Intermediate Care in Brent

Report of the Scrutiny Task Group

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Executive Summary

Membership of the Joint Commissioning Strategy (Intermediate Care Provision) Task Group includes:

- Councillor Uma Fernandes, Chair
- Councillor George Crane
- Councillor Chandubhai Patel
- Councillor Abdul Sattar-Butt

The group has been grateful for the professional expertise of the Chair, Councillor Uma Fernandes who has been able to provide the group with a clearer understanding of the functions of, in particular, the district nursing service. It should be pointed out however that her professional role has not presented any conflict of interest with the group's investigation.

The Task group met 6 times between June 2004 and January 2005 to investigate the effectiveness of intermediate care services in preventing avoidable admission to hospital and facilitating early discharge.

The group received information from a number of separate services that provide support to older people with the aim of promoting discharge and preventing admission:

- Care Co-ordination Service
- Collaborative Care Team
- Intermediate Care Team
- Housing Service

The group also met with a number of older people themselves or their representatives:

- Members of Dollis Hill Day Centre
- Brent Carers Centre
- Brent Pensioners' Forum
- Brent Pensioners' Service User Forum

The Task Group's main findings are:

- There is a range of innovative services directed towards preventing admission to hospital and promoting early discharge of vulnerable older people into the community and these services have made a significant contribution to improving the discharge experiences of older people and simultaneously to the effective use of inpatient resources.

- However, these services operate separately from each other and it is felt that this lack of co-ordination limits their effectiveness and the potential positive impact they might have on the well-being of older people.

- It is apparent that more generic services such as GP practices might make a more effective contribution to the provision of intermediate care services.

- The Brent Model for Rehabilitation and Intermediate Care will make a significant contribution to the development of effective care pathways for older people. However there appear to be areas where significant further work is required to ensure that the model is able to function effectively. In particular, the availability of sufficient resources, especially for community support and the configuration of services within the model needs further consideration and discussion between the different agencies.

- The new model of care must be appropriately resourced to ensure it can meet the needs of an increasing and increasingly diverse older population.

- There appear to be opportunities for greater co-ordination of general services which will improve the well-being of older people. Linked to this there appear to be opportunities to make more services available via day centres

- The role of and support for carers is critical

- The provision of information about services which maintain independence and promote rehabilitation is critical

The Task Group's recommendations are:

1. The potential for greater co-ordination of the delivery of domiciliary services to older people should be investigated, including their delivery from day centres and similar council, health or voluntary sector premises.

2. Consultation and communication on the development of the BECAD should continue to ensure that this unique and innovative model is able to deliver excellent services for Brent's older population

3. Within the context of the development of BECAD the allocation of sufficient resources to enable effective domiciliary support for older people must be guaranteed.

4. In the light of the changing profile of Brent's older population, demographic information should be monitored continuously by those responsible for service planning for older people to ensure that services are able to accommodate the range of needs of an increasingly diverse population

5. The high profile afforded to carers' representatives should be maintained via their involvement in such bodies as the Older People's Local Improvement Team. The Local Improvement Team should receive and respond to monitoring information gathered by carers' representatives to ensure that, as far as possible, new needs are identified and services are designed to support these needs.

6. Whilst the publication of the 'signpost booklet' for older peoples services is welcomed, it is recommended that the provision of information from a single source continues, and that funding is identified to ensure that this booklet and any other medium for providing information is regularly updated

1. Introduction

It is widely agreed that people should not remain in hospital for longer than necessary or be admitted inappropriately for a number of reasons: hospital acquired infections pose significant risk – particularly for the elderly; beds are in great demand and the hospital environment is not the ideal place to deliver rehabilitation and independent living. Intermediate care is one component of a range of services designed to address these problems by facilitating early discharge from and preventing admission to hospital.

The effectiveness of intermediate care is dependent upon interaction and co-ordination between a number of agencies and the success of outcomes for those using the service is also subject to the effectiveness of links between intermediate care services and wider rehabilitation. The intermediate care scrutiny task group has considered the performance of intermediate care services in Brent in this context looking specifically at:

- Whether our intermediate care services, in themselves result in effective outcomes for older people
- How effectively our intermediate care services integrate with the wider rehabilitation community

This report outlines the key findings of the intermediate care scrutiny task group and makes recommendations with regard to securing service improvements in this area.

