Learning Network

Care Provider Alliance and NHS England

Delivering care closer to home: co-designing intermediate care in ICSs

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Context

The Care Provider Alliance (CPA) and NHS England (NHSE) are supporting effective partnership working between the adult social care provider sector and integrated care systems (ICSs).

To support this, they have established a virtual Learning Network which will host a series of learning summits.

This session, held in October 2023, explored the emerging models for intermediate care – with a focus on frontrunners, the NHS framework for intermediate care, and the National Care Forum's blueprint for accommodation-based intermediate care. joint workforce planning across health and social care at local level.

This Learning Summit was co-chaired by Dr Jane Townson, Chair of the Care Provider Alliance and Chief Executive of the Homecare Association, and Jenny Keane, Director of Intermediate Care and Rehabilitation at NHS England.

It included examples from intermediate care frontrunners - Warwickshire and Croydon, and a presentation by the National Care Forum on accommodation-based intermediate care.

Key learning

- Intermediate care is 'setting agnostic'. All appropriate settings should be considered – for example, in the patient's own home or residential care.
- Access to system-wide data is crucial to planning, assessing and delivering intermediate care. Work with data and IT system leads to develop and improve this.

- Manage communication with family carers and patients in order to understand and manage expectations. Include them as co-designers of the care – and be clear about what will happen if the situation deteriorates, as well as if it improves.
- Focus on wellbeing of the whole unit at home – including family members. This should include mental wellbeing, even if physical improvement is likely to be limited.
- Set goals with the patient and family and review these within the home setting.
- Transfer of Care Hubs should start planning when a patient is admitted to hospital. They do not have to wait for a referral.
- Transfer of Care Hubs should have an overview of all available capacity and when that capacity is coming online, and they should have senior decision makers from both health and care.

Chair's introduction

Jenny Keane, Director of Intermediate Care and Rehabilitation at NHS England

We have an opportunity for the NHS, local authorities, and social care providers to come together to create a community-based recovery model which enables people to stay well, safe and independent in the place that they call home. It is enabling people to "walk, talk, eat, drink, and sleep in wherever they call home".

The priorities within the NHS England intermediate care framework are:

1. **Demand and capacity planning** – including the need for system oversight and whole system planning.
2. **Workforce utilisation** - having the right staff in the right place at the right time, and focusing on what will improve capacity.
3. **Implementing effective care transfer hubs** at system level, not on an acute footprint.
4. **Improving data quality and sharing** across the system to support planning, delivery and outcomes.

The key enabler to delivering these priorities is working together in an integrated way across health and care.

Dr Jane Townson, Chair, Care Provider Alliance and Chief Executive, Homecare Association

Intermediate care is not a new idea. The goal has been to enable all of us to live well in our communities and keep out of hospital as far as possible. We can achieve so

much when the NHS social care providers, local government and the voluntary sector work together.

The care workforce is over 1.6 million – larger than the NHS, so together we form an essential part of a combined workforce supporting our communities.

Integration needs to happen at both national and local level to ensure that everyone can access care who needs it in all of its forms.

Key issues include relationship building and working together to solve problems and to identify solutions. Having effective IT systems that enable us to share data and knowledge, as is supporting the estimated 10.6 million 'informal' carers who support their loved ones.

Local approaches

Summaries of the intermediate care services in Warwickshire and Croydon are outlined below. You can access more detailed case studies on the Care Provider Alliance website.

Community Recovery Services – Warwickshire

Ryan Stocks, Clinical lead, The Community of Recovery Service at South Warwickshire University NHS Foundation Trust and Sera Bailey, Operation Manager, Social Care and Support at Warwickshire County Council.

Background

Like most areas, Warwickshire faces higher demands for support for older people to return home from hospital, increasing demand for domiciliary care services and pressure on acute hospital beds. There is increased demand, growing costs, and pressure on both health and care services.

The Community Recovery Service strives to increase partnership working between social care, the NHS and care providers. It is committed to the 'home first' delivery and vision, in line the national discharge to assess ethos.

Objectives

The vision for the service is:

> "Our vision is that Warwickshire people in an acute hospital, who need further support to recover, will have access to effective therapeutic intermediate care services within 24 hours of no longer meeting criteria to reside."

Through the delivery of a new Community Recovery Service, Warwickshire aims to:

1) Reduce hospital length of stay and bed days lost.
   - Decreasing the number of people staying in hospital who should be at home.

2) Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission.
   - Increasing people's functional outcomes.

