INTERMEDIATE CARE SERVICE REVIEW

JOINT COMMISSIONING TEAM

April 2007
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- Appendix 1  Remit of the Intermediate Care Review
- Appendix 2  Review Group and Programme
- Appendix 3  Draft Intermediate Care Protocol
- Appendix 4  List of terms
Remit of the review

The Adult Planning & Operations Group (APOG) commissioned a review of Intermediate Care services on 13th November 2006 (Appendix 1). The purpose of the review was to establish clear and simple pooled budget arrangements and consider whether the service has been achieving the objectives set out in the Intermediate Care Strategy.

The review has subsequently focused on the following areas;

- Mapping current provision
- Performance of the Intermediate Care Beds service
- Pooled budget arrangements
- Ensuring appropriate service levels agreements are in place
- Reconfiguration of services so that they address the aims of the IC Strategy
- Delivering better integration of health and social care teams
- Development of a joint performance management framework
- Timetable for implementation of review recommendations
- Potential future developments

The reviews main focuses is on the pooled budget arrangement and the use of IC beds. Further work is required on the Community Rehabilitation Team, the Millennium Day Centre and the Fast Response Service.

The Intermediate Care Review has been coordinated by the Joint Commissioning Team and overseen by an IC Review Group. Appendix 2 sets out the membership of the group and a schedule of meetings. It also provides details of the interview programme undertaken. Supporting documentation, including minutes and presentations are available from the Joint Commissioning Team

Impact of the review

Social care

The review recommendations, if implemented, should have a positive impact on the following adult services key performance indicators;

- BVPI 54 Older people helped to live at home
- AO/C72 Older people aged 65 or over admitted to residential/nursing care
- AO/B12 Cost of intensive social care for adults and older people
- AO/C32 Older people helped to live at home
- AO/D41 Delayed transfers of care
The review will also assist the local authority in achieving the outcomes set out in the Adult Social Care Framework for Performance Assessment. The main standards of performance which are relevant to Intermediate Care include:

- The promotion of services which facilitate health and emotional well-being
- Promoting independence and supporting people to make the most of their potential
- Ensuring that people are encouraged to participate fully in their community
- Access to choice and control of good quality services, responsive to individual need
- Development of corporate arrangements which promote consistent, sustainable and effective improvement
- Commissioning and delivery of services to clear standards of both quality and cost

**Health objectives**

Standard 3 of The National Service Framework for older people sets out the responsibilities of the NHS in relation to intermediate care. It places a responsibility on PCTs to develop enhanced rehabilitation services which will prevent unnecessary hospital admission and enable early discharge from hospital.

The Intermediate Care Review addresses priorities within the NHS Plan aimed at promoting independence for older people. Through developing a range of services that are delivered in partnership between primary and secondary health care and local authority services, Rotherham PCT should be able to reduce hospital admissions and facilitate early discharge.

**Definition of Intermediate care**

The Rotherham Intermediate Care Strategy defines an Intermediate care service as one which:

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

A summary of the review recommendations are set out below.
It is recommended that;

R1 The services identified on Page 13 are classified as Intermediate Care.

R2 The Fast Response Service is taken out of the Intermediate Care pooled budget and reviewed separately as part of an overall review of unscheduled care services.

R3 Management of the six IC beds at Ackroyd Residential and Nursing Home be transferred to the Fast Response Team.

R4 All services identified as Intermediate Care (IC) are transferred into the pooled budget and are subject to joint commissioning arrangements.

R5 Subject to verification by Heads of Finance at Rotherham PCT and Rotherham MB, the value of the Intermediate Care pooled budget for 2007/08 is set at £3,711,813

R6 Responsibility for commissioning the Intermediate Care Service is transferred to the Joint Commissioning Team, acting on behalf of the Adults Board.

R7 The Joint Commissioning Team will prepare a service level agreement, to be agreed between the chair and deputy chair of the Adult Board and RMBC Provider Services.

R8 Provider responsibility for Intermediate Care remains with Rotherham MBC.

R9 A separate block contract is developed between Neighbourhood & Adult Services and Rotherham PCT Provider Services to deliver therapy services to Intermediate Care.

R10 Subject to verification by Heads of Finance at Rotherham MBC and Rotherham PCT, the contract value for Intermediate Care Therapy Services should be set at £857,143 for 2007/08

R11 The Intermediate Care Residential Service be split into two categories; Step-down and Intensive rehabilitation.

R12 Those beds ring-fenced at Netherfield for people under 60 years should be re-designated so that Netherfield only accommodates older people.

R13 The admission and discharge protocol for the ICB Service is revised to ensure that future admissions are appropriate to the service.

R14 Performance targets are set for the Intermediate Care Service on bed occupancy and length of stay in accordance with the proposed performance management framework (Page 32)
R15 Additional capacity generated as a result of improved performance is ring-fenced for community based, step-up provision

R16 Service utilisation levels set out in figure 8 are adopted as a baseline for performance targets for the ICB service for 2008/09.

R17 The Community Rehabilitation Team is reviewed with a view to increasing the number of referrals from the ICB service.

R18 Consideration is given to using CRT to monitor the long term impact of the ICB service.

R19 The GP contract is reviewed so that reflects the changes in this review and the new Admissions Protocol.

R20 Rotherham MBC appoint a Service Manager for Intermediate Care Services and adopt the organisational structure set out in figure 7.

R21 The Specialist Mental Health Occupational Therapist Post is unfrozen.

R22 The SLA developed between Rotherham PCT and Rotherham MBC for delivering therapy services stipulates cross-over from CRT to the ICB service when the ICB service is under pressure or under-staffed.