Councillor Uma Fernandes, Chair
On behalf of Intermediate Care Scrutiny Task Group

2. Scope

In April 2004, the Social Care Scrutiny Panel agreed to establish the Joint Commissioning Strategy (Intermediate Care Provision) Task Group to review intermediate care aimed at promoting independence in the home or in designated care settings to prevent unnecessary admission to long term residential care or enable early discharge from hospital. The task group was tasked to identify any gaps or weaknesses in the existing provision and attempted to track the care services through the eyes of users by looking at the following issues:-

- Integration of the service
- Equity and choice considerations
- Engaging older people in the review of services
- Evaluating targets and outcomes
- Delivering best value

The task group has considered the work and performance of a number of services:

- Care Co-ordination Service
- Collaborative Care Team
- Intermediate Care Service – Social Services
- Housing and Supporting People service

It has also drawn on the experiences of older people and their representatives:

- Users of Dollis Hill day centre
- Pensioner's Service User Consultative Forum
- Pensioner's Forum
- Elders Voice
- Brent Carers Centre

3. The policy context

The National Service Framework for Older People[1] (NSF) provides the policy context for the development of intermediate care services. The overall framework identifies the need for older people to continue to enjoy good health and remain independent for as long as possible. It points out the need for health and social care services to be effective enough to deliver this outcome. The NSF is a ten-year programme of action linking services to support independence and promote good health, specialised services for key conditions and culture change so that all older people and their carers are always treated with respect, dignity and fairness.

Standard three of the NSF relates specifically to intermediate care. It specifies that:
"Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care."

Department of Health[2] defines Intermediate Care as services which:

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

The guidance further states:
"Intermediate care should form an integrated part of a seamless continuum of services linking health promotion, preventative services, primary care, community health services, social care, support for carers and acute hospital care. Support from these linked services remains essential for the successful development of intermediate care to ensure that its benefits are fully realised."

Whilst recognising the contribution that intermediate care will make to the extension of independent and active life for older people, the service should also be seen in the broader context of the government's drive to reduce delayed discharge thus making more effective use of acute capacity, supporting targets on waiting times and enabling the NHS to respond more effectively to emergency pressures. A study by Commission for Social Care Inspection (CSCI) 'Leaving Hospital, the price of delays' [3]for example, suggests that on any day in 2003, as many as 3000 people were unable to leave

[1] Modern Standards and Service Models – National Service Framework for Older People: Department of Health
[2] Intermediate Care - LAC (2001)1: Department of Health
[3] 'Leaving Hospital, the price of delays': Commission for Social Care Inspection

hospital despite being well enough to do so, as a result of non-availability of community care services. The Community Care [Delayed Discharges] Act 2003 placed an obligation on council's to reimburse NHS acute trusts in circumstances where a discharge cannot be made solely because of a lack of community care support.

This drive to promote early discharge runs the potential of a number of risks. In particular the quality of outcomes for older people and the services they receive and the implications of pressure placed upon them to make longer-term decisions about their future. Good quality intermediate care thus has a major role to play in delivering quality outcomes for older people. In general the CSCI study recommends:

- A holistic, cross-organisational approach to planning and delivering services for older people
- A greater focus on person-centred care management
- More robust, deliverable joint commissioning strategies designed to support independent living
- A more flexible, responsive provider market
- More follow up to assess longer term outcomes for older people leaving hospital
- A revised regulatory framework that better meets the modern needs and pressures

Experience from around the country suggests that there is debate as to whether specific services known as 'intermediate care' services need to be established separately or whether the principles of the intermediate care service should be reflected in the broader remit of rehabilitative services; could the principles of intermediate care become a model for the provision of rehabilitative services as a whole?

The Ladyman proposals on the future organisation of services to adults are expected before the end of the year or early in 2005. It is anticipated that the proposals likely to be included in the Green Paper will have implications for the organisation of intermediate care services. However, even in the absence of specific proposals, the Children Act has previously directed councils to create two statutory posts: Director of Children's Services and Director of Adult Social Services. It is proposed that the Director of Adult Social Services will play a key role in driving the shared agenda for the integration of service, working closely with health partners.

4. The Brent Perspective

A profile of older people in Brent

Although Brent is a relatively young borough there are still 42,000 older residents (60+). This represents 16% of the population, higher than the London average and this proportion is growing. Population predictions suggest that in the next 20 years Brent will see a slight decrease in residents under 44 years old and a significant increase in the 45-64 age group combined with a increase of all age groups over 65 years old.

Over 66% of people aged between 60 and 74 are from black and ethnic minority (BME) communities with 40% from BME communities over the age of 75. It is predicted that the ethnic composition of the older people population will change and this will have a significant impact on the services required.