3) Decrease the need for long-term care.
   - By decreasing demand and acuity.
   - Decreasing long-term care costs.

Service model

The CRS delivers intermediate care, involving up to a maximum of six weeks of free care – dependent on individual patient's needs – after a stay in hospital. Carers and therapists work towards assessing and reducing care and increasing patients' independence.

The hospital will determine the patients exit pathway and refer to the appropriate service. Referrals into the CRS are accepted on a trusted assessment basis. Hospitals only need to decide if the care calls are singles or doubles rather than prescribing the amount of care.

The CRS accepts patients with any condition.

The aim is for care to commence within 24 hours of the referral being received.

All patients using the CRS initially go home with four care calls. Within two hours of the individual returning home an assessment is completed by the care agency to understand someone's individual needs and formulate a care plan.

Care agencies have full autonomy and are expected to actively seek to reduce care. This is supported by therapy staff if needed, who may also advise carers to reduce care. All cases can be discussed at weekly multi-disciplinary team meetings.

An escalation log/contact list has been created alongside Warwickshire's Standard Operating Procedure to support staff in resolving any issues identified during the pathway.

Structures

The Community Recovery Service has commissioned 7 care providers and established a service criteria and standard operating procedure (SOP). The SOP has been instrumental in establishing integrated working practices which are now, after six months, becoming business as usual.

They have focused on improving integrated working with a multi-disciplinary team (MDT) including social workers, therapists and social care providers across health and social care. The MDT meets three times a week and discusses all patients on

their caseload and troubleshoots any challenges such as blocked flow or capacity within the system.

Integration and engagement have been fundamental to building relationships and supporting cultural change. This has been encouraged and developed through a range of methods, including: therapy-provider engagement meetings; establishing CRS Champions; holding away days; joint patient visits; enhanced communication methods; a monthly CRS Newsletter for updates; shared training sessions; and regular stakeholder meetings.

Actions

Working with care providers

Warwickshire County Council ran an expression of interest exercise with the existing domiciliary care market and were able to select 7 providers to work with that are paid using a pre purchased block model which includes time for initial assessments.

A key change is that care providers have been given full autonomy to assess and amend care packages.

Enhanced communication and collaboration between therapists, care providers and the Council has been established. Staff have access to key contacts lists for support, an escalation log, scenarios, links to individuals within the Council and MDT meetings. There is also a CRS domiciliary care reference group and plans to develop a learning network and provider ambassadors.

Information sharing is currently completed via email as the partners work across different IT systems. In the long-term, it is an ambition to work towards shared systems.

Therapy Workforce

Warwickshire has been assessing the capacity and demand for therapy staff to support workforce planning. The aim is to ensure they have the right staff in post to meet the needs of their current and future client base.

The recruitment focus has been on the band 4 unregistered workforce. Recruitment into new non-clinical roles aims to increase Therapists clinical time/patient contact.

Impact

Anecdotal feedback from care staff and managers is that they have greater job satisfaction and feel valued as a result of the Community Recovery Service (CRS).

Between April and October 2023:

- 1,150 packages of care had started on the Community Recovery Service.

- 53% of them started the service within three days of referral.
- There has been an 80% increase in the number of patients using therapy services which is in line with the CRS objectives.
- 85% of all referrals are accepted by therapy.
- Hospital discharge teams report feeling a reduction in waiting times. This is currently anecdotal, and they are awaiting data to support reporting.
- Data sets for exits and the impact on long-term care need is also being developed, but the majority of patients exit the CRS with some level of long-term care which is to be expected given caseload acuity.
- Patient and staff feedback is being collected. It indicates that patients welcome the service, with people mobilising quicker and improving their quality of life.

Examples of patient exit routes from the CRS include:

- Reduction in long-term care.
- Discharged independent without ongoing care requirements.
- Long-term care needs unchanged – but improved wellbeing.

Next steps

Warwickshire is expanding the data set available to them, continuing workforce planning and behaviour change, and considering how they can integrate and collaborate even further.

Lessons learned

- Communicate and engage with all stakeholders regularly.
- Manage patients, family members and staff expectations.
- Build in patient engagement and coproduction from the start.
- Find workarounds to integrate technology and data.
- Be open to continuous review and learning.
- Understand capacity and demand for key roles – such as therapy staff.
- Understand the impact of new pathways on the wider care market and mitigate any risks.

Further information and contacts

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One Croydon Alliance

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Introduction

The One Croydon Alliance is piloting a 'wraparound' service to support people following a hospital discharge.

