social care
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SCIE Highlights No 1 – July 2017

Intermediate Care

Intermediate care can deliver better outcomes for people and reduce the pressures on hospitals and the care system. Yet its potential has not been fully realised. Evidence offers some clear learning points that can guide the growth of intermediate care.

Definition

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital.

Intermediate care:

- helps people to avoid going into hospital or residential care unnecessarily
- helps people to be as independent as possible after a stay in hospital
- can be provided in different places (e.g. community hospital, residential home or in people's own homes).

Source: NHS Benchmarking (2015) National Audit of Intermediate Care Network Report

Policy context

Intermediate care is not a new idea. Promoting independence and shifting care away from hospitals and residential homes has been a policy objective for over 30 years.

Intermediate care was developed as part of the NHS Plan in 2000 and was one of the national standards in the 2001 National Service Framework Service for Older People.

It is an important focus of efforts to integrate health and social care through the Better Care Fund. It is central to the ambitions of most Sustainability Transformation Plans across the country to shift more care closer to home and to the NHS Five Year Forward View triple aim of better health, better care, and better value.

Models of intermediate care

Four broad service models of intermediate care have evolved:

1. **Bed-based services** are provided in an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based settings.
2. **Community-based services** provide assessment and interventions to people in their own home or a care home.
3. **Crisis response services** are based in the community and are provided to people in their own home or a care home with the aim of avoiding hospital admissions.
4. **Reablement services** are based in the community and provide assessment and interventions to people in their own home or a care home. These services aim to help people recover skills and confidence to live at home and maximise their independence.

70%

of people who received intermediate care after a hospital stay, returned to their own home

92%

maintained or improved their dependency score

72%

did not move to a more dependent care setting

Source: National Audit of Intermediate Care 2015

The case for intermediate care

There are at least three reasons why the development of intermediate care requires fresh impetus.

More of the same is not sustainable
The health and social care system faces major challenges arising from squeezed budgets, rising demand, increasing costs, greater transparency about the quality of care, and rising public expectations. Levels of hospital activity – especially admissions – have continued to rise over the last eight years.

These pressures will be intensified by demography. The number of people aged 85 and over will increase by a third over the next ten years, and the number of people living with dementia is expected to grow to around 1.3 million in 2025.

One estimate suggests that if admission rates continue to increase, the growing and ageing population alone means that the NHS would need approximately 17,000 additional beds by 2022 (Smith and others, 2014).

Responding to these challenges with 'more of the same' – acute hospital beds and care home places – is not sustainable – or the best option for individuals.

Intermediate care offers a more cost-effective, if not cheaper, response.

Performance is variable
There are wide variations in the performance of local heath and care systems in offering care closer to home. Intermediate care could make a much bigger difference to people's experience, outcomes and use of resources.

Key variations between different parts of the country include:

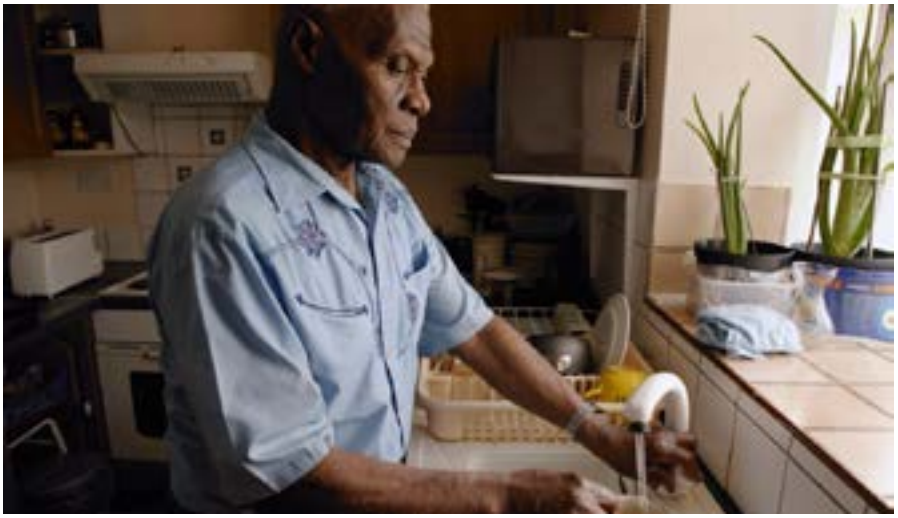
- Emergency hospital admissions of people aged 75 and over varies nine-fold
- Hospital admission of people aged 75 and over from residential care/ nursing homes varies 604-fold
- Admissions to residential care and nursing home of people funded by councils varies six-fold
- The number of people still at home 91 days after being discharged from hospital to a reablement/rehabilitation service varies nine-fold.