R23 CRT enabler capacity is reduced from 21 and the resulting savings are ring-fenced to regrade and recruit to additional posts.

R24 The Performance Management Framework and reporting arrangements for the ICB service set out in Table 6 are adopted.

R25 The proposed timetable for implementation set out in Table 7 is adopted.

R26 The Joint Commissioning Team develop an action plan setting out a schedule for the following pieces of work

- Review of the Joint Intermediate Care Strategy
- Whole-system review and recommissioning of the Intermediate Care Service
- Development of a PMF for the whole of the Intermediate Care service
- Alignment of the IC service with QF principles
Map of current provision

Rotherham currently has the following intermediate care services:

**Fast Response Service**

This is a multi-disciplinary team of therapists and district nurses who deliver short term hospital-at-home and palliative care services. The team is managed by Rotherham PCT but funded through a pooled budget. The main aim of the service is to prevent hospital admission by delivering intensive primary medical support in the community. The intervention period is 72 hours, by which time the patient should be sufficiently stable to allow mainstream primary health & social care services to take over. Referrals mainly originate from Accident & Emergency although there are referral pathways from the Yorkshire Ambulance Service, local GPs and Social Services.

The Fast Response Team has access to temporary nursing home beds for people who require a short period of rehabilitation. These dedicated beds can be accessed for up to two weeks and can sometimes be used as a route into Intermediate Care. The Fast Response beds are currently managed by Rotherham MBC.

**Intermediate Care Residential Beds (ICB)**

This service provides rehabilitation for people who are considered unsafe to remain in or return to their own homes but who would have the capacity to live at home if provided with suitable rehabilitation services. Table 1 shows where these beds are currently located:

<table>
<thead>
<tr>
<th>Name of home</th>
<th>No. of beds</th>
<th>Status</th>
<th>Nursing /Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ackroyd</td>
<td>6</td>
<td>Independent</td>
<td>Residential</td>
</tr>
<tr>
<td>Netherfield Court</td>
<td>21</td>
<td>Local Authority</td>
<td>Residential</td>
</tr>
<tr>
<td>Broom Lane</td>
<td>8</td>
<td>Independent</td>
<td>Dual registered</td>
</tr>
<tr>
<td>Rothwell Grange</td>
<td>12</td>
<td>Local Authority</td>
<td>Residential</td>
</tr>
</tbody>
</table>

Rotherham MBC has recently closed down 9 ICB beds at Laudsdale Residential homes. The Council is intending to replace these with another 9 beds at Rothwell Grange in 2007.

The service is available for up to six weeks, although this is flexible depending on individual need. 40 beds are registered with the Commission for Social Care Inspection (CSCI) to
provide residential care for older people. Seven beds at Netherfield are registered with CSCI to provide residential care services to people under 60 years.

**The Community Rehabilitation Team (CRT)**

The Community Rehabilitation Team is a multi-disciplinary team which brings together occupational therapists, physiotherapists and home care enablers to deliver rehabilitative support to people in their own homes. The service focuses on reducing home care packages by increasing levels of independence. The service is generally available for up to six weeks, although this is flexible depending on individual need.

**Millennium Day Rehabilitation Unit**

This service provides rehabilitation in a day care setting to improve safety, function and independence. The service is available for people for up to six weeks, although this is flexible depending on individual need. The multidisciplinary team consists of an occupational therapist, physiotherapist, rehabilitation support workers and rehabilitation assistants.

**Mental Health Services**

All the above services are supported by a specialist Mental Health Occupational Therapy Service. This carries out assessments of need and signposts people to relevant specialist services. The Mental Health OT Service is currently managed by DASH.

**Current Performance – Residential Care Beds**

The review has focused primarily on the profile and performance of the Intermediate Care Beds.

**Bed occupancy and length of stay**

In 2006 there were 20,440 available bed nights of which approximately 14206 were used. The bed occupancy rate was therefore 69%. The low bed occupancy rates are partly explained by lack of use of the Netherfield ring-fenced beds for people under 60. Other factors which could have driven down occupancy rates include; reduced staffing levels and slow turnaround times.

The average length of stay in an IC bed during 2006 was 27 days. This figure is higher than expected for a rehabilitation service and could be reduced significantly. The main reasons for increased length of stay include:

- Delays in initiation of occupational therapy support after admission
- Therapy staff unable to deliver support packages of sufficient intensity
- High level of need on admission
- Residual medical issues requiring resolution before therapy input can begin
- Inappropriate admission where therapy input has little impact
- Delays in discharge because of difficulties with putting in place appropriate home care package

**Admissions/Referral Profile**

Figures 1 set out the admission profile for the ICAB service during 2006. All units performed at a similar level in terms of admissions/bed/year (approximately 9 people/bed). Broom Lane was the best performer, operating at a rate of 10.3 people/bed. Netherfield and Rothwell, the specialist units developed specifically for delivering residential Intermediate Care, received 58% of total admissions.

**Figure 1 – Admissions profile - 2006**
Figure 2 shows the referral source profile for the ICAB service. This shows that during 2006 the Intermediate Care Beds were primarily being used to facilitate hospital discharge. 97% of all admissions in 2006 were from hospital.

Figure 2 – Referral Profile – Intermediate Care Beds - 2006

- Transfer from Fast Response Bed: 16
- Hospital from outside Borough: 39
- Rotherham District General Hospital: 464
Age profile

Figure 3 sets out the age profile of people using the residential care beds in 2006. Over 85% of admissions were people over 75 years (13% over 90 years). This would indicate that the residential care beds are targeting the most vulnerable older people. It also demonstrates that the Intermediate Care Beds are essentially an older people’s service, 96% of admissions being over 60.