The Alliance includes social care providers, the local authority, NHS services, Age UK, South London and Maudsley NHS Trust (SLAM) and the local GP Collaborative.

Objectives

The key objectives are to:

- Simplify processes and SOPs and minimise steps to transfer of care
- Establish a true single point of access for hospital discharges and community step-ups
- Offer Discharge to Assess as default for all patients
- Deliver a truly integrated discharge team
- Introduce blended roles
- Define the workforce and skill mix required
- Decide where to treat patients to maximise outcomes (home vs hospital)
- Optimise provision of social care and reduce overprovision
- Define joint funding arrangements and budget

- Define clinical responsibility, oversight, and ownership for a truly integrated care offering
- Agree operational delivery by a single blended team with everyone managed under one collective
- Develop a permanent integrated health and social commissioning team
- Define data we need to record to support operations and performance reviews
- Define KPIs and operational information for all teams
- Improve IT systems and interoperability.

Actions

The One Croydon Alliance is developing an integrated team which will have a joint health and social care manager, together with new blended roles across the hospital and community services.

Within the hospital, they are establishing a **Transfer of Care Hub** which will be responsible for coordinating discharge from the acute setting to the Discharge to Assess settings. The hub does not wait for a referral. They start planning the transfer of care once the patient is admitted to hospital. They have oversight of all available capacity and when it is coming online. They have senior decision makers from both health and care. As the hub matures, the expectation is that they will become the hub for shared integrated data which will support demand and capacity planning.

The Wraparound service provides health and care support for up to seven days after discharge.

Recovery care: Croydon has brought together all of their therapy and rehab services including their falls, physio and therapy services. They have streamlined their assessments and processes, and the aim is to reduce waiting times.

Centres of Excellence: Croydon Council is reviewing how to develop their care homes into centres of excellence to include more rehab and reablement beds. They are also planning to locate their recovering team at the homes, and create a bedded facility for short term support after hospital discharge.

Joint budget: One Croydon is establishing two key joint budgets across the NHS and social care. One will be for the Transfer of Care Hub and one for the wraparound and recovery service. These budgets will enable the teams to recruit and work together.

Data and IT systems: One Croydon is integrating its IT systems so that social care, local authority and NHS acute systems can connect with each other through the use of APIs. They are also working with the data analysts team to standardise recording across teams with the aim of understanding demand and use of workforce time.

Primary Care Networks: the PCNs have weekly meetings which includes a social worker, PIC, and nursing staff to prevent unnecessary hospital admissions. They also have a team in A&E which can refer to the recording team to prevent unnecessary hospital admissions.

Wraparound service

The wraparound service provides full holistic support to patients for up to seven days following discharge from hospital into the community. The aim is to get them back to their baseline before admission to hospital and avoid readmissions.

The hospital-based therapists carry out the initial assessment and discharge to assess referral. The hospital has a triage team in place to ensure all the information is available on the referral so that they can brokerage the package of care.

The welfare check within about 20 hours after discharge is carried out by the Council's health and wellbeing assessor *and* the care agency.

The assessment is then reviewed by the MDT (including therapists, pharamacists etc) to ensure that it has been completed to a high standard and to consider any other issues that need to be included.

Recovery care is then provided by the LIFE team – One Croydon's reablement and rehabilitation provision which manages all hospital discharges in the community.

Goals and managing expectations

Goals that are set in the hospital are reviewed and revisited at home to make sure these are achievable within the home environment. These can be changed depending on time frames and patients and family members' cooperation.

The senor reablement officer goes out when the patient is discharged. They see them mobilising within their setting and assess whether then need to be referred on to any other service (e.g. OT or physio) or if the care package can actually be reduced. The assessors also consider the mental health and wellbeing of the main carers, family, friends and neighbours.

All team members – including hospital staff, therapists, care workers and assessors – are reminded that this is a reablement not an ongoing service. They reinforce this message with patients and family members in order to manage expectations.

Lessons learned

- The hospital and local authority teams need to **work with care agencies to set KPIs and deliver services** from the outset. Involve them at the start of any process.

- **Rapid access to equipment** is essential to successful reablement. It increases the patient's confidence, and enables care staff to commence reablement rapidly.
- **Other aspects of the client's life** should be considered such as family dynamics (positive and negative), other comorbidities.
- **Mental health of clients and their main carer** should be considered. These will affect the outcome of an individual's reablement and whether they return into the hospital cycle.
- **A hybrid model** is required including the use of internal reablement service with the hospital as well as the external care agency.
- **Access to comprehensive data to provide 'one version of the truth'** is challenging. Croydon is using front runner funding to invest in a connected data system across health and social care.

