The Age of Intermediate Care

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Foreword

What is Intermediate Care?

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).[1]**

1 https://www.scie.org.uk/prevention/independence/intermediate-care/highlights

Lived experience

Before he died in 2006, I looked after my husband who had vascular dementia. His stay in hospital in the later part of his life raised serious questions regarding admission, management and discharge of a patient with dementia. Instead of criticising, I became involved in several projects in Somerset aimed at improving approaches to admission and discharge. It became clear that many patients should never have been admitted, and far too many deteriorated during their stay until they were unable to live independently again. But systematically, nothing really changed.

When I was offered a place on the Discharge to Assess (D2A) group in 2020, I felt the conversation shift. Here was a real attempt by frontline staff to understand the impact of organisational culture on admission avoidance and early discharge to home. The importance of bringing patients' positive hospital experience to the forefront of care was being explored. So too was the importance of sensitive leadership and of not stifling the great work being done on the wards with outdated processes and unthoughtful system redesigns; the investment in D2A capacity was enabling change, not suppressing it. Overall, the complexity of change was being recognised and faced-up to.

Cultures can change. Covid 19 has shaken up the system, shattering complacency. The unthinkable has happened so perhaps now really is the time for rethinking, and for the 'early discharge into careful hands' conversation to have a national impact. I do hope so.

Frances Pitt, Musgrove Partner, Musgrove Park Hospital, Somerset

Health

No one should underestimate the importance of being at home. For most people being able to stay at home when we are ill or frail is what we would truly wish. And that independence, in turn, is likely to keep us as well as we can be and reduce costs to the system. We have always known this, and the health and care system has had this goal for as long as I can remember. But never before has intermediate care been so important, as the number of citizens with some element of frailty increases, nor so accessible, as advances in technology give us new support tools. It must now be top of the agenda for all systems as they strive to deliver integrated care in a truly meaningful way.

Dame Barbara Hakin, Former Deputy Chief Executive of NHS England, IMPOWER Advisor

Adult Social Care

This should be 'the Age of Intermediate Care'. With increasing levels of frailty in our aging population, and higher expectations that people will want to go home rather than to care homes, we should be in the age of the physiotherapist and occupational therapist, complemented with integrated nursing and care services and the latest technology. But we are still buying beds without a real plan to rehabilitate people and give them the confidence and motivation to get better.

Iain MacBeath, Strategic Director, Health and Wellbeing, City of Bradford Metropolitan District Council, and Honorary Treasurer, ADASS

Executive summary and introduction

The time has come to make a shift into what this report calls 'the Age of Intermediate Care'. The pandemic has proved to be a lightbulb moment in recognising this, building on what has been learned over the previous 20 years. For the first time, there is now unanimity on the strategic importance of Intermediate Care across the health and care sector (hereafter 'the sector').

However, the importance of this unanimity was underplayed in the white paper[2] and has not been properly recognised elsewhere. To capture the zeitgeist, in early 2021 ADASS and IMPOWER collaborated with leaders from across the health and care sector to discuss the future of Intermediate Care and feed into the content of this report.

Over the last year, the benefits of Intermediate Care have been proved beyond question. The case study included in this report showcases a real-world example from Somerset, where it resulted in an 86% reduction in residential care placements, and a 62% reduction in unnecessary admissions. Such examples – and there are many of them - illustrate why the narrative around Intermediate Care has become so convincing.

The coming year marks an inflection point. If Intermediate Care is to fulfil its significant potential for positive change, it will be necessary to rapidly overcome four key challenges related to culture and behaviours, operating model, workforce and funding. If they are all addressed, the results will be game changing in terms of improving independence and outcomes for tens of thousands of people and spread investment more equally across the sector. One recent estimate is that it would also help deliver £1.6billion[3] in savings every year (predicated on there being a long-term funding solution in place). But if these challenges go unresolved, the sector is liable to transition back to business as usual – and the opportunity for change will have been missed.