This age profile for the ICB service is in line with the Intermediate Care Strategy priority to “increase the proportion of older people supported intensively to live at home”. However the strategy recognises that restricting the use of residential units to older people involves inverse age discrimination which is in conflict with the aims of Standard 1 of the Older People’s NSF. The strategy also recognises the potential for Intermediate Care Beds to meet the needs of younger people with long term conditions.

Outcomes profile

Figure 4 illustrates the outcome profile for the Intermediate Care Beds. Over 70% of service users returned home in 2006 with, with only 4% having to move on to long term residential
care. This indicates that the service is having a positive outcome for people in terms of maintaining independence.

There was however a 21% hospital readmission rate. The available performance data does not adequately explain the reasons for the high rate of readmissions. There are a number of potential factors:

- Inappropriate discharges from hospital to Intermediate Care as a result of poor assessment or pressure to discharge
- Mismatch between the therapeutic needs of the patient and the current capacity of the service to meet those needs
- Low threshold for readmission by the Intermediate Care GP
- Reduced quality of care and therapeutic support to residents

Further investigation is required to establish which of these factors contributes most to readmission rates.

**Figure 4 – Outcomes profile – Intermediate Care Beds - 2006**

![Figure 4](image)

**Analysis of current performance**

At the point of admission the general profile of a service user is someone over 75 years, who has rehabilitation needs and is not fit to return home. This profile indicates that the service is targeting a particularly vulnerable group, who without intervention, would be at high risk of admission to long term residential care. Despite these presenting needs the
service successfully returned home over 70% of users in 2006. Only 4% moved on to long term residential care.

The review therefore concludes that the Intermediate Care Residential Service significantly reduces the number of older people who move from hospital into long term residential care.

The Intermediate Care Strategy states the priorities of Intermediate Care should be to “facilitate timely, effective and safe discharge from hospital” and “prevent unnecessary admission to long term care". The admission and outcomes profile for 2006 indicates that the residential provision is addressing these priorities.

However the strategy also states that Intermediate Care should "prevent unnecessary admission to hospital" and “provide access to appropriate pathways of care”. The admissions profile indicates that the residential beds are almost exclusively being used to facilitate timely hospital discharge. Consequently there are very few community based admissions and the pathways into Intermediate Care are limited. In order to be able to address all the priorities set out in the Intermediate Care Strategy the residential service needs to develop a broader range of referral routes so that people can receive appropriate intervention before hospital admission or before admission to residential care.

The admission profile indicates that the Intermediate Care Residential Service is almost exclusively delivered to older people. Only 4% of admissions last year were from people under 65 years. This is despite the fact that 8% of beds are ring-fenced for younger adults. The low number of referrals from younger adults is having a significant impact on bed occupancy, reducing capacity and the cost effectiveness of the service. In 2006 these ring-fenced beds had an occupancy rate of approximately 40%.

Re-registering the IC beds set aside for people under 65 years so that they are available only to people over 65 would have a significant impact on bed occupancy. Assuming that bed occupancy rates for older people remain constant across the service, re-registration would increase bed occupancy for these four beds from 40% to 69%. The resultant impact on overall occupancy levels would be an increase from 69% to 72%, generating an additional capacity of 37 beds.

**Pooled budget arrangements**

**Identifying relevant services**

The Review Group looked at which services should be included in the Intermediate Care pooled budget. The following criteria were used to identify the most appropriate services. All these criteria had to be met in order to qualify as an Intermediate Care Service:

- The service had to be an integral part of the Intermediate Care pathway
- It had to incorporate rehabilitative support as part of its function
It had to facilitate hospital discharge or prevent admission to hospital or long term care
There had to be strong links between health and social care in terms of delivery
Its focus should not be on crisis intervention

R1 Using these criteria it is recommended that the following services be classified as Intermediate Care.

- All the Intermediate Care Beds
- Community Rehabilitation Team (CRT)
- Millennium Day Centre
- GP contract for Intermediate Care
- Intermediate Care Social Work Service
- All therapy services connected to the ICAB Service or CRT
- The Intermediate Care Occupational Therapy Service delivered by DASH

The Review Group did not consider the Fast Response Service to be Intermediate Care. This service does link into the Intermediate Care pathway and there is a strong connection between health and social care. However the Fast Response service is primarily a crisis intervention service forming part of an unscheduled care service network. The service responds to people in crisis and maintains them in the community until their condition improves and/or until mainstream health and social care services can be activated.

R2 It is recommended that the Fast Response Service is taken out of the Intermediate Care pooled budget and reviewed separately as part of an overall review of unscheduled care services.

R3 It is also recommended that management of the six beds at Ackroyd Residential and Nursing Home be transferred to the Fast Response Team.

Setting the value of the pooled budget

The Review Group looked in detail at the pooled budget arrangements for Intermediate Care. Table 2a identifies those elements of the current pooled budget arrangements. Table 2b sets out an estimated budget for the Intermediate Care Service for 2007/08.

Table 2b incorporates those services that have historically been part of the pooled budget arrangements with those that are currently commissioned and financed separately. Budgets for the Millennium Day Centre, Rothwell Residential Service, Broome Lane and the Community Rehabilitation Team are currently commissioned exclusively on a single agency basis and are therefore not currently included in the pooled budget arrangements.

The ICB Service and Therapy Services are all currently subject to split funding arrangements, with a proportion of their finance coming from the pooled budget and the
rest provided by Rotherham MBC. Total contributions from both agencies are identified in both tables.

It is proposed that all Intermediate Care services are brought into the joint commissioning framework and incorporated into the pooled budget arrangements.

