill health". Some people felt that a large benefit could be gained from this area in the long term, whilst others were not sure whether this would be possible.
- Mixed views were received regarding having "responsibility for your own health" – whether this was for longer waiting times or increased charges for people who choose not to look after their own health. In particular, there were concerns about "self-inflicted" injuries or illnesses. Some respondents argued that it was not always possible for everyone to look after themselves and that vulnerable, ill or disabled individuals should not be disadvantaged.
- Most respondents agreed that "People should be able to live in their own home for as long as possible, providing they have the right health and social care support from the States of Jersey, the Third Sector and parishes.
- The vast majority of people (90%) agreed that "Instead of going to a hospital doctor or GP, I would be happy to be seen by a nurse, a pharmacist or other care professional, for appropriate minor procedures such as measuring blood pressure or monitoring my diabetes."

- Most respondents said they would welcome qualified nurses working with GPs to free up their time, but others were not in favour of nurses doing what they considered to be the work of a GP. Some respondents commented that the GP system in Jersey was already very efficient and they were concerned about damaging patient-GP relations, and others were concerned about the cost of Primary Care to individual patients.
- Respondents also indicated that off-island travel was acceptable for some treatments. Some respondents would rather not have off island treatment, whilst others felt that going away for care to be inevitable on a small island like Jersey. Respondents also expressed views on whether patients should travel off island to see a doctor, or whether doctors should visit Jersey to treat patients.
- Professionals working together to deliver better integrated care was important, but some respondents noted that Jersey's charities should receive more funding and support.
- The vast majority of respondents thought that health and social care should be accessible and affordable, if not free, to all. However, there was a range of views about who should fund this care, and how.
- The need for affordable care was often stressed, and many respondents felt payment and funding needed to be explored in more depth.
- Most respondents said that those who cannot pay should still enjoy high quality health and social care. Opinion was then split about whether the amount of free care available for each person should be capped, with respondents expressing concern about the costs of care for people with long term illnesses and whether they would be able to pay.
- Some respondents commented that if health and social care was capped, for some conditions or for all, this should be means tested. However, others disagreed with means testing and felt that if someone had worked all their lives, they should have as much right to free care as others.
- Some respondents felt it would be fair that those who had lived in Jersey all their lives received free access to treatment – but that people who have not paid into the system should not enjoy the same benefits.
- According to many respondents, significant numbers of people visit the Emergency Department rather than seeing a GP because there is a charge associated with the GP, while a visit to the Emergency Department is free. The majority agreed that if a charge applied to visit the Emergency Department for treatment of a minor condition, they would be more likely to go to see their GP. Many also suggested that GP consultation costs should be reviewed at the same time as Emergency Department costs.
- Many respondents felt that there are opportunities to improve current system. Suggested ways to improve efficiency included reducing bureaucracy in health and social services, improving communication between organisations and bringing in more third party and profit making organisations to provide care.

2.6 Development of the Outline Business Case

This Outline Business Case (OBC) presents the case for change for Intermediate Care. It explains, within the context of current and future safety, sustainability and affordability and against the strategic principles agreed by Ministers in late 2010, the reasons why 'do nothing' is not an option.

The OBC was developed by a Working Group between August and November 2011. Between November 2011 and March 2012, significant work was undertaken with Treasury to ensure that financial projections are within an indicative cost envelope and sufficiently detailed and accurate for the Medium Term Financial Plan submissions in Summer 2012.

The OBC outlines in brief a range of factors that have been considered in connection with the proposed new Intermediate Care service being introduced, referring to the three Scenarios outlined in the technical document and Green Paper. It presents an outline cost/benefit analysis of the options.

The OBC then outlines the features and timescales of the proposed service changes and assesses the potential impact against a range of factors, including workforce, cost and quality.

This OBC has been prepared by John Cox, Policy Development & Quality Assurance Manager with Richard Jouault, Managing Director of Community and Social Services as Senior Responsible Officer, after consultation with service providers, Third Sector organisations, service users and carers.

3 Intermediate Care Services

3.1 The Service Case

International evidence

The UK Partnership for Older People's Projects ('POPPs') work has increased the evidence base about the benefits of prevention, early intervention and the integration of services.

Better outcomes for older people appear to be aligned with approaches which target the right people at the right time and provide personalised community responses focused on 'working with' the person rather than 'doing for' them. Based on a desktop analysis of the UK research this proposal is based on the most effective models of provision in the UK.

The preliminary work on the national POPP analysis indicates that promoting the independence of older people through a strategic shift to prevention, early intervention and intermediate care can produce better outcomes and greater efficiency for health and social care systems. Interventions across the POPP programme have produced an average of £1.20 saving in emergency bed days for every extra £1 spent on prevention (the range is between £0.80 and £1.60). These efficiency gains are on top of the £1 of additional service benefit from addressing older people's presenting needs. Quality of life has also been demonstrated to be improved through such preventative approaches.

3.2 Current Services in Jersey

Analysis undertaken by KPMG indicates that non-elective hospital admissions are driven by general medical patients, of which 53% are over 65 years old.

Currently, other than the Samares Rehabilitation Ward, there are no step-up/step-down facilities for patients who may be demonstrating exacerbation of long-term conditions and who could be managed outside of a hospital environment if services were available.

Jersey has a high number of delayed hospital discharges - 369 incidences of delay in 2010, equating to 410 delays per 100,000 population. These delays are mainly caused by the lack of availability of funded Nursing/Residential Care home placements and adults awaiting rehabilitation within Samares unit, which account for 40% and 29% of the delays respectively.

Inpatient spells are projected to increase by 33% by 2040. This increase in activity will lead to a more significant need for Hospital medical beds – a projected increase of 25% by 2020 and 72% by 2040. This significant increase in demand for hospital beds will mean that hospital capacity is insufficient within the current model of health and social services, and will start to be exceeded in the very near future.

There are currently major gaps in health and social services, which lead to the high utilisation of hospital beds. Other than the Samares unit, intermediate care services are not currently available in Jersey; community services do not operate 24 hours, there is no night sitting services and respite is limited.

The resulting pressure on hospital services will compound to unmanageable levels in the future, as demand increases. With no changes to the health and social care system and to the range and location of services, safety will be impacted, the system costs will increase significantly (predominantly due to the need for additional beds), and sustainability will be impacted.

Service design principle	Challenges of the current services
Create a sustainable service model	• The landscape of rehabilitation and community care services is limited in variety and availability • Services are not integrated • Health and social services are medicalised and institutionalised. The limited availability of care in non-acute settings is placing pressure on the hospital. As the population ages, this will increase to unsustainable levels and capacity within the hospital will be exceeded within 2 years.
Ensure Clinical/service viability	• Community services are not available 24 hours per day • Other than the Samares Rehabilitation Ward, there are no step-up/step-down facilities for patients who could be managed outside of a hospital environment • Services are not organised to reflect the needs of service users; they are arranged across various tiers resulting in inefficient use of resources • Best practice, innovative service delivery enablers are not utilised widely – for example, telehealth and telecare • Budgets for aids, adaptations and equipment are low
Ensure financial viability	• Additional acute capacity will need to be built as more beds will be required. This will incur a significant capital cost, plus the revenue cost of staffing new wards • Additional Nursing and Residential Care home placements will need to be funded • Value for money, best practice service delivery is hampered by the existing service model. It is also impacted by the lack of robust commissioning (and decommissioning)