Maintenance of older peoples, health and quality of life and the potential effectiveness of rehabilitative and intermediate care services is dependent on a number of 'environmental' factors – the specific impact of these services is discussed in greater detail below. However, in general terms the following are key issues influencing the health, well-being and rehabilitation of our older residents:

- Single pensioner households have an income of 25% of the average for the borough
- People with the highest level of deprivation are older people living alone, dependent on state benefits, spending 49% of their income on fuel and food with fewer possessions to aid daily living
- Households of two or more pensioners have the highest heating costs of any households
- Single pensioner households (26% of all households in the borough) have the greatest cost for repairs
- 6% of Brent's unfit housing is lived in by older people (500 homes)
- Almost 23,000 people in Brent provide unpaid care
- 50% of older people in Brent receive hospital care - 46% are emergency admissions, 36% day cases
- 96% of older people with a limiting long term disability stay in their own homes
- 44% of those aged 65 – 74 and 49% of those over 75 are likely to have two of the six most chronic diseases – heart disease, stroke, hypertension, diabetes, chronic obstructive pulmonary diagnosis (COPD) and asthma
- Each year 3000 older people in Brent are supplied with equipment and the number appears to be rising in 2004

The council and partners in health and the voluntary sector have adopted the following vision for the delivery of services to older people:

'Older people in Brent will enjoy an independent, active and healthy life, in a safe environment in the community. If health and/or local authority services are required, they will be provided in partnership with local people and the independent sector in ways that:

- maintain and promote independence and safety
- are of a high quality and meet required standards
- meet diversity and equality standards
- are provided in a timely and responsive way
- promote dignity, self respect, individuality and privacy
- offer choice whenever possible
- meet the needs of individual older people and their carers
- take account of age, gender, ethnicity, religion and culture
- are publicised widely and made accessible
- provide opportunities for older people to influence the development and delivery of services
- involve older people at each stage of the planning and decision making process'

Services contributing to Intermediate Care

Delivery of effective intermediate care is as much about ensuring greater co-ordination between existing services and developing a whole systems approach using a single assessment process as it is about designing new services. The paragraphs below examine the different components intermediate care services in Brent.

Care Co-ordination Service

The aim of the Care Co-ordination Service is to promote the independence of older people through the delivery of person-centred, co-ordinated services. The service recognises that traditionally care has been prescribed in discreet health and social care packages and that this lack of co-ordination has delivered poor outcomes for residents.

The service provides pro-active community based co-ordination of services delivered by senior nurses, therapists and social workers, targeting mostly people over the age of 75 with high health and/or social care needs.

The service actively identifies potential clients and promotes independence and improved care pathways by:

- Strengthening joint assessments and case management
- Integrating services and care planning mechanisms and improving communication
- Delivering care closer to home

The team comprises five co-ordinators, one administrative assistant and one team leader. Each co-ordinator manages one locality, working with referrals from within this area and promoting health and improved co-ordination. Overall management of the service is undertaken by the service advisory group which is made up of representatives from a range of organisations including PCT and Social Services Department

Referrals can be made for:

- Older people experiencing multiple crisis:
- A client who is over 75 and has not had an annual health screening
- Someone who has consistently missed their GP/hospital appointments
- Someone who has experienced major change in their daily living/life e.g. bereavement, deterioration in health, self neglect – that provokes concern and may lead to a crisis at home

Services are provided up to a maximum of 12 weeks and are then handed over to care managers.

Since its establishment in February 2004, the CCS has case managed 165 clients, the average age of whom was 82. 47% of these clients were white British and 62% were female. The largest source of referrals to the service was GPs – 43%. No referrals were made from the Accident and Emergency Service which is considered a limitation on the service – the task group was advised that a bid to fund direct work within the A&E services was being considered though concern about this was expressed by other service providers. 44% of referrals were made to the service to prevent crisis and 12% were made to prevent admission to hospital.

As part of the evaluation of the service, Brent Carers' Centre undertook a number of discovery interviews with clients before and after service intervention. The task group has not been given access to this data but discussions with the Carers' Centre suggest that the impact of the service has been good with outcomes for service users and satisfaction levels considerably improved.

Collaborative Care Team

This team promotes appropriate early discharge from hospital for those considered medically stable and prevents inappropriate hospital admission via access to observation facilities rather than hospital admission through A&E. The aim of the service is to deal with 'revolving door patients' - promoting discharge from hospital as soon as the patient is medically stable but ensuring that s/he receives appropriate support at home to meet their needs.