Table 2a – Breakdown of current pool budget

<table>
<thead>
<tr>
<th>Service</th>
<th>Budget</th>
<th>RMBC</th>
<th>RPCT</th>
</tr>
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<tbody>
<tr>
<td><strong>2006/07</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Netherfield Court</td>
<td>£618,400</td>
<td></td>
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<tr>
<td>ICAB Beds – Other</td>
<td>£709,588</td>
<td></td>
<td></td>
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<tr>
<td>GP Contract</td>
<td>£28,439</td>
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<tr>
<td>Social work team</td>
<td>£325,273</td>
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<tr>
<td>Occupational Therapists</td>
<td>£114,353</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£1,796,053</td>
<td>£1,147,641</td>
<td>£648,412</td>
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Table 2b – Proposals for new pooled budget arrangements

<table>
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<th>Service</th>
<th>Budget</th>
<th>RMBC</th>
<th>RPCT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2006/07</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy Service</td>
<td>£836,231</td>
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<tr>
<td>ICAB Beds</td>
<td>£2,072,535</td>
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<tr>
<td>GP Contract</td>
<td>£28,439</td>
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<tr>
<td>Social work team</td>
<td>£164,769</td>
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<tr>
<td>Millennium Day Care</td>
<td>£339,104</td>
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</table>
Under the revised pooled budget arrangements there would be an increase in the overall contribution by both Rotherham PCT and Rotherham MBC. Also, the proportion of pooled budget contribution from Rotherham MBC would increase from 64% to 70%. However this increase is only transfer of existing budgets already allocated to services identified as intermediate care. There should be no additional costs incurred to partner agencies as a result of the changes to pooled budget arrangements.

The 2.5% assumption on uplift is for indicative purposes only and is subject to consideration by the Heads of Finance in both organisations. Currently the local authority uplift for pay is 2.25% and for non-pay 2%.

**R4** It is recommended that funding for all services identified as Intermediate Care be transferred into a pooled budget and that this pooled budget is subject to the commissioning arrangements setout in the new Joint Commissioning Framework.

**R5** It is also recommended that, subject to verification by Heads of Finance at Rotherham PCT and Rotherham MBC, the value of the Intermediate Care pooled budget for 2007/08 is set at £3,711,813* and that the baseline contributions set out in Table 2b are agreed.

*Assumes an uplift of 2.5% from 2006/07

The incorporation of services into one pooled budget will clarify the commissioning and financial arrangements for Intermediate Care. It will place the service in a position where it can be jointly commissioned. It will enable the development of co-ordinated care pathways from residential rehabilitation services to community and day care provision. Finally it will facilitate the delivery of integrated teams, case management and single assessment.

**Commissioning Arrangements and Service Level Agreements**

Currently Rotherham MBC acts as the service provider for Intermediate Care. The Council employs and directly manages the social work team, care staff and support workers. Rotherham PCT Provider services deliver all the therapy support and nursing care.
Rotherham PCT staff are funded through the pooled budget and this is administered by Rotherham MBC.

The Review Group considered the commissioning arrangements for Intermediate Care and concluded that they were not robust.

There were a number of key issues:

- There is no clear commissioner / provider split
- There is no joint commissioning arrangement in place for the service
- The Service Level Agreement between Rotherham MBC and Rotherham PCT for therapy services is inadequate
- The system of payment for therapy services is unnecessarily complex
- The Performance Management Framework is not robust
- There is no service specification

R6 In order to establish a clear split between commissioning and service provision it is recommended that responsibility for commissioning the Intermediate Care Service is transferred to the Joint Commissioning Team, acting on behalf of the Adults Board.

R7 It is recommended that the Joint Commissioning Team prepare a service level agreement for the service, to be agreed between the chair and deputy chair of the Adult Board and RMBC provider services.

It is proposed that the Joint Commissioning Team (JCT) would lead on all commissioning activity relating to Intermediate Care. It would be responsible for needs analysis, supply mapping, gap analyses, strategic development, contracting and performance management. The service would be commissioned as part of the new Joint Commissioning Framework, which was developed specifically to act as a vehicle for commissioning services subject to pooled budget arrangements.

R8 It is also recommended that provider responsibility for Intermediate Care remains with Rotherham MBC.

As the provider, the Council would hold the pooled budget and be responsible for overall performance. The Joint Commissioning Team would develop a service specification forming the basis of a Service Level Agreement between the Adults Board and Neighbourhood & Adults Provider Services. This Service Level Agreement would be underpinned by a robust outcome based performance management framework.

R9 It is recommended that a separate block contract is developed between Neighbourhood & Adult Services and Rotherham PCT Provider Services to deliver therapy services to Intermediate Care.
Currently Rotherham PCT recharges the Council for all expenditure on therapy services each month. There is no formal cap on therapy spending, a lack of clarity over sickness cover and an inability to track spending. It is proposed that the current Service Level Agreement (SLA) for IC Therapy Services is replaced with a block contract between Rotherham MBC and Rotherham PCT. The value of the block contract would be set at a level, equivalent to the current budget for therapy services. It is proposed that payments on the block contract would be made monthly, with no recharges required from Rotherham PCT for individual staff. This contracting arrangement would be simpler and clearer. The contract would be underpinned by a service specification for therapy services and an outcome based performance management framework.

Table 3 identifies the 2006/07 budget commitment for therapy services and the actual amount spent on these services. For 2006/07 there is currently an anticipated overspend of £25,956. It is proposed that the contract value for 2007/08 is based on the budget (not actuals) for 2006/07, with an uplift of 2.5%. Using this method of calculation, the contract value for Intermediate Care therapy Services would be set at £857,864 for 2007/08. This block grant is included in the pooled budget breakdown (Table 2b).