Source: NHS Atlas of Variation 2015

Demand for intermediate care is increasing
Investment in intermediate care is not keeping pace with rising need.

Expenditure in recent years has remained static and capacity is around a half of what is required. Reablement capacity is actually falling – despite increasing evidence of its effectiveness – and waiting times for intermediate care are rising (National Audit of Intermediate Care 2015).

As a result, the potential of intermediate care to reduce the pressure on hospitals and social care is under-utilised.



Evidence of effectiveness

Evidence shows that well-designed intermediate care can:

- improve people's outcomes and levels of satisfaction
- reduce admissions to hospital and long term social care services
- reduce delayed discharges.

92%
of people who used home-based or reablement services maintained or improved their dependency score (a measure of the help they need with activities of daily living).

93%
of people who used bed based services maintained or improved their dependency score.

70%
of people who received intermediate care following a hospital stay, were able to return to their own home.

72%
of people did not move to a more dependent care setting.

88%
of people using health based intermediate care services meet their goals (wholly or partially).

90%
of people said they were treated with dignity and respect. There is room for improvement about communicating with and involving people who use services and managing expectation about the short-term nature of the service.

Source: National Audit of Intermediate Care 2015

Key lessons and challenges

Evidence offers clear learning points that can guide the development of intermediate care.

1. **Local implementation and context impact on success.** Areas with a history of effective joint working tend to see more positive results from intermediate care. There is no single one-size-fits-all template for any of the four models of intermediate care.
2. **A more integrated approach to planning, funding and delivery** of all four models, including shared assessments that are accepted across all services, is likely to achieve better use of resources and outcomes. Currently, the four service models of intermediate care usually operate separately, delivered by different staff and funded from different budgets. (See Key elements of an effective system).
3. **Capacity should be planned across the whole patient flow.** There should be a balance between 'step-up' services (designed to prevent hospital admissions) and 'step-down' services (to enable timely hospital discharge). Step-up capacity is essential to support admission avoidance but can come under pressure as places are filled with people stepping down from hospital.
4. **The aims, objectives and purpose of intermediate care should be clear and understood** by people using the services, their families, and professionals from the wider health and social care system. There can be confusion between services funded through the NHS and reablement services funded by local authorities. The difference between active rehabilitation and reablement and other forms of intermediate care are not always understood, nor the time-limited duration of the service. Unless explained clearly, families may resist discharge from acute hospital and hospital staff may see discharge to long-term care as the only option.
5. **Multi-disciplinary working requires the right staff and skill mix,** and flexibility in how staff are deployed across the four types of intermediate care. Multidisciplinary teams should include: nurses, therapists, social workers and community psychiatric nurses, input from voluntary and community groups, and be led by a senior clinician or social worker.
6. **Effective leadership** is crucial to deliver clarity of shared purpose about intermediate care across the system and drive the development of the service as part of wider transformation plans, not as a separate stand-alone initiative. Leadership is needed at senior and operational level in the NHS and local authorities. Both involve a 'system leadership' role in overseeing how different service models operate as a single, joined-up service.
7. **New funding and payment mechanisms are available.** The roll-out of new models of care through the Vanguard programme and the development of accountable care systems creates opportunities to consider new mechanisms for intermediate care such as capitated budgets for a whole population, pooled health and social care budgets and 'year of care' commissioning.
8. **Expectations about what intermediate care can achieve, at what cost and over what timescale, should be realistic.** Shifting care out of hospitals is difficult to do and poorly designed intermediate might fuel more demand by revealing unmet need. Care outside of hospital generally is unlikely to be cheaper for the NHS in the short to medium term.

Key elements of an effective system

- ✓ A single point of access for all types of local intermediate care services, including a referral process that is widely understood across the whole system and a single assessment process.
- ✓ Shared access to health and social care records – ideally single patient record.
- ✓ A single management structure for the service as a whole and individual elements within it.
- ✓ An agreed multidisciplinary team composition in which staff are able to work flexibly across services and undertake trans-disciplinary roles.
- ✓ Joint training and induction programme for health and social care staff.
- ✓ Weekly multidisciplinary team meetings attended by health and social care staff.
- ✓ A mental health specialist included in the establishment of the service.
- ✓ A joint or integrated commissioning function for the service in which health and social care resources are aligned, if not pooled.
- ✓ A single performance management framework.