Service design principle	Challenges of the current services
Optimising estate utilisation	• Inpatient spells are projected to increase by 33%, leading to a significant increase in demand for hospital beds, most significant increase being in medical beds. Current hospital capacity is inadequate to meet this demand • Jersey has a relatively high proportion of older adults in care homes, more than double the rate of UK comparators, and there is currently a waiting list for States-funded access to nursing home beds. Demand for these beds too is projected to increase. Anecdotal evidence from interviews with staff indicates that the demand on care home usage is partly due to the lack of available intermediate care services. Therefore, bed capacity is insufficient to meet the projected demand and there is also a shortfall in nursing beds • The estate requires upgrading and modernising
Workforce utilisation and development	• Challenges in recruitment and retention of suitable numbers of essential health and social care staff • Limited numbers of "generic" support staff • Limited development of enhanced roles for professional staff • High cost of living in Jersey and competitive remuneration packages in the UK reduce the number of available staff • Rules for entry and residency in Jersey further reduce the number of available staff
Clinical governance	• Limited service integration • Lack of holistic needs assessment and care planning
Use of business intelligence	• Limited population needs assessment to inform robust service planning and commissioning • Limited data and metrics collected on service delivery • Limited assessment of service outcomes and value for money

Intermediate Care is required in order to:

- Provide the right care at the right time in the right place by the most appropriate staff

- Maximise independent living
- Increase health outcomes and wellbeing
- Provide choice and control to individuals and their carers, helping them make informed decisions to avoid crisis
- Care for individuals with a health and/or social care need in their own home or in a community setting where appropriate
- Implement best practice and evidence-based services
- Enable and support high quality, personalised care with new technologies and with additional aids, adaptations and equipment
- Utilise estate more cost effectively, by facilitating rapid discharge from hospital, reducing unnecessary hospital admissions, long hospital stays and premature use of long-term residential care
- Provide appropriate services to meet the increasing needs of our ageing population
- Integrate existing community services and increase coordination and communication
- Enhance community services to meet our population's current and future needs
- Support and develop the role of the Third Sector
- Contribute to sustainable Primary Care, and enhance the role of GPs

The potential demand for Intermediate Care has been calculated from UK evidence. In Medway and Swale, 45% of the 871 patients in the local acute, community, day hospitals and a day rehabilitation centre were found to need intermediate care. 89 individuals were occupying acute hospital beds and 63 were in community hospitals.

The greatest identified need was for rehabilitation / therapy (86%), social and personal care (72%), Nursing (50%) and medical support (15%). Most rehabilitation need was for physiotherapy or occupational therapy.

80% of service users were assessed as being able to receive care at home, of which 40% would need minor adaptations (e.g. handrails). Only 2% (8 people) needed community hospital beds.

At the time of writing this OBC there were 200 inpatients over the age of 65 in Jersey General Hospital. Applying a conservative figure of 28%, this would indicate that approximately 46 individuals in acute care could benefits from Intermediate Care services at any one time.

3.3 Description of Service

The proposed new system of health and social services aims to be responsive, high quality care, fair, accessible and value for money. It aims to support professionals and teams to deliver sustainable services which improve outcomes for Islanders.

System-wide transformation is predicated on partnership working with the hospital, statutory agencies, Third Sector and private sector providers, Primary Care, service users, carers, Parishes and the wider local community.

The aim is to move towards an integrated health and social care system, with an increased focus on delivering care in non-institutional settings. There will be closer joint working and coordination between secondary care, Primary Care, community-based health provision, public health, social care and other States Departments such as Housing, Social Security and Education, not through structural changes, but through local organisations working together to redesign local systems around the needs of our population to deliver a seamless service.

Intermediate Care will work within the new system for health and social services to promote faster recovery from illness, reduce unnecessary acute hospital admission and reduce premature admission to long-term residential care. It will provide short term support (up to 6-8 weeks), by supporting timely discharge from hospital, preventing avoidable admission and maximising independent living, working closely with Community multidisciplinary teams of health, social services and Third Sector professionals who will integrate physical health, mental health, social care and carer support.

The Intermediate Care service will be readily accessible and easily navigated by service users, carers and staff. The team will work closely with Primary Care to undertake risk stratification and case finding (to identify individuals who are at risk of presentation at the Emergency Department either through an exacerbation of a chronic disease or high risk of developing the first signs of one) and to monitor service users deemed to be at risk.

Service users will receive a personalised and coordinated service, driven by single assessment, active case management and close liaison with Community multidisciplinary teams. Care Co-ordinators will be responsible for supporting the individual, ensuring needs assessments are completed and individual care plans are produced. The individual's named Care Co-ordinator will tailor a package to meet their needs, and where longer-term support is required, this will be arranged by the Care Co-ordinator in collaboration with the person and their carer.

The ability to make informed choices and have fair access to services depends upon having good, relevant and timely information. Assistance with understanding the information is also vital. The Citizen's Portal will provide a 'one stop shop' for information. It will be easily accessible and will contain a variety of information sources, in different formats, for both professionals and individuals.

The Intermediate Care service will be based within an Intermediate Care Resource Centre, It will comprise co-located physical, mental health, therapy and social care professionals, providing a range of services in individual's homes (a 'virtual ward'), and in a small number of community beds:

- Access to **24/7 Nursing and home care**, including night sitting
- Short term community beds providing admission avoidance (**Step-up Unit**) and rehabilitation and recovery (**Step-down Unit**) from inpatient settings
- **Telehealth and telecare**

Potential demand and need has been assessed based on UK evidence (e.g. from Medway and Swale NHS, Torbay Care Trust and the Isle of Wight PCT).

The new Intermediate Care service will deliver a change in traditional roles, moving to an increasingly community-based and 24-hour model. A more attractive career path will be developed for Nurses, Allied Health Professionals and other non-medical staff. Social care, mental health and Third Sector staff will all need the skills and competencies to work within the agreed integrated care pathways, with improved communication and sharing of roles in order to avoid duplication and gaps in the service.

Undoubtedly there will be serious recruitment challenges; however, the new opportunities offered by integrated working, enhanced skill mix and generic working will mitigate these issues.

The demand projections for Intermediate Care Services have been calculated based on a study at Medway and Swale NHS Trust, which was overseen by a cross-section of their local health economy:

The patient census produced robust and quantifiable results. It reviewed 871 patients in the local acute, community and day hospitals, a day rehabilitation centre, and the existing Intermediate Care teams. Of these 871 people, 395 (45%) were found to need Intermediate Care. 89 of them were occupying acute hospital beds and 63 were in community hospitals.

The greatest need was for rehabilitation / therapy (86%), followed by social and personal care (72%). Nursing was required by 50% of patients. The lowest need was for medical support (15%). Most rehabilitation need was for physiotherapy or occupational therapy.

Medway & Swale discovered that the intensity of need varied; need for nursing and medical support tended to be low intensity, and need for social and personal care tended to be high

Having adjusted their calculations to preclude those already receiving Intermediate Care services, 28% of those surveyed were assessed as requiring Intermediate Care. Applying this percentage to Jersey inpatients (200 in 2010) would indicate that approximately 46 individuals in acute care could qualify for Intermediate Care services. Based on the Medway and Swale evidence it is estimated that approximately 80% of these individuals could receive their Intermediate Care service at home, and 10 individuals at any one time would require a Step-up or Step-down bed (4 Step-up beds and 6 Step-down beds). In addition, up to 4 Residential Step-up/down beds would be available for spot purchase).

Single Point of Access

The Single Point of Access will work closely with all services, including Primary Care, to undertake risk stratification and case finding. Individuals at risk of admission to hospital will be targeted, in order to proactively design care based on their needs, with the aim of avoiding an exacerbation and admission.

The Single Point of Access will also accept and allocate all referrals.

A named Care Co-ordinator will be identified for each individual, if the individual does not already have one. They will undertake assessment of need, and will work with the individual to understand their preferences.

The Care Co-ordinator will then produce a holistic care plan, and will ensure the individual accesses appropriate services at the right time.

They will also monitor the service user's progress through the care pathway and ensure an effective handover to the Community multidisciplinary team, at the end of the service user's intermediate care phase.

3.3.1 24/7 Nursing and home care

A survey of all residential and nursing care homes in Jersey was undertaken in 2010. The total number of individuals in care at that time was 1,018.

The tables below illustrate this and present the information by gender. Overall, there is a 70:30 split in favour of women.