R10 It is recommended that, subject to verification by Heads of Finance at Rotherham PCT and Rotherham MBC, the contract value for Intermediate care Therapy Services should be set at £857,143 for 2007/08.

The 2.5% assumption on uplift is for indicative purposes only and is subject to consideration by the Heads of Finance in both organisations. Currently the local authority uplift for pay is 2.25% and for non-pay 2%.

Performance for both the therapy services and the overall service would be reported to the Adults Board on a bimonthly basis.

Table 3 – Proposed value of Intermediate Care Therapy Contract*

<table>
<thead>
<tr>
<th>Service</th>
<th>2006/07</th>
<th>2007/08</th>
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<tr>
<td>Intermediate Care Beds</td>
<td>£346,899</td>
<td>£355,571</td>
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<td>Community Rehabilitation Team</td>
<td>£349,424</td>
<td>£358,160</td>
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<tr>
<td>OT service – Mental Health</td>
<td>£99,388</td>
<td>£101,873</td>
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<tr>
<td>Millennium Day care Service</td>
<td>£40,520</td>
<td>£41,533</td>
</tr>
<tr>
<td>Total</td>
<td>£836,231</td>
<td>£857,143</td>
</tr>
<tr>
<td>Actuals</td>
<td>£857,864</td>
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</tbody>
</table>

*based on 2006/07 RMBC budget allocation
Proposals on Intermediate Care Beds

Key issues arising from the review

There is a lot of evidence to indicate that a lack of occupational therapy cover in the ICB service is significantly affecting performance. The Audit of Goal Achievement in the Occupational Therapy Service for Intermediate Care (2006) suggests that even when fully staffed there is not enough occupational therapy cover to support 50 IC beds. The audit compares the performance of the ICB OT service from 2004 – 2006. It concludes that current OT staffing levels are insufficient to deliver the required therapeutic support when at full occupancy. There are a number of factors which affect the performance on therapy:

- Lack of support staff, reducing direct contact with residents
- Geographical spread of beds requiring significant travel time
- Having to work with residents who do not require intensive therapy services
- Lack of access to appropriate IT

As part of the review a snapshot was taken of current ICB residents to establish how many had cohort of needs that could not be met by the ICB service. Approximately 30% of the current cohort of residents had needs that could not be met and therefore classified as inappropriate admissions. There are a number of potential reasons for inappropriate admissions. There could be a lack of awareness of what the Intermediate Care service is able to deliver. The admission threshold may be too low because of the lack of available therapy support. Also, patients may be referred to ICB because there is no alternative care pathway available to hospital staff.

Delivering appropriate packages of therapeutic support

It is important to address this issue and create an environment where ICB therapists can deliver an effective service. However, it is also important that proposals from this review do not shut down care pathways, which are currently available to hospital staff with no other alternative being available.

Therefore it is proposed that the ICB service is split between “Intensive Rehabilitation” and “Step Down/Up”. Under these new arrangements the service would those patients who require intensive therapeutic support from those whose primary need is short-term care. Splitting the residential provision in this way would maintain the care pathway out of hospital whilst enabling therapists to work more effectively.

*Intensive rehabilitation – Netherfield Court*
Netherfield Court would, under these arrangements, deliver intensive rehabilitation packages to people who require a high level of therapeutic support. This does not necessarily mean that service users have a higher level of medical need than other people within the service. However the assessment made prior to admission would have to demonstrate that a person is likely to benefit from intensive therapeutic intervention. The categories of people who would be best suited to this type of provision are those who are:

- Medically fit to leave hospital but who require intensive therapeutic support to achieve independence
- Currently living in residential care but wish to move back into their own home
- At high risk of admission to hospital or residential care because of difficulties with managing a long term condition
- At high risk of admission to hospital or residential care because of mobility problems
- A high falls risk

Reconfiguring Netherfield in this way would require re-registration of the four beds set aside for people under 60 years. The service would be exclusively for older people with new care pathways opened up from residential care, primary health care and social care.

21 beds would be set aside for this type of provision. All the therapists employed to support the residential service would be located on site

Step up/down beds

These beds would be available for people who are unable to remain at home but who do not require a significant amount of therapeutic intervention. The beds would be targeted at people who are medically fit to leave hospital but who would benefit from a short stay in a community based residential setting before returning home. These beds could also be used for community referrals where a short stay in a residential setting reduces the risk of hospital admission. The categories of people who would be best suited to this type of provision are those who are:

- Medically fit to leave hospital but do not have the appropriate care and support packages in place to return home
- Medically fit to leave hospital but require a short period of convalescence before returning home
- Temporarily at high risk of hospital admission and require a residential placement of more than 72 hours but less than 6 weeks (step-up)

20 beds would be set aside for step up/down provision under these arrangements.

This would focus therapeutic support onto a smaller number of beds and open up the care pathway so that it can include referrals from the community.

**R11** It is recommended that the Intermediate Care Residential Service is split into two categories; Intensive Rehabilitation & Step-Down.
It is also recommended that those beds ring-fenced at Netherfield for people under 60 years should be re-designated so that Netherfield only accommodates older people.

Addressing high level of readmissions

The Review Group looked at the high number of readmissions to hospital from the Residential Service.

Analysis of IC bed usage for the period 2006 showed that out of 519 admissions approximately 108 were readmitted to hospital before discharge from Intermediate Care. Assuming that these readmissions were non-elective the approximate cost to the PCT was £2,400/amission. The estimated cost therefore of readmissions for 2006 was £259,200. Table 4 shows the potential savings that could be made if readmission rates were reduced.