CASE STUDY

Reablement: Stabilise and Make Safe, Trafford

The issue

Trafford was experiencing significant delays in home care providers responding to requests to provide multiple care visits for clients. This was resulting in significant numbers of delayed transfers of care and sometimes meant that older people were staying in a hospital bed longer than necessary.

The project

Stabilise and Make Safe (SAMS) is a short-term intervention designed to increase a person's chance of long-term independence following hospitalisation or a community referral. It is limited to up to six weeks.

Key features include:

- business model with providers based on geographic areas to foster good understanding of local demand
- pricing model with fixed cost to the Council but not based on an hourly rate in order to incentivise providers and quality of care
- high-calibre staff, enhanced pay rate and investment in training
- statutory assessment by a social worker at the start and a follow up assessment by a social worker at the end to measure outcomes (level of independence achieved).

Trafford Council now intends to trial this model for people using existing packages of care, in addition to new referrals. It is currently establishing an approach with providers to design flow and remuneration.

Impact

- 70 per cent of people achieving full independence. 10 per cent remaining the same, 10 per cent resulting in an increase in the care package and 10 per cent failing to complete (usually due to re-admittance to hospital)
- Reduced length of stay in hospital, preventing the risk of infection and/or loss of skills
- Greater independence and confidence
- Improved responsiveness – service accessed within 1–3 days of referral
- £1 million net savings in the first year (estimated)
- Return on investment of £7.78 for every £1 invested, compared to traditional in-house reablement services which are estimated to generate a benefit of £1.57 for every £1 invested.

70%
of people achieving full independence

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£7.78
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CASE STUDY

Bed-based intermediate care: Somerset Care and Yeovil District Hospital

The issue

In 2015, Somerset County Council's significant deficit meant that doing more of the same was not an option. Its task was to save money for the health and care system and improve the health and wellbeing of some of residents with highest levels of need.

The project

Yeovil District Hospital purchased 18 beds at Somerset Care's nursing home in Yeovil (Cooksons Court) to become intermediate care rehabilitation beds.

Members of the hospital's Rehabilitation Team work alongside Somerset Care nurses as a single team. They identify and assess patients in hospital to determine outcome goals and, with consent, transfer them to Cooksons Court for a ten-day period of intensive reablement. At the end of the period they are assessed and discharged home, with or without home care and support, as required.

The overall aims of this collaboration was to:

- improve patient flow at Yeovil District Hospital
- reduce unnecessary length of hospital stay
- enable reablement in an appropriate environment
- maximise patient clinical outcomes
- reduce ongoing costs of care.

Impact

- 402 admissions to Cooksons Court by April 2017
- 95 per cent of people were discharged home from Cooksons Court
- 42 per cent of patients required a reduction in their predicted home care packages upon discharge
- £1.6 million savings in ongoing care costs to the local authority

Feedback from people who have used the service shows the extent to which they have valued the care and expertise of staff. As one client said:

"There are no words to express my gratitude, thank you with all my heart. I've been born again."

Further information

Somerset Care and Yeovil District Hospital: Cooksons Court – full case study available on SCIE Prevention resource

Cooksons Court reablement video on YouTube

95%
of people were discharged home from Cooksons Court

42%
of patients required a reduction in their predicted home care packages upon discharge

£1.6m
savings in ongoing care costs

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Support from SCIE

SCIE carries out reviews and evaluations of local areas' strategies and plans for service transformation, including intermediate care, drawing on the latest evidence of what works.

Our support includes:

- reviewing proposals for system and service transformation in relation to national best practice
- analysing and segmenting data to identify the current state of service performance and demand for services
- conducting cost-benefit analysis to establish the potential cost savings and cost avoidance to the whole system
- working collaboratively with local stakeholders and people who use services and carers to re-design services
- producing actionable recommendations.

SCIE also provides CPD-accredited training.

Contact us

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Further information

Homecare reablement toolkit, (2011, archived), Care Services Efficiency Delivery programme, Department of Health

Intermediate care – Draft guideline (2017), National Institute for Health and Care Excellence

National Audit of Intermediate Care Summary Report (2015) NHS Benchmarking Network

Prevention and wellbeing, Social Care Institute for Excellence

Reablement resources, Social Care Institute for Excellence. Includes guide to Maximising the potential of reablement

Shifting the balance of care: great expectations (2017), Research report. Nuffield Trust