This report argues that it is possible to start making this shift today. While challenges around funding are unlikely to be resolved overnight, that should not put the prioritisation of Intermediate Care on hold. In particular, making changes to culture and behaviours provides a huge opportunity to move things forwards. This report also sets out how such opportunities can be realised, for the benefit of people and the system as a whole.

Intermediate Care can help me to…

Person
… avoid unnecessary hospital admissions or improve my personal outcomes by getting me back home with the right support as quickly as possible following a hospital stay

COO (acute hospital)
…tackle the backlog and capacity challenge from Covid without buying more beds

DASS
… support more people to be independent at home, reduce the flow of people into long term care placements, and maintain the voice of adult social care within the local system

ICS Chief Executive
…make a strong start towards collaboration and whole-system thinking, and win hearts and minds for the journey ahead

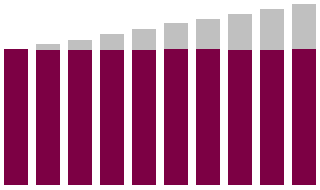
COO (Community Hospital)
…be an active player in the future role of community hospitals, including a shift away from a medical model to one that prioritises therapy, rehabilitation and reablement

Accountable Officer (CCG)
…deliver whole system financial savings whilst improving health and care outcomes for local people

2 https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all

3 https://www.countycouncilsnetwork.org.uk/new-report-thousands-of-people-could-live-more-independently-if-councils-continue-to-deliver-social-care/

Context



33%

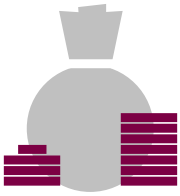
increase in number of people aged 85+ over the next 10 years[4]

1.3m

people living with dementia by 2025[5]

9 times

differential across the country in the number of people still at home 91 days after being discharged from hospital to a reablement service[6]



£3.5bn

funding gap in adult social care just to maintain services[7]

The challenge - it isn't new

Professionals in the health and care sector know the importance of helping people remain independent at home, including to prevent admission to hospital in the first place or to get them home as quickly as possible following a hospital visit. When this is achieved, it results in the best outcomes for people whilst reducing costs. But when it isn't, the impact on both outcomes and costs are significant.

Integrated health and care services and collaborative working around the person are often seen as the keys to achieving this goal - but they aren't new ideas. Intermediate Care - the term most associated with the parts of the health and care system where integration and collaboration are considered most valuable - has been discussed over the last 20 years in different guises (including through Reablement Grants, Vanguards, the Better Care Fund and latterly the Discharge to Assess and Integrated Care System frailty initiatives). While all these have contributed to progress in different ways, none have successfully delivered the overall ambition of integration and collaboration at scale, despite the significant investment involved.

Covid has brought investment, focus, collaboration and pace…

What has moved the integration agenda forwards was the injection of an additional £1.3billion for the sector in March 2020. This Covid-related emergency funding removed the emphasis on formally integrated structures and services and helped ease the financial constraints and 'turf battles' between organisations. This resulted in a step change in collaboration and focus on the person. Suddenly, the impossible was made possible. Super stranded patients with prolonged Lengths of Stay were supported to alternative settings. Hospitals would not have been able to cope with the pandemic without this level of additional investment in Intermediate Care, and new ways of collaborative working were achieved because of it - despite a lack of formal commissioning or service integration.

…but the fundamental problem remains

Despite this progress, and significant successes in some local areas, it has still not been possible to design or deliver optimal services that universally meet the needs of people across the country. A substantial part of commissioning activity over the last 12 months continued to centre on increasing the number of beds in acute and community settings, when the focus could and should have been on getting people home.

What stands out to me is how the problems haven't changed over the last two decades
Dame Barbara Hakin, Former Deputy Chief Executive of NHS England, IMPOWER Advisor

This is the Age of Intermediate Care – we need to move away from a bed based model
Bernie Enright, Executive Director of Adult Social Services, Manchester City Council

It is important to focus on the person – with a balance between process, structure and behaviour.
Julie Ogley, Director of Social Care, Health and Housing, Central Bedfordshire Council

4 Estimates from 2017. https://www.scie.org.uk/prevention/independence/intermediate-care/highlights

5 Ibid.

6 Ibid.

7 https://www.local.gov.uk/about/news/lga-launches-own-green-paper-adult-social-care-reaches-breaking-point

How can Intermediate Care fulfil its potential?