There are a number of potential reasons for the high level of readmissions. There is some evidence that patients admitted from hospital are presenting with a higher level of medical need. It is also possible that the quality of care delivered within the ICB service and the extended length of stay of some residents could exacerbate readmission rates.

There are also factors which could lead to premature readmission to hospital. The GP contract for Intermediate Care currently provides no incentive to explore alternatives to hospital care when a resident’s condition deteriorates. Also, GPs do not have access to hospital records or the originating GP’s case files. Lack of access to full medical history could result in a more cautious approach when considering hospital readmission.

<table>
<thead>
<tr>
<th>No. of readmissions / annual</th>
<th>% of total admissions</th>
<th>Saving against 2006 (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>108 (current)</td>
<td>21</td>
<td>0</td>
</tr>
<tr>
<td>100</td>
<td>19</td>
<td>19,200</td>
</tr>
<tr>
<td>80</td>
<td>16</td>
<td>67,200</td>
</tr>
<tr>
<td>60</td>
<td>12</td>
<td>115,200</td>
</tr>
<tr>
<td>40</td>
<td>8</td>
<td>163,200</td>
</tr>
</tbody>
</table>

There are two key steps to addressing the problem of readmissions. Firstly it is proposed that the service adopts a new Admissions Protocol with clear eligibility criteria. Then it is necessary to realign the service so that it is capable of meeting the needs of those eligible.
Appendix 2 sets out the proposed Admissions Protocol. The protocol focuses on the following areas:

- Admissions criteria for Intermediate Care Beds
- Protocol for readmission to hospital
- Protocol for recharging for inappropriate ICB admissions
- Role of the GP with responsibility for Intermediate Care

R13 It is recommended that the admission and discharge protocol for the ICB Service is revised to ensure that future admissions are appropriate to the service.

Implementation of the protocol and reconfiguring Netherfield as an Intensive Therapy Unit for older people should ensure that residents who meet the eligibility criteria for intensive rehabilitation receive the support they require. It should also ensure that the care and support needs of those who don’t require intensive therapy are still catered for. These measures combined should result in a reduction in readmissions from Intermediate Care to hospital.

Bed occupancy and length of stay*

In 2006 the number of occupied bed nights was 14,206 out of an available 20,440. The bed occupancy levels were 69%, with an average length of stay of 26.7 days (3.8 weeks).

Both the bed occupancy levels and length of stay are a concern and the service needs to perform better on both indicators. Factors which contributed to low bed occupancy included; the ring-fencing of beds at Netherfield for under 60s and delays in turnaround. On length of stay the main causes of delay were: delays in initiating therapy packages, inability to deliver intensive therapy and the higher level of need presenting on admission.

The following measures already put forward in this report should contribute to improved performance in bed occupancy and length of stay.

- Removing the ring-fence on beds at Netherfield (R12)
- Reconfiguring the SLA with RPCT for therapy services (R10)
- Splitting the beds between “step down” and intensive rehabilitation (R11)
- Revising the admission criteria (R13)

The Review Group considered the potential for increasing capacity by improving performance in bed occupancy and length of stay. Table 5 sets out how new capacity could be generated for community based referrals, without an increase in the number of beds and without reducing the number of people using the ICB service as a step-down from hospital.

An increase in bed occupancy levels to 80% accompanied by a reduction in length of stay to 24 days, would generate an additional 164 places/year. An increase in bed
occupancy levels to 85% with a reduction in length of stay to 21 days would generate an additional 310 places/year.

**R14** It is recommended that performance targets are set for the Intermediate Care Service on bed occupancy and length of stay in accordance with the proposed performance management framework on (Page 21).

**R15** It is also recommended that any additional capacity generated as a result of improved performance on bed occupancy and length of stay is ring-fenced for community based admissions.

* All 2006 figures are extrapolated from 1st three quarters of the year.

### Table 5

Impact of improvements in bed occupancy and length of stay (incr. places/year)

<table>
<thead>
<tr>
<th>Bed occupancy %</th>
<th>27</th>
<th>24</th>
<th>21</th>
<th>15</th>
</tr>
</thead>
<tbody>
<tr>
<td>69</td>
<td>0</td>
<td>70</td>
<td>154</td>
<td>423</td>
</tr>
<tr>
<td>75</td>
<td>50</td>
<td>121</td>
<td>213</td>
<td>505</td>
</tr>
<tr>
<td>80</td>
<td>88</td>
<td>164</td>
<td>261</td>
<td>573</td>
</tr>
</tbody>
</table>
Value for money

Figure 5 sets out the monetary impact of proposals on the unit cost of the ICB service. The chart shows the compounding effect of increasing bed occupancy, shortening length of stay and reducing hospital readmissions on the unit cost of the ICB service. The chart sets out how changes in these areas could reduce unit costs by over £2,000. It is still important that the service delivers a return saving in terms of reduced hospital admissions, early discharge or a reduction in care packages but the first priority here is to ensure that the service is as cost-effective as possible on unit spend.

Figure 5 - Value for money profile
Service utilisation

From the referral profile it is clear that the Intermediate Care service is currently almost exclusively used to facilitate hospital discharge. There are very few referrals into the service from the community and none from residential care. The care pathway is restricted and this is limiting the service’s capacity to prevent admissions to hospital and residential care.

Figure 6 sets out the service utilisation profile for 2006 and the potential profile if the anticipated increase in capacity was achieved.

By introducing measures to improve performance on bed occupancy and length of stay, it is estimated that service capacity could be increased from 519 places to 683 in the first year with a long term potential capacity of 829 places.

In 2006, 21% (108) of all ICB residents were readmitted to hospital. Revising the admissions criteria, realigning the GP contract and introducing recharges for inappropriate admissions should enable the service to reduce this to around 10% (68).