Category of resident	F	M	Total	F%	M%
Under 65's	54	52	106	51%	49%
Over 65's - Private care	569	218	787	72%	28%
Over 65's - H&SS-owned	79	45	124	64%	36%
All - Total	**702**	**315**	**1017**	**69%**	**31%**

Jersey has a high number of delayed hospital discharges - 369 incidences of delay in 2010, equating to 410 delays per 100,000 population. The lack of availability of funded Nursing / Residential Care home placements accounts for 40% of the delays. Increased availability of short term 24/7 Nursing and home care could help to reduce delayed discharges and increase the numbers of Islanders being cared for at home rather than in Nursing / Residential Care.

It is estimated that the Intermediate Care Service would enable 15 service users per week to receive intensive support in their own home and consequently avoid an unnecessary admission to hospital or nursing/ residential care.

District Nursing and home care services will be expanded, both in terms of numbers of staff (both District Nurses and Health Care Assistants) and in terms of hours of operation, in order to provide support to more people in their own homes throughout the day and night.

The volumes, intensity and caseloads of this service will need to be reviewed, to ensure that staff are meeting needs and prioritising their care and support.

A night sitting service will also be developed to provide short term support to those individuals who are at most risk in their own homes during the evening. This will also be supported where appropriate by telecare which can provide, for example, falls monitoring and enuresis sensors.
Example: Torbay Care Trust and the Isle of Wight PCTs have achieved the lowest bed-day use in England for both over-75s and over-85s – despite (or perhaps because of) already having populations significantly more aged than the UK as a whole. Both transformed their community health and social care services in order to provide more flexible and accessible health and social care for older people at home, promptly and collaboratively delivered. By responding to changing clinical needs and varying dependency with "right care, right place, right time", such services have greatly reduced the need for more expensive hospital care. More importantly they

enable older people to remain at home safely through minor illness and despite increasing mental and physical frailty.

Torbay has also greatly reduced the number of care home placements from hospital, and in the Isle of Wight free personal care at home, funded by the Local Authority, has allowed more and more older people to live longer at home.

In both approaches the establishment of integrated community health and social care teams helped to facilitate the development of a wider range of Intermediate Care services. Teams worked closely with General Practices to provide care to older people in need and to help them live independently in the community. The appointment of Care Co-ordinators was an important innovation in harnessing the contribution of all team members in improving care.

3.3.2 Step Up Unit

The Step-up Unit will provide short term care for individuals who do not need acute care but are too unwell to be cared for their own homes. This will help to avoid unnecessary admissions to acute care and avoid a culture of dependence.

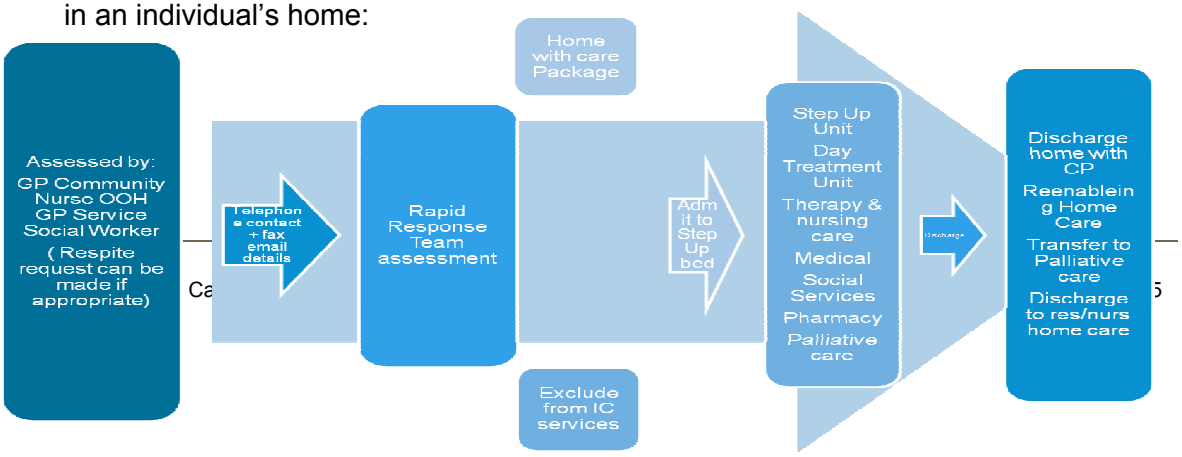
Step-up and Step-down care provided outside the acute hospital will enable individuals who strongly value their independence to receive more support than is currently available to avoid admission (Step-up) and to leave acute hospital and get ready to return home (Step-down).

Ideally, Step-up and Step-down services will be available 24 hours per day, every day of the year. Services will be easy to access and seamless for the service user.

The way in which care is delivered will be primarily determined by clinical need and be managed in partnership between organisations as a truly integrated system, with a co-ordinated approach to care which encourages active patient and carer choices and input.

Demand will need to be managed proactively to ensure individuals are cared for in a primary or community setting wherever possible and that hospital care is provided only for those individuals who can only be safely treated in hospital. Service users, carers and professionals will be provided with information regarding service availability and choice, and will be supported in understanding when it is most appropriate to access Intermediate Care services.

The diagram below demonstrates the 'Step-up' pathway. It illustrates that the Step-up Unit is one element of this pathway, and that the majority of services will be delivered in an individual's home:

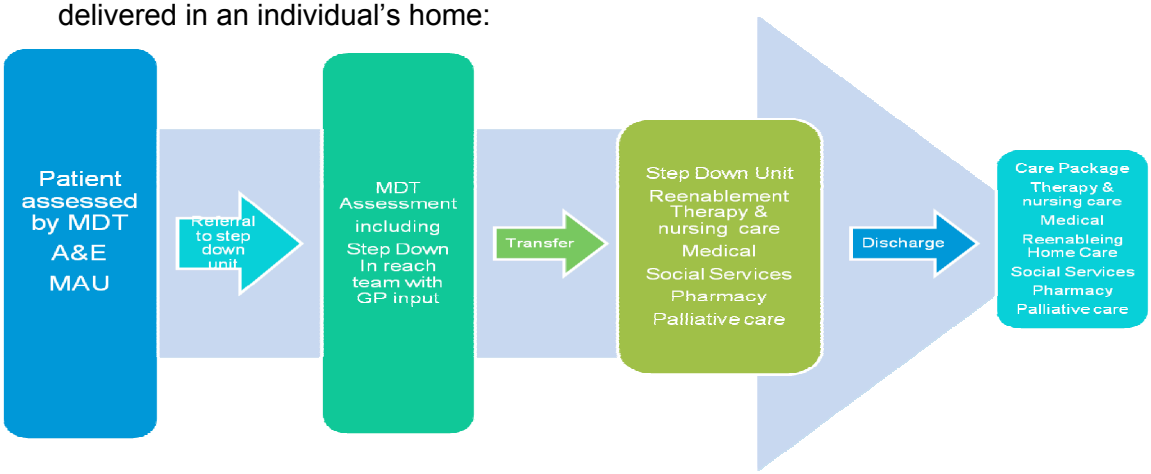


3.3.3 Step-down Unit

In 2010 there were 369 instances of delayed discharge, which accounted for 5,070 bed days .40% of these delays were caused by a lack of funded Nursing/Residential care home placements and 29% were for adults awaiting rehabilitation within Samares unit.

The Step-down Unit will provide an alternate to hospital care, providing short term support for those who are fit for acute discharge but due to their other care needs, (e.g. the need to re-learn some activities of daily living), cannot return home.

The diagram below demonstrates the 'Step-down' pathway. It illustrates that the Step-up Unit is one element of this pathway, and that the majority of services will be delivered in an individual's home:



Step-up and Step-down services will be provided by Nurses and HCAs, supported by other health and social care staff. It is intended that the services will be delivered in partnership between HSSD and Third Sector providers.