There is an inherent tension within hospitals: the desire to optimise acute capacity and improve the flow of people - whilst keeping them 'safe' – versus the need to optimise people's outcomes through unnecessary admission avoidance and appropriate discharge (where the default is to go home).

Intermediate Care models are the cornerstone for resolving this challenge, yet have so far failed to achieve the outcomes they seem to promise[8]. But before jumping to solutions or looking for a quick fix, it is essential to properly define the problem that needs to be solved.

The starting point is that the health and care system – like other systems which exist to deliver public services to people - is 'complex' rather than 'complicated'. The problems that exist in these systems (such as those facing Intermediate Care models) are therefore also best defined as complex problems.

Complex problems cannot be solved but can be systematically managed, whereas complicated problems can be solved by following the same blueprint for a solution each time. If the problems facing Intermediate Care are misdiagnosed as complicated problems, and a complicated solution is applied to a complex problem, this will not result in sustainable change.

The complex problem facing Intermediate Care is made up of four key challenges:

Culture and behaviour
The need to create parity of esteem across system partners, and to encourage collaboration, trust, positive risk taking and strengths-based approaches.

Operating model
The need for national guidance on the overall operating model and leading practice, whilst empowering local systems to innovate and create local solutions.

Workforce
The need to optimise the use of the existing workforce, understand the additional skills needed to support Intermediate Care, secure support and investment to develop these skills, and recognise that siloed working undermines collaboration and a focus on the person.

Funding
The need for a long-term funding solution and single financial governance model.

8 https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20(Providers)/2017/NAIC%20England%20Summary%20Report%20-%20upload%202.pdf

Key challenge: Culture and behaviours

The disproportionate focus on operating model and structures when compared to culture – in other words form over function - has increasingly been recognised as a significant issue in recent years. Research by IMPOWER in 2019[9] highlighted the suboptimal impact this was having on people's outcomes through hospital admission and discharge. Although the challenges facing health and care systems were typically equally split between operating model and culture, the investment in solution interventions was typically skewed towards operating models, structures and pathways.

Evidence from across the sector[10]. (including from IMPOWER's work with clients and other organisations) continues to show that:

- Discharge decisions are still made in the wrong place and by the wrong people, often in acute settings. This inadvertently influences the person, their families and carers to consider options other than getting the person home.
- Pressure for hospital flow and acute capacity undermines optimal discharge decisions. To free up a hospital bed, sometimes 'any pathway will do' – the default is often to transfer people to beds in care homes or the community. This is a prime example of how a complicated solution is being applied to a complex problem.
- A lack of confidence in out-of-hospital care drives risk averse decision making in hospitals. The question of 'safety' and 'risk' requires exploration at a more holistic level; the risks of staying in hospital are often lost or not properly considered in this thought process.
- The solution of removing the post-hospital care decisions from the acute setting (e.g. into Discharge to Assess) does not resolve the root cause of cultural misalignment between health and social care. In other words, it does not remove the influence that clinical professionals can have on the person, their families and carers.
- The working environment within hospitals, given the unpredictability of unplanned care, is often highly operational and focused on management of reactive issues. As a result, and in order to manage stress, anxiety and wellbeing within this environment, frontline staff understandably grip ever more tightly onto the things they can control. These two things together mean that it takes significantly longer to work with frontline staff to change and embed new ways of working. Strengths-based practise in social care has proved to be effective but has so far not been successfully embedded within health, which is insufficiently therapy-led, risk averse and hierarchical.
- The outcomes that the hospital wants to achieve (such as increased flow) are often at odds with the order and control that frontline staff feel they need. Freeing up beds typically requires discharging a person in the morning. The reality of this for the ward is that they then receive a new (often complex) person from A&E. If a ward is stable and calm but short staffed, and the team are exhausted, there is little incentive for them to push for a timely discharge.

9 https://www.impower.co.uk/insights/the-impact-of-culture-and-behaviour-at-the-interface-of-health-and-care

10 Ibid

How can Intermediate Care fulfil its potential? (cont.)