The extra capacity generated from the above measures would free up bed capacity so that the service can act as a step-up rehabilitation facility, providing up to 170 places in the first year from the community.

The Review Group has considered the use of the ICB service as vehicle for rehabilitation from residential care to the community. More work needs to be done on this but there is a
strong argument for using the ICB service as a step-down facility for people who would like to move back into their own home or into an Extra Care Housing scheme from long term residential care. It is therefore proposed that targets are set in the first year for rehabilitation from residential care.
Figure 6: Service Utilisation – Intermediate Care Beds (2006) (2008/09)
R16  It is recommended that the future service utilisation levels set out in figure 5 are adopted as performance targets for the ICB service for 2007/08.

The increased capacity in the ICB service does have implications for the Community Rehabilitation Team (CRT). In 2006 only 15% of people discharged from the ICB service were referred on for further support from CRT. If CRT were to work with the same number and the ICB capacity increased in accordance with the above service utilisation profile this referral rate would reduce to 11%.

The performance data available does not provide information on the rehabilitation needs of people after discharge from the ICB service. It is unlikely however that only 15% of discharges would benefit from further rehabilitative support in the community. There is probably a greater need for follow-up support and monitoring and CRT should be meeting this need.

R17  It is recommended that the Community Rehabilitation Team is reviewed so that it can respond to the newly configured ICB Service

R18  It is also recommended that consideration is given to using CRT to monitor the long term impact of all ICB service users.

Intermediate Care GP Contract

GP services to the ICB service are covered by a separate contract between Rotherham PCT and two local GP Practices. These contracts cover the delivery of medical cover for Nursing and Residential Homes providing Intermediate Care.

The GP service provides medical cover in line with the standards set out in core PMS or new GMS contracts. The ICB service is required to inform the relevant GP practice of an admission. The GP is then required to visit the resident as soon as is practicable to assess the resident, review their medication and prescribe as required. The GP practice must, when requested, visit residents within an agreed timeframe. The GP should also make arrangements to visit the care home on a regular basis. Finally, the GP has specific responsibilities to ensure that the appropriate medication is available to residents on discharge from the ICB service.

There is no performance management framework attached to this contract so it has been difficult to assess contract compliance. It is therefore proposed that the GP contract be reviewed and that the new contract is monitored effectively. The revised contract should reflect the changes set out in the admissions protocol. It should also build in incentives to reduce hospital readmissions and set
out the relationship with the Community Physician who has responsibility for reducing hospital admissions.

**R19** It is recommended that the GP contract is reviewed so that it reflects the changes proposed in this review and the new Admissions Protocol.

### Service Structure

Figure 7 sets out the current management structure for the Intermediate Care Service. The Review Group recognised the strong relationship between front-line health and social care staff. However the line management structure is not properly integrated and there is an unnecessary separation between health & social care professionals and between the CRT & ICB services. There is no cross-over between CRT and ICB staff during times of high activity in the ICB service. There is no common performance management framework and no service manager with overall responsibility.

Figure 8 sets out a proposed structure for the Intermediate Care Service which would bring together health and social care staff under one management structure. Under this structure therapy staff would remain as employees of Rotherham PCT but operational line management would transfer to Neighbourhood & Adult Services. Responsibility for clinical supervision of these staff would remain with Rotherham PCT.

Under the proposed structure Rotherham MBC would recruit an Intermediate Care Service Manager who will line manage all aspects of the service except the Assessment and Care Management Team. The Service Manager will also be responsible for the budget.

The staffing structure proposal is subject to the current reorganisation of Neighbourhood & Adult Services.

**R20** It is recommended that Rotherham MBC appoint a Service Manager for Intermediate Care Services and adopt the organisational structure set out in figure 8

The Specialist Mental Health Occupational Therapy post is currently frozen so there are significant difficulties in meeting the needs of residents in the ICB service who have mental health problems.

**R21** It is recommended that the Specialist Mental Health Occupational Therapist Post is unfrozen.

The Review Group noted that although the capacity for CRT care enablers was 21, there were difficulties with recruitment. Currently there are only 11 care enablers in post. However the therapy staff in CRT are at full capacity.
imbalance between care enablers and therapy staff and the inability to transfer CRT therapy staff to support the ICB service must lead to under-utilisation of the CRT therapists.

It is therefore recommended that the SLA developed between Rotherham PCT and Rotherham MBC for delivering therapy services stipulates cross-over from CRT to the ICB service when the ICB service is under pressure or under-staffed.

It is also recommended that CRT enabler capacity is reduced from 21 and that the resulting savings are ring-fenced to re-grade and recruit to additional posts.

Reducing the capacity of the CRT care enabler team whilst maintaining the budget set aside for these workers should generate the finance to pay for the re-grading of the remain posts. Problems relating o recruitment of these posts should therefore be resolved and result in an increased number of care enablers employed by the service.
Figure 7: Current Service Structure

Divisional Manager

Group Manager (Intermediate Care)
- Unit Managers
  - Netherfield
  - Rothwell
- Care Enablers
- Support staff
- RMBC Neighbourhoods & Adult
- Rotherham PCT
- Millennium Day Centre
- OT: 1
- Physiotherapist: 1
- Support workers: 1
- Rehab assistants: 1

Group Manager (Domiciliary Services)
- CRT Manager
- Home Care Enablers: 21
- Assessment & Care Management Team
- Divisional Manager

Architectural details:
- Head Occupational Therapist
- Occupational Therapists
  - ICB: 4
  - CRT: 5.1
  - M. Health: 1.5
  - Support workers: 2
- Head Physiotherapist
- Physiotherapists
  - ICB: 4.5
  - CRT: 3.8
  - Support workers: 2
Figure 8 - Proposed Service Structure