It is assumed that the Intermediate Care service is co-located within an Intermediate Care Resource Centre. This is essential to ensure the most effective use of estate and workforce. Options for the location of the Intermediate Care Resource Centre include:

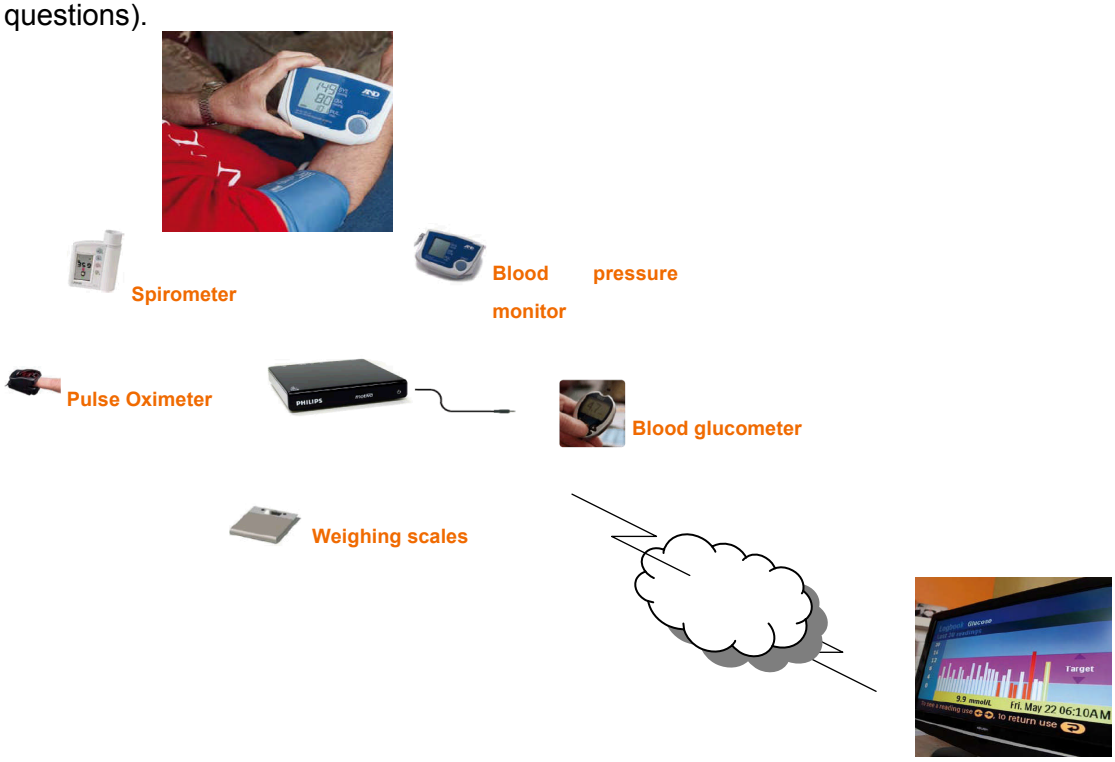
- Westmount
- The Limes
- Sandybrook

- Clinique Pinel
- Poplars and William Knott

3.3.4 Telehealth and telecare

Telehealth and telecare are also known as 'Advanced Assistive Technology'. They comprise a range of solutions to enable individuals to live independent lives in their own homes, by providing monitoring of health vital signs such as blood pressure, or risks such as flooding and falls.

Telehealth and telecare are enablers, which support redesigned care pathways. They enable a professional to be alerted should a problem arise (in telecare, through an alarm system), or they enable the professional to monitor an individual's health (in telehealth, through sending daily vital signs readings and/or responses to health questions).



Telehealth and telecare, working within a redesigned pathway of care, can lead to:

- Reduction in risk for those living at home
- Rapid and appropriate response to emergencies
- Improved condition management
- Delayed admission to residential or nursing care
- Safer discharge from hospital or care
- Reduction in admissions to hospitals
- Reduction in falls
- Reduction in care packages
- Increase in choice, control and confidence
- Increase in self care

- Reduction in anxiety for carers

The Whole System Demonstrator programme was set up by the Department of Health in May 2008 to assess whether telehealth and telecare are value for money and effective, to provide a clear evidence base for investment decisions and to demonstrate how technology can supports people to live independently, take control and be responsible for their own health and care.

The programme is the largest randomised control trial of telehealth and telecare in the world, involving 6191 patients and 238 GP practices across three sites, Newham, Kent and Cornwall.

The initial findings published in December 2011 show that, if delivered within an effective system, telehealth and telecare can substantially reduce mortality, reduce the need for admissions to hospital, lower the number of bed days spent in hospital and reduce the time spent in A&E:

- a 15% reduction in A&E visits
- a 20% reduction in emergency admissions
- a 14% reduction in elective admissions
- a 14% reduction in bed days and
- an 8% reduction in tariff costs.

More strikingly they also demonstrate a 45% reduction in mortality rates. The UK Government has set out an ambition to extend the use new and emerging healthcare technologies to 3 million people over the next 5 years.

In 2009 the London Joint Improvement Partnership Efficiency Telecare Programme Survey reviewed 23 London Boroughs using Telecare. It concluded that detailed evidence of the effectiveness of Telecare was still limited, however, anecdotal evidence was clear that Telecare had:

- Prevented hospital admission
- Reduced domiciliary care need
- Facilitated hospital discharge
- Provided additional support to carers
- Reduced community matron visits
- Supported learning disability placements in the community
- Reduced residential care placement
- Reduced overnight care packages
- Replaced a waking/sleeping service for service users with learning disabilities.

Five areas were able to report that savings made were being reinvested into Telecare provision and prevention workstreams.

North Yorkshire County Council (NYCC) has introduced Telecare support for everybody needing Adult and Community Services support, as part of the range of mainstream personalised solutions designed to suit each individual's circumstances. In September 2008, analysis of 132 new users of Telecare highlighted an average saving of £3,600 per person per year - a 38% reduction in care costs. In the first year of the programme, NYCC reportedly saved over £1 million that would otherwise have been spent on domiciliary or residential care, and in August 2009, they had 12,265 Telecare users.

Essex County Council offers new users aged 85 and older a completely free Telecare service for one year, covering installation, equipment and a care line connection. The service is being made available to these older residents without reference to other eligibility criteria. Initial indications show for every £1 spent on Telecare, £3.82 has been saved on traditional care.

The initial estimate of the number of telecare users in Jersey is 40 in the first full year of operation. By 2015 we expect this to rise to over 700 people.

3.4 Activity Impacts

Service	Activity Impact
24 Hour Nursing and Home Care Service, including night sitting	• 15 service users per week in 2013 estimated to increase to 180 in 2015
Step-up Unit	• 6 beds Nursing Step Down • 4 spot purchased beds Residential Step Up/Down
Step-down unit	• 4 beds Nursing Step Up
Telehealth and telecare	• Estimate of 40 service users in year 1, with a minimum of 700 service users in receipt of telecare services by 2015

Activity and need projections for Intermediate Care need to be further analysed as the Full Business Cases developed.

3.5 Workforce Impacts

Service	Staff	Number	Comment (e.g. timing)
24/7 Nursing and home care, including night sitting	Nurses Health Care Assistants	8 FTE 36 FTE	Phased in from 2012 over 4 years
Rapid Response Team	Nurse CPNs Social Workers Senior Social worker	1 FTE 2 FTE 2 FTE 1 FTE	All staff from 2016

	Occupational Therapists Occupational Therapists Physiotherapy OT Assistant Team Assistants Health Care Assistants	1 FTE 1 FTE 1 FTE 1FTE 4FTE 8 FTE	
Community Reablement	Occupational Therapists OT assistant & Technician Physiotherapists Psychology S&L Therapists Social Workers Dietetics	2 FTE 2 FTE 1.5 FTE 0.4 FTE 2 FTE 2 FTe 0.5 FTE	Phased in over 2016 - 2018
Step-up Unit	Nurses HCAs Support from other Health and social care staff	1 FTE 8.75 FTE	From 2013
Step-down Unit	Nurses HCAs	1 FTE 8.75 FTE	From 2013
Telehealth and telecare	No additional staff		From 2013

3.6 Infrastructure Impacts

Estates: The proposed Intermediate Care service is predicated on the assumption that the various component parts of the service are co-located. This is essential to ensure the most effective use of workforce and to facilitate coordination, communication and operational integration. Consequently, the proposal is to site the service in an Intermediate Care Resource Centre.