Key challenge: Operating model

The integration ambition of recent years has focused on bringing together structures, processes, system and governance - with form too often being placed before function.

As the concept and delivery of Integrated Care has evolved over time, there is no commonality of approach or single operating model. The design of Integrated Care at a local level is often the result of local estate and staffing arrangements, funding settlements and ad-hoc innovation. In most cases it has not been grounded in a local needs analysis. Pathways typically fall into two camps: broad pathways to get people home, and specialist pathways focused on specific conditions or acuity. As services have often not been commissioned from an in-depth understanding of need, the challenge has always been in effectively aligning demand from people to the pathways.

Commissioning decisions have consistently been too heavily influenced by the 'bed is best' mantra. National waiting times for beds are almost three times shorter than for home or reablement support, and clinicians tend to vastly favour hospital beds over home support[11]. In addition, the concentrated focus, guidance and investment in transfer or discharge from hospital (instead of on admission avoidance) has resulted in a missed opportunity to prevent demand flowing into hospitals, with knock-on effects in terms of deconditioning patients, leading to reduced independence and increased levels of support. Admissions have continued to rise for the past eight years[12], indicating that the health and care sector is more inclined to build a model of care that reacts to presenting demand, as opposed to preventing that demand in the first place.

It is a flawed approach that we look at Intermediate Care almost exclusively as a step down provision
Glen Garrod, Executive Director of Adult Care and Community Wellbeing, Lincolnshire County Council

We need to absolutely dismantle the 'bed is best' mantra, and show that in fact 'bed is best for deterioration'
Stephen Chandler, Corporate Director of Adult and Housing Services, Cherwell District Council and Oxfordshire County Council

11 1.5 clinical WTE per bed for bedded settings by comparison to 2.1 WTE per 100 service users for home-based support (Ref NAIC NHS Benchmarking Network)

12 (Ref SCIE)

Key challenge: Workforce

There is no doubt about the scale of positive intent across the sector, and the level of commitment to trying to do the best for the person. It is also the case that most of the skills needed for a person-centred approach are already present in the workforce. However, because of the current operating model, the lack of a needs analysis to map resources against, and cultural misalignment, at a system level these skills are not having the impact they could have on improving people's outcomes.

The health and care sector knows that interdisciplinary teams which blend the use of doctors and highly skilled nurses with therapy, geriatricians, social care, pharmacists, the voluntary and community sector, and technology-savvy frontline staff can help people achieve greater levels of independence at home[13].

Despite this, insufficient focus has been given to non-clinical skill sets and the often equally (if not more) important role they play in helping people to remain independent or regain independence at home.

Individual sections of the workforce are often narrowly focused on their own part of the process, and multiple hand-offs of patients between professionals can lead to a poor experience for the person. Where there is a capacity gap of specific skillsets this can also undermine the sector's ability to maximise people's independence[14].

Without a system-level workforce strategy in place, professionals and voluntary staff are left trying to wrap around and support the person, but are unable to communicate or collaborate to best effect. This ultimately leads to poorer outcomes and higher costs for the sector.

The concept of 'Team Oxfordshire' that we have developed levels everyone up and down. It doesn't matter if you are a medical consultant or an Age UK volunteer, you are all part of the team and your contribution is equally valued.
Stephen Chandler, Corporate Director of Adult and Housing Services, Cherwell District Council and Oxfordshire County Council

13 Interdisciplinary teamwork is associated with better outcomes for patients in intermediate care services (Ariss et al. 2015).

14 https://socialcare.blog.gov.uk/2017/08/03/we-need-to-talk-about-intermediate-care/

How can Intermediate Care fulfil its potential? (cont.)