Subject to NAS reorganisation

- Modernisation Manager
- RPCT Provider Services
  - Assessment & Care Management Team
  - Service Manager (Intermediate Care)
    - Unit Managers
      - Netherfield
      - Rothwell
    - Millennium Day Centre
    - Head OT
      - OT
      - Physiotherapist
      - Support workers
      - Rehab assistants
    - Head Physiotherapist
      - ICB
      - CRT
      - M. Health
      - Support workers
    - CRT Manager
      - ICB
      - CRT
      - Support workers
    - Home Care Enablers
      - 21
  - Care Enablers
    - Support staff
  - RMBC Neighbourhoods & Adult
    - Rotherham PCT
Performance Management Framework

Table 6 sets out proposals for key indicators and targets for Intermediate Care Beds. The table combines activity and outcomes targets. The targets are ambitious, in particular those on reducing hospital readmissions and increasing the number of step-up beds. However, if the measure set out in this report are adopted these targets should be achievable and would lead to demonstrable improvement in the service. It is proposed that performance against these indicators is reported to the Adults Board bimonthly.

This performance framework will assist both Rotherham MBC and Rotherham PCT in achieving their key performance indicators. In particular, for the local authority the new service will have a direct impact on:

- BVPI 54: The number of people helped to live at home
- AO/C72: No. of people aged 65 or over admitted to residential/nursing care
- AO/B12: Cost of intensive social care for adults & older people
- AO/D41: Delayed transfers of care

**R24** It is recommended that the Performance Management Framework and reporting arrangements for the ICB service set out in Table 6 are adopted.

Table 6 – Key indicators and targets for the ICB Service

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of admissions</td>
<td>519</td>
<td>683</td>
</tr>
<tr>
<td>No. of admissions from community (step-up)</td>
<td>16</td>
<td>170</td>
</tr>
<tr>
<td>Bed occupancy</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>Average length of stay (days)</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Readmissions to ICB after 6 months</td>
<td>?</td>
<td>Baseline</td>
</tr>
<tr>
<td>No. of admissions from residential care</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Readmission to hospital</td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>Returning home</td>
<td>75%</td>
<td>70%</td>
</tr>
<tr>
<td>Still at home after 6 months</td>
<td>Baseline</td>
<td>TBC</td>
</tr>
<tr>
<td>No. of hospital admissions after 6 months</td>
<td>Baseline</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Implementing the recommendations of this review will have a substantial impact on the performance and quality of the current Intermediate Care Service. The Review tries to build on the excellent work already being carried out by health and social care staff. Table 9 sets out process that the review has undergone so far and the proposed timetable for implementation.

**R25** It is recommended that the proposed timetable for implementation set out in Table 7 is adopted.

**Table 7 – Proposed timetable for implementation**

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review specification approved by APOG</td>
<td>JCT</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; November 2006</td>
</tr>
<tr>
<td>Review Group convened</td>
<td>JCT</td>
<td>15&lt;sup&gt;th&lt;/sup&gt; November 2006</td>
</tr>
<tr>
<td>Preliminary report to APOG</td>
<td>JCT</td>
<td>15&lt;sup&gt;th&lt;/sup&gt; January 2007</td>
</tr>
<tr>
<td>Endorsement by the Adults Board</td>
<td>JCT</td>
<td>13&lt;sup&gt;th&lt;/sup&gt; September 2007</td>
</tr>
<tr>
<td>Report to NAS – DMT</td>
<td>JCT</td>
<td>October 2007</td>
</tr>
<tr>
<td>Report to Cabinet Member</td>
<td>JCT</td>
<td>October 2007</td>
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<tr>
<td>Report to Rotherham PEC</td>
<td>JCT</td>
<td>May 2007</td>
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<tr>
<td>Implementation Plan -</td>
<td>NAS</td>
<td>September 2007</td>
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<td>Performance Framework in operation</td>
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<td>April 2008</td>
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<td>Review Community Rehabilitation Service</td>
<td>JCT</td>
<td>November 2007</td>
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<tr>
<td>Action</td>
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<td>Date</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------</td>
<td>----------</td>
</tr>
<tr>
<td>Pooled budget arrangements take effect</td>
<td>NAS/PCT</td>
<td>April 2008</td>
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<tr>
<td>Service Level Agreements come into effect</td>
<td>NAS/PCT</td>
<td>April 2008</td>
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<td>Service reconfiguration of ICAB complete</td>
<td>NAS</td>
<td>June 2008</td>
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<tr>
<td>Review Intermediate Care Strategy</td>
<td>JCT</td>
<td>April 2009</td>
</tr>
<tr>
<td>Recommission Intermediate Care Service</td>
<td>JCT</td>
<td>July 2010</td>
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**Future Development**

The review has been limited in that it has focused on the Intermediate Care Beds and commissioning arrangements. There is a need to carry out a whole-system review of the service, re-write the Intermediate Care Strategy and recommission the service in line with the new strategic direction. This review will, if implemented, place the service in a position where it can be commissioned jointly through the Joint Commissioning Framework. Ring-fencing the Intermediate Care budget, identifying those services that are relevant and putting in place the appropriate service level agreements will ensure that, once the new strategic direction is determined, service reconfiguration should be more straight forward.

There is also a need to review the Community Rehabilitation Service and Millennium Day Service. This review has focused on the residential service but there are significant issues that need to be addressed in the Community Rehabilitation Service and associated day care provision. These include;

- The relationship between the PCT and Council elements of the service
- The location of workers and the impact this is having on delivery
- The utilisation of the Millennium Day Care Service
- The role of the home care enablers.