On a working assumption that the Community multidisciplinary teams for older adults will be located at Overdale, and given the range of available estate options available for 2013 – 2015, the preferred location for the Intermediate Care Resource Centre is Westmount. However there are a range of other potential locations including:

- The Limes
- Sandybrook
- Clinique Pinel
- Poplars and William Knott

The proposed Intermediate Care service is predicated on the assumption that the service is co-located (other than any Step-up and Step-down beds which are contracted from the private sector.) Co-location is essential to ensure the most effective use of the workforce.

IT: From 2014, health and social care professionals, children, parents and families will access information via a citizen's portal. The citizens' portal will enable care to be designed by the individual and care professional, based on the individual's needs and, where appropriate, they choices. It will also enable care packages to be delivered and monitored in a coherent and co-ordinated manner.

The citizen's portal will provide real time information regarding service availability, self care, family support groups etc, to assist the child and family with feeling more in control of their situation. The citizen's portal is included within the IT cross cutting workstream.

To streamline processes and support a single care pathway for service users/patients, a new IT system will be required with integration of current IT system. This could cost up to £1m.

3.7 Service Delivery: Benefits

The new Intermediate Care service will provide short tern support to enable patients and service users to be cared for in their own homes, avoiding unnecessary admissions to hospital, reducing lengths of stay and thereby maintaining independence and wellbeing for as long as possible.

The service will be integrated, and will work closely with the Community multidisciplinary teams. It will be aided by the citizens' portal, which will provide real time information on service availability, and by telehealth and telecare, which support individuals in their own homes.

The Care co-ordinator role will improve service user/patient experience as well as provide service users/patients with choice, which can further increase confidence and a sense of control.

Anticipated benefits include

- Faster and easier transition between acute and community services
- Reduced Emergency Department presentations and unnecessary admissions
- Integration, providing a coordinated service operating for the benefit of patients / service users and carers
- Increased independent living by supporting people in their own homes where possible and supporting them "to do" rather than be "done to"
- Cost deferment of £8.5m for the period 2013 – 2015
- A more attractive career path for a range of professionals
- Reduction in acute admissions
- Reduction in delayed transfers of care
- Reduced hospital length of stay
- Reduction in the rate of admissions to residential and nursing homes
- Reduction in hospital acquired infections

- Reduction in test / drug costs
- Reduced pressure on the Long Term Care Benefit
- Increase in the number of people maintained in the community, 3 and 6 months after leaving Intermediate Care
- Treating service users promptly, and providing the appropriate support to enable people to return to independent living sooner and require less longer term (institutional) care in the future

In addition, the intangible benefits include:

- Improved integrated working, coordination and communication between constituent organisations
- Closer working between a range of care professionals, meeting and treating individuals' needs
- Care professionals able to prioritise their workload, with reduced unnecessary visits to patients
- Increased support for Third Sector organisations
- Reduced time spent travelling (either for patients or professionals)
- Increased confidence in service users, leading to reduced exacerbations
- Increased confidence in carers
- Time saved by referrers by having a Single Point of Access
- Improved efficiency of the service by triaging calls and sending the right service, at the right time, in the right place for the service user
- Personalisation of care
- Improved service user experience through receiving care across a seamless pathway

3.8 Service delivery: risks

Anticipated risks include:

- A lack of acceptance that services of the need for change
- Disagreement regarding service provision – exacerbation by a current lack of robust commissioning and decommissioning
- Additional investment not available
- Reticence to develop and change roles
- Continued recruitment and retention challenges
- Lack of capital investment in IT systems and
- Changes in funding streams and charging policy, including a lack of clarity on the likely impact of the LTCB
- Lack of available information and data, both for commissioning / decommissioning and for assessing benefits, outcomes and value for money
- Challenges with information flow and accessibility
- Data protection
- Unrealistic expectations from service users and professionals
- Accommodation availability for Intermediate Care Resource Centre
- Current state of the estate from which services are being / will be delivered – need for urgent upgrade in some locations

- Lack of an integrated and/or shared IT system

3.9 Enablers

The focus of the Intermediate Care service is to support local organisations working together across the island to ensure that the needs of the population are met through suitable integrated community care services. Third Sector involvement is a key component, and Parishes and other community based organisations will have the opportunity to support the delivery of better services, and to support vulnerable members of our community to remain independent for as long as possible.

The Intermediate Care OBC supports 3 other OBCs (End of Life, Dementia and Long Term Conditions).

In addition this proposal resonates with:

- Developments in the Housing Department
- The development of the Long Term Care Benefit
- Renegotiation of the Family Nursing & Home Care SLA
- New Registration of Care Law
- New Hospital Charges Law

All of these, with the exception of the last one, are part of the Policy Development & Quality Assurance Manager's work plan.

Interactions will also be required with:

- The entire range of services provided for individuals and their carers (including Primary Care)
- Other States Departments
- Older Adults Policy group

And with:

- HSSD Business Plan 2012
- States Strategic Plan
- Medium Term Financial Plan
- Health and Social Services White Paper
- HSSD Community & Social Services Business Plan
- Long Term Care Benefit
- Service Level Agreements with Third Sector providers, including Family Nursing & Home Care
- Registration of Care Law
- Transport
- Integrated IT
- States Housing Department outsourcing
- Development of extra care sheltered Housing

Workforce:
The development of intermediate care will require workforce development, as new ways of working will be required, both in terms of skills, locations and care delivery.

Mechanisms will also be required to address the existing recruitment and retention challenges, both in terms of additional staff and changing skills and ways of working.

More generic staff will be required, in particular Health Care Assistants. These individuals will need to be fully trained and supported.

Roles for other professionals will evolve, for example, through enhanced roles in Nursing such as Community Matrons.

Estates:
As noted above, a suitable location will be required for the Intermediate Care Resource Centre. This will need to be close to, or co-located with the Community multidisciplinary teams for Older Adults.

Some existing estate is also in urgent need of refurbishment.

Commissioning:
New Intermediate Care services will be robustly commissioned. Services will be provided transparently, with visibility on activity, outcomes and value for money. The provider market will be supported, in order to sustain Jersey's vibrant Third Sector and other providers. This will include the development of an Approved Provider List, and services developed and delivered in partnership.

Metrics and outcome measures, including Patient Reported Outcomes, will be collected in order to assess the benefits provided by IAPT, to contribute to future commissioning and to demonstrate value for money.

Primary Care:
Primary Care services are integral to the delivery of intermediate care. This includes case finding, assessment and provision of ongoing care and the transition to supporting individuals long term.

IT:
IT and informatics will be critical to the service's success, as these will support multidisciplinary community working, support individuals in their own homes and provide visibility of outcomes, activity and benefits.

Awareness and information will require a range of media, including the citizen's portal.

In addition, IT will be required to support the integration of intermediate care with the range of other services in health and social care, e.g. the Community multidisciplinary teams.

Telehealth and telecare are essential elements of the new Intermediate Care service.

Informatics:
Data and information will need to be improved in order to maintain the register, to monitor activity and to assess the benefits (both qualitative and quantitative, and in terms of outcomes).

Finance:
There is currently a lack of clarity regarding the impact of the Long Term Care Benefit on the Intermediate Care service.

Legislation:
- Regulation of Care Law
- Approved Providers List
- Hospital Charges Law
- Long term Care Benefit

3.10 The Financial Case

3.10.1 Revenue costs

The total additional recurrent revenue cost for the Intermediate Care service (at 2015 prices) increases to £2.9m by 2015.