It is a multi disciplinary, multi-skilled outreach team that comprises:

- Nurses
- Physiotherapists
- Occupational therapists
- Health care assistants
- Care manager
- Delayed discharge co-ordinators
- Administrative staff

It also liaises with clinical medical specialists and chronic disease practitioners.

Intervention from the team is short term, if longer term care is needed the patient is referred to appropriate support for care planning/review. The team only take referrals for those patients who are being discharged early. Normal time discharge is handled by the Community Rehabilitation Team.

The team also works to promote effective chronic disease management – by being aware of the support needs of patients and thus preventing exacerbation it can reduce the level of inappropriate admissions to hospital.

Between January and September 2004 a total of 1079 referrals were accepted by the team – 49% of these were emergencies and 19% were to prevent admission. The service estimates that a total of 6446 bed days were saved over this period.

Intermediate Care Team, Social Services
The Social Services Intermediate Care Services plays and important role in supporting and ensuring that older people can stay within their own homes by providing them with a range of personal care services, Older people can also have up to six week intensive support in a nursing home.

The service is user focused and at the start of the care package individual goals and desired outcomes are agreed with the older person to ensure that maximum independence is achieved. Towards the end of the care period usually between the 4th and 5th week a review of the care plan is undertaken to establish whether the objectives have been made. At the review meeting decisions are taken about the need for ongoing services.

Within the team there is a gender and ethnicity mix to ensure that the older persons religious and cultural needs can be met.

The team comprises the following:-
- 1 care coordinator
- 1 care manager
- 1 liaison officer
- 8 senior care workers

During a six month period 123 cases were referred to the team, 61% of those referred regained their independence with 80% achieving this within the 6 week period. 19% of older people required ongoing support.

Housing Services
The Housing Service has a significant role to play in improving the quality of life of older people and providing a positive environment for rehabilitation.
- Provision of extra care sheltered accommodation in accordance with proposals in the Joint Commissioning Strategy.
- Disabled Facilities Grant – facilitates discharge by enabling adaptations to property – up to £25k for major work and £5k for small works. The Private Housing Service, which administers the grant, has recently recruited an occupational therapist to work directly on the scheme.
- Houseproud scheme – equity release scheme which enables property rich cash poor older residents to realise the equity in their property. The scheme offers a number of safeguards for residents not available via commercial schemes – they cannot be evicted nor have their property repossessed.
- Home Improvement Agency Service – the provision of minor works to keep older people's property in good order with particular focus on maintenance of independence/prevention of falls

- Fuel Poverty Strategy – Heatstreets scheme with Powergen. Under this scheme, properties that may benefit from the funding available for energy efficiency home improvements are identified using the housing needs survey.
- Housing and single assessment process – the current pilots of single assessment process are involving health and social services. Housing will become involved in these.
- Private Housing Information Unit – identification of private sector resources for homeless older people and for people whose current accommodation is no longer suitable post-hospital.
- Effective planning for BME older people – numbers of older people from BME communities is increasing and housing needs of these groups are being identified in order that they can be met.

These programmes have delivered significant benefits for older people:
- £4M bid to the DoH if successful would provide:
  - *15 units of converted extra care sheltered and*
  - *36 units of additional accommodation*.
- 100 Disabled Facilities Grant's were awarded in 2003/04
- 136 Empty property grants have been awarded
- 532 tenanted properties have been improved
- The Willow Housing programme has delivered refurbished sheltered stock taking their amount of sheltered stock to 670 and the additional extra care sheltered to 76

The task group was advised that the amount of funding available for older people under Supporting People scheme is the lowest in London. It was not clear why this is the case but, coupled with the overall (7%) reduction in Supporting People funds, it could have serious implications for the provision of housing support for vulnerable older people. The task group welcomed the review of older people element of Supporting People proposed for 2005.

Other professionals

A number of other services contribute to effective intermediate care. In particular a significant role can be played by GPs as a key contact point for more vulnerable residents. It is acknowledged that the capacity to influence this group of professionals and secure their involvement in the broader preventative/rehabilitative agenda is difficult. Nonetheless it is an area which would benefit from further investigation. The introduction of GPs with special interest and the community geriatrician may improve these services by ensuring specific issues of concern for older people e.g. falls, stroke, mental health are a specific focus.