Further information

One Croydon Alliance

NCF Blueprint for accommodation-based intermediate care

Liz Jones, Director of Policy, National Care Forum

The National Care Forum has produced a blueprint which describes what effective, high quality, timely rehabilitative care in a variety of community settings looks like to ensure that people being discharged from hospital to a place they call home can achieve the level of independence they desire.

The document highlights the importance of intermediate care delivered in **accommodation-based services in care settings**, which support people out of hospital who are medically well, but need on-going therapy, reablement and 24-hour care before they can safely go home.

Care providers can use the blueprint to enhance their existing services, or establish new ones, and commissioners can use it to identify the key elements they should look for in intermediate care services.

NCF's blueprint, developed in partnership with the Care Provider Alliance, identifies five key elements or ingredients that need to be considered in intermediate care:

Environment

Residential homes are often people's long-term homes. But residential intermediate services require a different sort of environment to support shorter-term recovery and

reablement. For example, they need intensive physio and occupational therapy to support exercise for mobility and building confidence in the environment before going home. This may involve directly employed OTs, designated therapy areas, gyms, access to gardens, use of the kitchen, and support to use equipment properly.

Workforce

The whole workforce needs to have a 'recovery mindset', which is quite different to the mindset for delivering long-term care. All the support workers – including care staff and therapists need to have a reablement mindset so that every interaction is potentially a rehabilitative and recovery interaction which builds confidence and skills.

It is essential to have an intermediate care lead who is a key partner in the multi-disciplinary team that supports and coordinates care for individuals. The take responsibility for planning their whole journey into and out of the intermediate care service.

Multidisciplinary Commitment and Collaboration to Intermediate Care

It is essential to have the right people involved to ensure people requiring reablement services are given access to the right services. This includes access to the right assessments, therapists, and wraparound services that someone is likely to need both in the short-term residential service, and when they go home to their permanent accommodation – whether that is their own home or a long-term residential service.

Technology

Digital systems, communication and data sharing is absolutely critical to effective intermediate care.

NCF members that have run successful services have reported that they have good joined up technology and data systems so that information about people's needs are going straight to their digital social care record. Before they arrive in the service, the care planning has started with their family, clinicians, therapists and other experts.

Work is already underway to support adult social are providers become more digital, which in turn will support effective discharge and recovery.

Sustainable Commissioning and Funding

Intermediate care – whether it is home based, or accommodation-based – requirement significant investment including training and supporting staff to focus on recovery, and to take part in the multi-disciplinary approach to reablement.

Partnership working is critical – yet care providers are often viewed by commissioners as organisations that they buy support from – not as strategic partners. Commissioners should see the provider sector as strategic partners with insights and creativity, who are invested in achieving the best outcomes they can for the people and communities that they support.

Care providers must be involved in strategic planning including measuring capacity and demand.

Chairs' reflections

The chairs acknowledged that presenters and attendees showed a very strong sense of wanting to do the right thing for individuals and for the populations that they served. That is often lost in discussions around processes and numbers.

They identified key themes from presentations and discussions including:

- The focus should be on effective rehabilitation – not on the setting in which it takes place. Jenny Keane emphasised that she is 'agnostic of setting'.
- Genuine collaboration with social care providers as equal partners is essential. Good communication and joint training can help build relationships across different organisations and teams.
- Joint workforce planning is key. Work is already underway with Skills for Care and NHS England on this.
- Funding can be managed in a more integrated way – with potential use of polled budgets.
- Practical issues, such as ensuring equipment is rapidly available can also make a major difference to the delivery of intermediate care.
- Measuring the outcomes and building the evidence around intermediate care needs to be considered: how many people went on to other long-term care services and how many were able to go with reduced or no care packages? What are the costs?
- More consideration needs to be given to involving and supporting family carers in planning and delivering intermediate care.

Themes from Q&A

Definitions and language

1. **Intermediate care isn't new but we are still referring to it as magic 6 weeks - are there any current definitions of the difference between intermediate care and community residential rehab, D2A placements? It can be confusing for staff and patients / relatives as all used interchangeably.**

   Intermediate care is short-term multidisciplinary care with a focus on rehabilitation (rehabilitation also being reablement and recovery).D2A (discharge to assess) is waiting a long term care assessment.