The revenue cost is estimated to be:
2013 - £1.3m
2014 - £2.3m
2015 - £2.9m.

Non-recurring implementation costs are estimated at £199k in 2013, £58k in 2014 and £27k in 2015.

Summary costs 2012 - 2015	2013	2014	2015	TOTAL
	£'000	**£'000**	**£'000**	**£'000**
Implementation Costs	199	58	27	**284**
Recurrent revenue costs	1,325	2,338	2,888	**6,551**
Capital costs		538		**538**
TOTAL				

The service will require an additional 96 FTE Nurses and Health Care Assistants, plus other professional staff, of whom 63.5 will be recruited in the first three years (2013-2015). In addition there will need to be an additional sessions from a range of clinicians including podiatry, speech and language therapy, psychiatric nursing and dietetics.

3.10.2 Revenue savings

A number of benefits are anticipated by the second quarter of 2015, including:

- Cost containment of £3.3m, from a significant reduction in the demand for hospital beds. This is estimated to equate to 24 hospital beds and 1 nursing home bed.
- A reduction in delayed discharges
- A reduction in avoidable admissions
- A reduction in unnecessary attendances at the Emergency Department

3.10.3 Capital costs

£538k of capital expenditure is required during 2013 – 15.

3.10.4 Funding

It is envisaged that the Intermediate Care service will be provided at no charge to patients / service users

.

The alternative option is to consider if Intermediate Care could be funded from the Long Term Care Benefit as an "invest to save" approach. However the co-payment requirement could be a disincentive for patients / service users.

3.10.5 Managing risk

Due to the nature of this scheme there is an inherent risk of increasing capacity and costs within the community services while not achieving the level of intended cost deferments in the acute hospital sector. To minimise the financial risk we intend to:

- Identify robust metrics for monitoring quantitative benefits
- Monitor the Intermediate Care service to ensure that maximum efficiency is achieved delivering a value for money service
- Monitor the acute metrics to ascertain impacts in the Emergency Department, non-elective admissions and length of stay
- Make staged investments to ensure the expected benefits are being realised.

3.10.6 Sensitivity analysis - scenarios

Consideration will need to be given to potential changes in assumptions in:

- Estates - Early agreement on the location of the 6 Step-down beds required
- FN&HC – Renegotiated SLA from 2013 on must reflect OBC priorities
- Domiciliary and Nursing agency sector – Full use of the established Provider Workshops should be made
- Residential & Nursing Home sector – Full use of the established Provider Workshops should be made
- Voluntary sector
- Parish – Ongoing work needed to develop the FBC with the Parishes
- Emergency Department Activity
- Primary Care -funding has been included in 2013 within the 24/7 community service for GP costs prior to the introduction of nurse prescribing in 2014

- Carers – new Carers Strategy from 2013 required which will need to reflect the principles embodied in Intermediate Care

3.10.7 Assessment of affordability and value for money

Based on the total anticipated activity, the revenue cost for the Intermediate Care service is estimated to be £6.5m over 2013 – 2015, with £0.5m of capital expenditure required during the same period.

It is anticipated that the annual cost containment of £3.3m will be achieved by 2015, this being predominantly the release of acute beds to meet other increasing demand.

3.10.8 Verification processes and assumptions

The following assumptions have been made:

- Staffing – it will be possible to recruit and retain the necessary staff
- Activity prevalence – based on the recent KPMG and UK analysis
- GP funding – that this will be resolved
- Parish – that low level preventative schemes will be developed

3.11 Implementation Actions and Timescales

The following represent a proposed timeline for developments which will need review if this OBC progresses to a Full Business Case.

		2012				2013				2014				20	
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
24/7 Nursing and home care	Funding agreement for new model														
	Recruitment and training of additional staff														
	Establishment of initial community team														
	Service commences Second phase of recruitment														
Single care pathway	Review current service provision across health, social care and the Third Sector														
	Procurement of an IT package to develop the information hub														
	Redesign the pathway with Single Point of Access and Care Coordinators														
	Consultation and training on new assessment and Care Coordination process														
	Development and implementation of redesigned assessment and Care Coordination process														
Intermediate Care Resource Centre and Step-up/ Step-down Unit(s)	Business planning for the development of the site for the Intermediate Care Resource Centre														
	Capital investment agreed														
	Recruitment of additional staff for Step-up/Step-down Unit(s) commences (if relevant)														
	Training of new staff commences														
	Partial start-up of service														
	Recruitment begins for the full complement of staff														
	Full service goes live														
Telehealth and telecare	Scoping and service specification														
	Tendering of service														
	Review and design of operational procedures														
	Training														
	Service available														

4 Stakeholders

4.1 Stakeholder involvement in service model development

The Working Group that assisted the development of this OBC and service model were:

- Richard Jouault H&SS
- Dr Michael Richardson H&SS
- Ian Dyer H&SS
- Helen Hooper H&SS
- Gill Rattle H&SS
- Pam Massey FN&HC
- Eileen Crabbe JCF
- Gloria LeLivre JCF
- Paul Cotillard H&SS
- Dr Gareth Hughes GP
- Dominique Caunce Housing
- Hugh Neylan KPMG
- Mark Richardson E&SS
- John Cox H&SS

The Working Group identified that going forward, the key stakeholders for development of the FBC and implementation of the service change are:

Stakeholder	Responsible	Accountable	Consulted	Informed
Professional H&SS Staff SRO	✓	✓	✓	✓
Professional Other Staff	✓		✓	✓
Voluntary Sector	✓		✓	✓
Provider Sector	✓		✓	✓
Service Users and Carers				✓
Provider Market: Care Homes Domiciliary Care agencies Family Nursing & Home Care				✓
Workforce Training				
GPs			✓	✓
Parishes				
Social Security Department	✓		✓	✓
Housing Department			✓	✓
Planning Department				
Treasury & Resources Department			✓	✓
Ministers				
Day Centres				
HSSD Community Teams				✓

A full outline of stakeholder involvement is presented in the Appendix in Section 6.

4.2 Communications to Internal Stakeholders

Stakeholders have been informed that once the OBC has been agreed, they will be involved in co-producing the Full Business Case. Stakeholders will also be involved in the consultation process for the White Paper.

4.3 Communications to External Stakeholders

Providers, including Third Sector organisations are communicated with regularly via the Provider Workshops run by Community and Social Services.

Regular communication with the Parishes is urgently required.

The White Paper consultation process will include other external stakeholders.

5 Conclusion and Next Steps

5.1 Conclusion

Gaps exist in the range and availability of community services. Consequently, many services are medicalised and are predominantly hospital-based. This leads to pressure on beds and reduced choice for patients, service users and carers.

International best practice identifies a need for Intermediate Care service to be developed, to make available the short-term services required in order to provide care for individuals in their own homes for as long as possible, supporting independence and relieving pressure on the acute and residential / nursing home sectors.

Services need to be developed as a priority, as the challenges are immediate. These challenges will compound further in the future as our population ages.

Intermediate care services will comprise 24/7 care in community settings, Rapid Response, night sitting and community reablement. These will be supported by telehealth and telecare. Step-up and Step-down beds will also be available, in addition to the 'virtual ward' model, which will work closely with the Community multidisciplinary teams.

The preferred model will be centred around an Intermediate Care Resource Centre, which will be located jointly, or close to, the Community multidisciplinary team, in order to further support integration, communication and co-ordination.

A recurring additional revenue investment of £1.3m in 2013, £2.3m in 2014 and £2.9m in 2015 is required. This should deliver cost containment of £3.3m per annum 015.

5.2 Capacity and project management requirements

The development of the Full Business Case will require additional resourcing.

In addition, project management resource is required from 2012 in order to manage the developmental and delivery stage of this project.

The Project Manager will require support from Information Services and Jersey Property Holdings.