In discussions with service users themselves, it became apparent that the effectiveness of services they receive is sometimes limited by professional inflexibility. The provision of domiciliary services at times that are convenient to the service provider but not the service user can have a serious impact on the capacity of the client to participate in other activities. For example, the task group heard from a number of service users about the timing of services from home helps, district nursing or transport which means that they are unable to attend day centre activities. The task group would welcome the opportunity to investigate further options for the provision of these services

Day Care
As part of the investigation members of the task group visited Dollis Hill Day Centre, one of only two council-run day centres for older people in the borough. The group was impressed by the service and noted the comments made by a number of service users about the benefits they gain from using the centre – the reduction in isolation and general support for older people's well being provided by the centre is highly valued by service users and from the council's perspective can make a major contribution to intermediate care regime by improving or maintaining the well-being of vulnerable older people. However, the task group felt that co-ordination of services could be improved in order to enable services currently available on a domiciliary basis to be made available via the day centres. For example, it might be feasible to make district nursing, GP or dietician services available via the day centres.

The task group was concerned that the proposed closure of Dollis Hill Day Centre, at the end of its lease, should not have an adverse impact upon the well being of older residents.

Carers
A critical component in the provision of prevention, rehabilitation and intermediate care services are carers. The capacity of the acute trusts to discharge 'medically fit' residents promptly will be immeasurably increased if there is care and support available to these residents. Providing adequate support to carers is a priority for the council and a number of arrangements have been put in place:

- A Carers Priority Action Group has been set up and this group is represented on the Older People's Local Improvement Team, the key planning body for services for older people
- A multi-agency carers strategy has been produced by the Priority Action Group which sets out the vision, values and key aims for coming years
- A user and carer development worker has been appointed to increase the focus on carers' needs
- training and guidance for all staff has been established to ensure we meet duties identified in the Carers (Equal Opportunities) Act 2004

During the deliberations of the task group a focus group of carers was held. Participants talked about the pressures under which they look after their friends or family members and comments such as *'I have no life it's all them 24 hours a day'* and '*I still don't know what my rights are'* made the task group acutely aware of the need to make sure that carers needs are addressed. In summary, the focus group led the task group to conclude that:

- It cannot be assumed that the carer does not need support in their own right
- Carers can feel resentful which can lead to guilt
- Carers are often confused re the different services that can be provided
- The number of service providers coming into home can be confusing

Findings
Effectiveness of co-ordination/collaboration/communication between different components
It is clear that the services designed to promote rehabilitation and intermediate care provide useful and effective support for Brent residents. They have clearly made a huge contribution to the improvement in the outcomes and experiences of our older residents and have made a major contribution to improving their lives.

However, the task group is concerned that the large number of different teams/services operating within this area is preventing successful integration and co-ordination and thus limiting the potential impact of services – there is no single pathway through this area of service provision and as such residents can be missed, and may receive different services dependent upon where they live or who they come into contact with.

Whilst the role of carers in the provision of support for older people is clearly recognised and both the council and PCT make significant effort to support carers and integrate them into the planning process at both an organisational and individual level, the task group wishes to place on record its concern that this commitment to carers is maintained and enhanced.

During the course of its investigation the task group heard from a number of older people and their carers about the importance of having access to effective information about the kind of services that can prevent deterioration of their circumstances and ultimately prevent admission to acute services. In this context the task group reiterates the findings of the 'Quality of Life for Older People' overview task group for the provision of an effective information service from which a wide range of information on services available to older people can be obtained.

Brent Model for Rehabilitation and Intermediate Care

During the task group's deliberations, negotiations have been ongoing between the council and Brent Primary Care Trust on the design and development of rehabilitative and intermediate care services. These recently published innovative and exciting plans propose a complete re-engineering of services. The model reflects an analysis of the performance of those services which have been considered by this task group and the conclusions echo the findings of the task group: "The general consensus ……. is that the current system [for rehabilitation and intermediate care] has not been working as a system. The vision of user and carer being central to individually planned holistic and integrated packages of treatment and care has not been possible because of the way provision has been structured and due to barriers in processes between services"[4]

Specifically with regard to intermediate care, the priorities of the model are to:

- Reduce avoidable hospital admissions and readmissions
- Improve discharge and transfers from hospital
- Avoid premature dependence on long term care
- Provide an 'ageless' rehabilitation and intermediate care service

The model is dependent upon a joint working approach from:

- Social Services
- Primary care Services
- Acute hospital services
- Community rehabilitation and Care Co-ordination Services
- Voluntary Sector
- Informal carers

[4] Brent Model for Rehabilitation and Intermediate Care, Brent tPCT

The model is being driven by the redevelopment of the Central Middlesex Hospital into the Brent Emergency Care and Diagnostics Centre (BECaD). BECaD is based on three concepts:

- The majority of acute care will be provided by the local hospital and primary care services
- An immediate expert assessment for patients with acute problems will be available when required
- Continuity of service and support will be maintained for patients.