   The Intermediate Care Framework was published in September 2023 (**NHS England » Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge)**

   Intermediate care covers the time from discharge and the following 'up to' six weeks of rehabilitation and reablement for recovery, in either a community bed or the person's own home. The accompanying framework **A new community rehabilitation and reablement model (england.nhs.uk) NHS England »** describes the services more fully.

Roles

2. **Can you give an example of how intermediate care and reablement have integrated and how the roles are differentiated please?**

   In the NHS IC framework and the community rehabilitation reablement and recovery model, rehabilitation, reablement and recovery are all a continuum of need with reablement being a component of rehabilitation. The model of care is agnostic of setting or sector.

Discharge and system flow

3. **The discharge from acute setting can have an intense focus on 'patient needs to leave here as soon as it is safely possible'. Is there a perception that once a patient is on the pathway 2 journey in a bedded setting, the focus is on 'rehab takes as long as it takes'? Is there a disconnect between acute and community setting in terms of the sense of urgency for creating flow through the system? How have the Warwickshire team improved that system flow?**

   The multidisciplinary team within the Care Transfer Hub decides along with the person and their family the discharge pathway option that enables strengths-based, outcomes focussed recovery in the best setting according to the person's needs. If it is decided a person will benefit the most from a Pathway 2 rehab bed

setting, their recovery will be assessed regularly during the timeframe of the Intermediate Care service. This will determine whether they need long-term care, or can be discharged home.

There is a piece of work being led nationally to improve flow and productivity in community beds, with community health beds having the same oversight and accountability as acute with the equivalent community sit rep. The expectation is that this will be referenced in the next iteration of the NHS planning guidance.

In Warwickshire, when someone is in pathway 2, there is still a strong focus on how we get those individuals discharged home via Pathway 1 - Home First being the preferable option if appropriate to the person's needs.

4. **Are there any lessons from the pilot in respect of improving partnership working across health, LA and ASC providers?**

   Engagement, communication and updates have been key. Face-face engagement sessions were very beneficial so staff could meet together and understand each other's needs and challenges. From this, staff were able to suggest and implement different ways of working together - such as sharing the goals sheet.

   A challenge to achieving full integration has been technology – as partners all use different IT systems. A key lesson is to integrate or use one system if possible in order to improve communication and information sharing

   Joint commissioning across health and social care, with pooled budgets is enabling the integrated agenda for intermediate care across health and social care.

Family carers

5. **What is being done for family carers who are often pivotal?**

   One area is exploring the options of reablement workers "training" and supporting the carers/families with any available capacity as they receive block funding for the service in Cornwall with staff on guaranteed hours. They commission the voluntary sector to work alongside the service and provide support which helps confidence and re-engagement into local community support.

Assessment and care packages

6. **What would people agree is the biggest challenge/anxiety around assessing capacity and demand?**

   The biggest challenge is understanding the unmet demand and commissioning adequately to cover this.

Workforce and roles

7. **Has workforce been a challenge? Therapy workforce and recruitment into vacant social care roles presents challenges for us in delivering our current IMC and Reablement services.**

   The NHS community rehabilitation and reablement model just published focusses on this.

   In Warwickshire, understanding capacity and demand for therapy staff was a key starting block. Recruiting to registered therapy roles has been challenging – but they have recruited 11 new starters to date. They have also recruited to their unregistered assistant practitioner workforce.

8. **Has the therapy workforce been shifted out of acute to support implementation?**

   This is one of the key recommendations in the National Integrated Care Framework. The aim is to reduce the number of handovers and to ensure that as much of the rehabilitation is provided outside of the acute setting.

   In Warwickshire they have not moved therapists from acute setting. They do not ask for prescriptive assessments or goals from staff in the acute setting. They complete those goals outside of the hospital setting.

Service model

9. **Is there one role you would suggest is a must for all ICSs to have in place?**

   A multi-disciplinary team transfer of care hub and a Trusted Assessor within it would be ideal, however pilot sites are being given the flexibility to test what works for them depending on local need and resources.

Contacts

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Next steps

- **Register** for Learning Network updates.
- **Contact us:** info@careprovideralliance.org.uk
- **Visit:** https://careprovideralliance.org.uk/integrated-care-learning-network
- **Follow us on X** @CPA_SocialCare

Useful links

Access the recording, slides, report, resource pack and detailed case studies from this Learning Summit on the Care Provider Alliance website.

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