5.3 Next steps

- Identify potential demand
- Explore and develop indicators and outcome measures
- Identify key challenges of workforce development
- Ensure OBC is endorsed by the Older People's Policy Group
- Continue engaging with stakeholders
- Complete the Full Business Case, including developing detailed service design.

This OBC will be finalised in the Full Business Case (FBC). The FBC will aim to:

- Verify the continuing need for investment in the project
- Demonstrate that the preferred solution represents value for money
- Establish that the HSSD is capable of delivering the project
- Confirm that the planned investment is affordable
- Demonstrate that HSSD is capable of managing a successful implementation and subsequently sustaining success
- Provide an essential audit trail for decisions taken
- Identify how benefits will be realised and monitored
- Confirm the investment decision

The FBC will need to be approved and provide sufficient assurance to senior management that the project can proceed and resources can be committed. The FBC is used as a reference point in the event of any business changes during the project lifecycle and in the event of a post project review or equivalent major review following implementation of the project.

Sign off by Minister

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6 Appendices

Appendix 1 - Benefits log

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
Improvement in quality of life	Service users Carer Family	Ongoing	JASS Survey	JASS Survey 2010	10% improvement in QALY measure from 2010
Reduced pressure on Long Term Care Benefit	Taxpayers	Ongoing	Reduction in proportion and amount of long term funding for institutional care in comparison to home care	Long Term Care analysis prior to introduction of LTCB	15% annual reduction
Reduced hospital costs by: • reduced hospital admissions • reduced hospital acquired infections • reduced test / drug costs	Service user Carer	Ongoing	Regular analysis utilising TrakCare system	2012 figures	Reduction of 25 hospital bed days p.a and 1 Nursing home bed p.a
Reduced Emergency Department presentations	Acute hospital Service users Staff	On-going	Number of inappropriate admissions (Acupid, UTI)	TrakCare	10% Reduction

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
Reduced proportion of older people being admitted to nursing homes / residential homes	Service users Family	Ongoing	Proportion of older people being admitted to institutional care	2007 – 2010 referral rates	10% reduction
Defer the age at which institutional care is required	Service users Family	Ongoing	Reduction in age on admission	Jersey Care Federation Law	10% reduction
Move of people from institutional care back to their own homes	Service users Family	One-off over first three years	Discharge no from institutions to home	2010 long term care survey of people in long term care	10 people over 3 years
Increased choice	Service users Family	Ongoing	Annual analysis of development of personalisation of care tool	None	90% patient choice
Reduction in avoidance hospital admissions	Acute hospital beds Service users Family Staff	Ongoing	Number of inappropriate admissions (Acupid, UTI)	TrakCare	10% Reduction

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
Reduced length of stay in hospital	Acute hospital beds Service users Family Staff	Ongoing	Reduction in length of stay	TrakCare	10% reduction in bed days
Reduced delayed discharge (transfers of care)	Acute hospital beds Service users Family Staff	Ongoing	Reduced number of delayed transfers of care Reduced length of stay	TrakCare	10% reduction in bed days
Reduced deaths in hospital Planned end of life in home environment	Acute hospital beds Service users Family Staff	Ongoing	Increase in end of life in home	? 60% hospital	National Average
Cost deferment of £8.5m for the period 2013 – 2015	Acute hospital beds	Ongoing	Savings delivered	Reduction in targeted bed days	26 beds bed days per annum
Integration, providing a coordinated service operating for the benefit of patients / service users and carers	Integrated single assessment service and care management	Ongoing	Service user feedback Transaction cost efficiencies	Current service configuration	Single point of access for all service users 2013

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
A more attractive career path for a range of professionals	Hospital and Community staff	Ongoing	Staff survey IPR and annual appraisal	Current analysis of staff attitudes	Staff satisfaction levels
Increase in the number of people maintained in the community, 3 and 6 months after leaving Intermediate Care	Service users Family	Ongoing	Case finding of Intermediate Care service users	Current FN&HC analysis	10% improvement
Treating service users promptly, and providing the appropriate support to enable people to return to independent living sooner and require less longer term (institutional) care in the future	Service users Integrated single assessment service and care management Intermediate care	Ongoing	Service user feedback Annual analysis of institutional care figures	Long term care survey 2010	Outcome of improved client satisfaction
Improved integrated working, Closer working between a range of care professionals, meeting and treating individuals' needs	Integrated single assessment service and care management	ongoing	Service user feedback and transaction cost efficiencies	LEAN analysis of current pathway	Integrated multidisciplinary assess and care management team by 2013

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
Care professionals able to prioritise their workload, with reduced unnecessary visits to patients	Assessment Care management	Ongoing	Caseload Performance management	Current caseloads LEAN analysis	Introduction of workload management system
Increased support for Third Sector organisations	Commissioning Carers strategy	Ongoing	Development of a Cares Strategy Third sector commissioning	Current position	Carers Strategy 2013 2016
Reduced time spent travelling (either for patients or professionals)	Telecare Telehealth Locality focus Care management	Long term	Workload management	Current position	Reduction of 15% by 2015
Increased confidence in service users, leading to reduced exacerbations	Intermediate care Reablement service Rapid response	Long term	Analysis of FN&HC data and Hospital admission data	KPMG analysis	10% reduction
Increased confidence in carers	Carers strategy	Long term	Carers strategy recommendations	Existing strategy outcomes	Achieve all recommendations by 2016

What is the benefit	Type	Short term or long term?	How will the benefit be measured	What is the baseline	Target
Time saved by referrers by having a Single Point of Access	Referrers Service users And Family	Long term	Service user feedback and transaction cost efficiencies	LEAN analysis of current pathway	Reduction in waiting times
Improved efficiency of the service by triaging calls and sending the right service, at the right time, in the right place for the service user	Referrers Service users And Family Staff	Long term	Performance management	LEAN analysis of current pathway	Outcome of improved client satisfaction
Personalisation of care	Service user Provider sector	Ongoing	Service user feedback and analysis of transaction cost efficiencies	Current level	Annual 20% increase in numbers of personalised care packages
Improved service user experience through receiving care across a seamless pathway	Referrers Service users And Family	Ongoing	Service user feedback	Current level	Annual review

Appendix 2 - Stakeholder log

Stakeholder	Responsible	Accountable	Consulted	Informed
Professional H&SS Staff SRO	✓	✓	✓	✓
Professional Other Staff	✓		✓	✓
Voluntary Sector	✓		✓	✓
Provider Sector	✓		✓	✓
Service Users and Carers				✓
Provider Market: Care Homes Domiciliary Care agencies Family Nursing & Home Care				✓
Workforce Training				
GPs			✓	✓

Parishes				
Social Security Department	✓		✓	✓
Housing Department			✓	✓
Planning Department				
Treasury & Resources Department			✓	✓
Ministers				
Day Centres				
HSSD Community Teams				✓

Appendix 3 - Risk log

Risk	**Likelihood** *(High / Medium / Low)*	**Impact** *(High / Medium / Low)*	**Overall Risk Rating** *(Likelihood x Impact)*	**Controls/Actions**
Lack of acceptance of the need for change	M	H	M/H	• Strategic ownership • Consultation
Disagreement regarding service provision – exacerbation by a current lack of robust commissioning and decommissioning	H	M	H/M	• Engagement of 3rd sector • Carers strategy
Additional investment not available	H	H	H	• Robust business case • Audit service delivery • Prioritise investment
Reticence to develop and change roles	H	M	H/M	• Resource Training. • Add to timeline. • Add to Resources level.
Lack of available staff	M	H	H/M	• Workforce development plan