In order to deliver this BECaD will comprise:

- An integrated acute and critical care unit
- Step down service combining hospital and community services
- Ring fenced elective services
- Specialist teams in the Expert Consulting Centre
- Patient manager posts to case manage acute load

Patients will move quickly through their period of in-patiency and discharge planning will commence as soon possible following admission. The assumption is that hospital in-patiency will be strictly controlled with residents moving quickly from acute facility through to the rehabilitation/intermediate care service provided from Willesden Hospital and ultimately to full rehabilitation. All components of this model are interdependent. Intermediate care services will provide short term support to prevent the need for hospitalisation or promote early discharge. Broader rehabilitation service will provide a comprehensive package of support with no long stay element or transitional beds (beyond 14 weeks). All intermediate and rehabilitative services will be provided by a single team, the Brent Intermediate/Rehabilitative Team, from a single outlet at Willesden General Hospital, currently being redeveloped under a Private Finance Initiative (PFI) deal.

Findings:

Implications of the new model of care

This model of care is broadly welcomed by the task group – it will facilitate holistic service delivery and by using a single assessment process can ensure that residents are placed at the centre of service delivery and planning and that discrepancies in the equity of provision experience under the current arrangements are removed. However, the task group is concerned about a number of issues that were identified during consideration of the proposal.

Co-location of staff and joint working between teams from different agencies under the proposals, cannot, as yet, be construed as integration of staff teams. Whilst a long term ambition, there are still concerns regarding the professional support that will be available, in particular, to social services professionals. The introduction of the National Health Service and Community Care Act 1990 made a significant change to the role of social workers changing them to care managers with a much broader range of responsibilities and this has implications for the type of support that is available from social services for the model and thus for successful integration.

The use of Willesden General Hospital as a central component in the delivery of the new model is critical. There are currently 60 beds in the hospital for which a significant change of use is prescribed by the model. Under the new model, beds in Willesden Hospital will be used to promote discharge and can be used by GPs in order to prevent admission to acute hospital. While they are occupied, under existing arrangements, by patients who may not benefit from rehabilitative input, the model will stall. Resources therefore must be found to facilitate their discharge from Willesden Hospital. Whilst it is accepted that resolution of the care needs of these people is critical to the success of the model and that additional resources may need to be identified to do so, there is further concern that this apparent gap in the range of services may be more than just a one-off and that this may be indicative of more systemic problems – is it likely that there will still be a group of residents for whom transition to appropriate care may take some time and who will then constrain the effectiveness of the new model by blocking the through-flow of patients in one or other of its component parts?

The task group is also concerned to ensure that the model has properly budgeted for the increase demand for community/domiciliary care services. Whilst these services are clearly a more cost-effective option than in-patiency, the provision of support within the community will require significant additional services if older people are not to be put at risk. The PCT has suggested that the removal of 35 beds under the BECaD model will release acute resources that can then be invested into community care facilities. However, these resources must be guaranteed and ring-fenced. The task group was concerned about potential financial implications of maintaining a consistent level of services for older people..

The task group also noted that the new model of care must be able to cater for the likely increase in numbers of older people potentially living longer and developing more complex needs. This is further compounded by the ethnic profile of our residents – as one of the most ethnically diverse boroughs in the country and with this diversity increasingly reflected amongst our older residents, the need for appropriate services to support this rich cultural mix may well place additional financial pressures on the model of provision – one size will not fit all.

5. Conclusion

The provision of effective intermediate care services is a critical component not only in maintaining independence and quality of life for older people but also in ensuring the effective use of acute hospital services for all. The task group has been impressed by the commitment and innovation evident in the delivery of intermediate care services to Brent residents. The task group is particularly impressed by the proposals to deliver the new model of care to residents in the BECaD and Willesden model which is designed to address the identified shortcomings of the current method of provision. However, we remain concerned that this new model is properly resourced and organised in order to really put older people at the centre of their care provision. Less than properly resourced, fully integrated services will do little other than reproduce existing provision and existing problems.

7. Acknowledgements

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- Margaret Magee, Collaborative Care Team
- Judith Thomas, Collaborative Care Team
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- John Soloko, Brent Carers Centre
- Brent Carers Centre members
- Dollis Hill Day Centre and users
- Brent Pensioners' Service Users Consultative Forum
- Brent Pensioners' Forum
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