Risk	Likelihood *(High / Medium / Low)*	Impact *(High / Medium / Low)*	Overall Risk Rating *(Likelihood x Impact)*	Controls/Actions
Retention of appropriate staff	H	H	H	• Key worker accommodation • Develop generic care workers • Quality training provision
Lack of clarity, or lack of availability of GP funding	H	H	H	• Identify GP funding streams
Information flow around the system. Data protection	H	H	H	• Agree protocols
Disagreement from public on proposed service model	M	M		• Green / White Paper consultation
Unrealistic expectation from service users and professionals	H	M	H/M	• Monitor – survey and focus groups • Involve in developing FBC
Risk averse service	H	H	H	• Manage risk • Risk Policy, criteria • Risk for carers
Lack of available information and data, both for commissioning / decommissioning and for assessing benefits, outcomes and value for money	H	H	H	• C&SS develop commissioning capacity • LEAN Methodology

Risk	**Likelihood** *(High / Medium / Low)*	**Impact** *(High / Medium / Low)*	**Overall Risk Rating** *(Likelihood x Impact)*	**Controls/Actions**
Accommodation availability for Intermediate Care Resource Centre	M	H	M/H	• Review current estate • Explore 3rd sector options
Lack of political will	M	H	M/H	• Public consultation
Underestimated level of demand	M	M	M/M	• Single point of access • Multi-Skilled assessment team • SAP
Changes in funding streams and charging policy	H	H	H	• HSSD/SSD Strategic group • HSSD/SSD Operational group
Lack of capacity in Third Sector / Parish	H	M	H/M	• 2012 Consultation

Appendix 4 - Issue log

Description	**Impact** *(High/Medium/Low)*	**Lead**	**Comments** *(What can we do to work around the issue?)*
Transport – Staff and Patient	M	IC Lead	Day services review and CSR should assist in this area
Current state of the estate from which services are being / will be delivered – need for urgent upgrade in some locations	H	C&SS	Review current stock
Lack of an integrated and/or shared IT system	H	IC Lead	Funding is needed in the Transition Plan
States Housing and development of extra care housing	H	IC Lead	Develop a joint workstream with Housing

Appendix 5 - Dependency and enabler log

Description of Dependency	Dependency Lead	Dependency 'Strength'	Comments
Transport – staff and patient	HSSD	M	
Long Term Care Benefit	SSD	H	Clarify relationship Issue of transfer from IC to LT care
Inspections and Registration	CB	H	Update on progress. What happens if this falls over
Integrated IT	C&SS	H	Progress report
Planning for extra care and sheltered housing	JC	H	Progress report
Housing Department outsourcing	DC	H	2014 – opportunity to develop extra care sheltered housing – Parish – Housing – Not for profit
Early confirmation of direction of travel to work in system redesign for 2013	JC	H	Will be clarified as part of FBC process

Appendix 6 – Financial Analysis

Note: the costs shown in the table below, and throughout the document, have been inflated to reflect the relevant prices for each year.

Initiative Title	Initiative Description	Assumptions	Implementation Date	Additional FTE	Total Implementation costs 2012 - 2015 (£000's)	2013 Revenue (£000's)	2014 Revenue (£000's)	2015 Revenue (£000's)	2013-15 Capital (£000's)
				No.	£	£	£	£	£
Infrastructure costs for Intermediate Care Service	Estates Refurbishment Costs	Sufficient capacity exists to accommodate the 6 Step Down beds and resources required for this service	Jan-13		-	-	-	-	538
Infrastructure costs for Intermediate Care Service	IT Equipment / Tablets / Mobile Phones etc		May-13		-	28	43	44	-
Infrastructure costs for Intermediate Care Service	Day Treatment Centre Estates Set Up Costs	Modelled on IOM centre linked to step down beds (Hospital to Home scheme)	Jan-15		-	-	-	-	-
24/7 Community Respite Services	District Nurses, includes prescription duties from 2014 onwards. Consider revising cost as non-additional dependent on FNHC SLA	Supported by Rapid Response team (and includes annual mileage allowance £2.4k) 2016 onwards	25% Jun 2012, 25% Jun 2013, 25% Jun 2014, 25% Jun 2015	8.00	35	148	252	362	
24/7 Community Respite Services	Intensive Home Care Support (& relatin to Telecare)	Includes annual mileage allowance	25% Jun 2012, 25% Jun 2013, 25% Jun 2014, 25% Jun 2015	36.00	46	443	772	1,102	-

Initiative Title	Initiative Description	Assumptions	Implementation Date	Additional FTE	Total Implementation costs 2012 - 2015 (£000's)	2013 Revenue (£000's)	2014 Revenue (£000's)	2015 Revenue (£000's)	2013-15 Capital (£000's)
				No.	£	£	£	£	£
24/7 Community Respite Services	Equipment	Cost of Hire is £100 per unit per week. 15 Units required. Unit consists of Bed, Hoist, Mattress, Commode	25%Jun 2012, 25% Jun 2013, 25% Jun 2014, 25% Jun 2015		-	41	52	75	-
24/7 Community Respite Services	Man with a Van / Parish handyman	Pay annual fee to Parish to manage (£3k - £7k pa based on size. Used avg £5k per parish) -	Start with 2 Parishes from Jun 2012		-	31	48	66	-
24/7 Community Respite Services	Training included as CPD costs within staff costs per FTE (consider increase per headcount). Backfill costs at £200 per day - 5 days.	Based on 5 days per fte per year at cost of £200 per day (to cover backfill £750 CPD pp/pa included in staff cost line)	25% Jun 2012, 25% Jun 2013, 25% Jun 2014, 25% Jun 2015		-	23	30	42	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	HCA's	Westmount Staff relating to Westmount Nursing Beds	Jun-13	5.80	10	114	235	241	-

Initiative Title	Initiative Description	Assumptions	Implementation Date	Additional FTE	Total Implementation costs 2012 - 2015 (£000's)	2013 Revenue (£000's)	2014 Revenue (£000's)	2015 Revenue (£000's)	2013-15 Capital (£000's)
				No.	£	£	£	£	£
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	HCA's	Westmount Staff relating to Westmount Nursing Beds	Jun-13	11.70	20	177	364	373	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Nurses	If Reablement Team not to start until 2016 then Respite Nurse will be needed for 2013 to 2015	Jun-13	1.00	15	27	56	57	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Nurses	If Reablement Team not to start until 2016 then Respite Nurse will be needed for 2013 to 2015	Jun-13	1.00	15	32	65	67	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Access to Equipment	Phased costs in line with Nursing Beds staffed by HCA's	Jun-13		-	18	43	44	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Spot Purchase Beds in Nursing Care Homes for Step Up facility (2 x Limes & 2 x Sandybrook)	4 beds all year round - Loss of income from current bed stock (eg £1000/£480) -	25% Jan 2013 25% Jun 2013 25% Oct 2013 25% Jan 2014		-	65	107	110	-

Initiative Title	Initiative Description	Assumptions	Implementation Date	Additional FTE	Total Implementation costs 2012 - 2015 (£000's)	2013 Revenue (£000's)	2014 Revenue (£000's)	2015 Revenue (£000's)	2013-15 Capital (£000's)
				No.	£	£	£	£	£
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Spot Purchase Respite Beds in Residential Care Homes	4 beds all year round (£750 pw per bed)	50 % Jan 2013 25% Jun 2013 25% Jan 2014		-	103	168	172	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	GP Costs for Intermediate Care Service in the community	Based on £75 per visit / 1,800 visits per year for 2013 as nurse prescribing will be introduced in 2014	Jan-13		143	-	-	-	-
Step Down / Step Up Service (Step Down 6 beds in existing H&SS Estate and Step Up 4 beds in Nursing Care Homes)	Training included as CPD costs within staff costs per FTE (consider increase per headcount). Backfill costs at £200 per day - 5 days.	Based on 5 days per fte per year at cost of £200 per day (to cover backfill £750 CPD pp/pa included in staff cost line)	Jan-13		-	22	22	23	-
Telecare Provision (24/7)	Annual rental costs for Telecare, since transferred to recurrent revenue costs (equip hire)	Based on annual costs of £1.0K pp for 100 service users by 2015	2012 - 2015		-	53	81	110	-
	TOTAL COSTS			**63.5**	**284**	**1,325**	**2,338**	**2,888**	**538**

Rev	Date	Author