Summary of the problem definition

These challenges have led to a health and care system which:

- Is out of date, with services that have not kept pace with the needs of local people, the ever-increasing complexity of conditions, or the need to understand the wider determinants of health
- Focuses too heavily on transfer or discharge from hospital as opposed to admission avoidance (often reinforced by national guidance and funding)
- Defaults to a 'bed is best' and risk averse model of care (the easiest option is still to buy and use more beds)
- Places too much emphasis on the acute / medical model – giving priority to hospitals at the expense of the wider system
- Lacks parity of esteem across professional groups and organisations, leading to trust, knowledge, empathy and collaboration issues
- Has placed insufficient emphasis on fostering a high-performance culture and associated behaviours
- Has failed to utilise and develop the knowledge, skills and expertise of its staff
- Lacks a long-term funding solution and the strategic leadership required to move away from the short term quick fixes and interventions of recent years

Key challenge: Funding

The debate regarding the need for additional funding to support effective Intermediate Care is not new. As far back as 2008 the Leicester Nuffield Research Unit found perceived shortages of funding to be a key barrier to effective practice. The long list of interventions over the past 20 years has simply perpetuated a complex patchwork of services which are neither grounded in needs nor provide an holistic approach to supporting independence. The challenge of funding can be broken down into three key parts:

1 **Quantum of investment**
The injection of an additional £1.3billion to help deal with the Covid pandemic highlighted the scale of investment required to effect positive change in this area of the system.

2 **Sustainability of funding**
The key challenge with previous funding solutions is that they have all been short term in nature. The lack of a long-term settlement has driven short-term thinking in relation to system leadership behaviours, decision making and focus.

3 **Governance**
The lack of a single governance structure results in organisational fights over investment decisions. This is the fundamental issue that undermines system working, relationships, trust, and focus on the person. The response to Covid showed us how previous financial governance processes were undermining the ability of the sector to collaborate and innovate effectively.

REPORT REFLECTIONS

It is interesting to reflect on the discussion and consultation that fed into this report. Bringing together organisations from across health and care highlighted that:

- **This was an unusual exercise for the sector**
- **The majority of those involved were not familiar with the other organisations consulted to any great extent**
- **Concerns about equity and parity of voice at the event were evident**

How to move forward together into an 'Age of Intermediate Care'?

Moving forward together would require building on the positives from the response to Covid, establishing effective system leadership and managing the four key challenges previously outlined.

Ensure that the positive learnings from Covid are maintained and built on

- The creation of a single pooled budget within the improved Better Care Fund (iBCF) focused on older people
- Joint or collaborative working across organisational boundaries
- Increased therapeutic input (in beds and at home)
- Equal focus and investment in preventing unnecessary admission
- Never going back to long lengths of stay in hospitals – focus on keeping people at home or getting people home after hospital treatment and supporting carers

As everybody wants a quick fix, people often give up on things that take a long time. There is a viable strategy that needs time to come to fruition – but how can we convince people to stick at it?

Dr Eileen Burns, Geriatrician, Leeds Teaching Hospitals NHS Trust; Past President of British Geriatric Society

Establish effective system leadership

System leaders must recognise that the problem is complex not complicated - that they can influence but not control it, that they can manage but not solve it. The fixation on short term quick fixes must come to an end. The sector requires leadership that will hold its nerve and prioritise Intermediate Care.

This will necessitate developing a clear vision and strategic narrative, building inclusive ambition amongst system actors, winning the case for continued investment, bringing people together across place, and empowering local innovation within national guidance.

It is well known that tensions and issues of trust exist between system partners. But bringing people together from different organisations and professions for the roundtable event that informed this report proved invaluable. Collaborating on a shared challenge was not always easy but showed the potential for what could be achieved together. It was clear there was significant alignment of thinking in relation to defining the problem and proposing next steps.

The importance of system leadership in prioritising Intermediate Care should not be underestimated. Where significant successes have been made to date, local systems have been led jointly by adult social care and the voluntary and community sector, supported by acute settings.

Manage the four key challenges

1 **Culture and behaviours**
Build parity of esteem across organisations and professionals, improve collaborative working, optimising the value placed on independence at home, and moved away from a highly medical / bed based model

2 **Operating model**
Take a whole system view that focuses on the person and helps people remain independent at home, and balances the importance of both admission avoidance and improved transfer / discharge from hospital

3 **Workforce**
Develop a therapy-led workforce strategy which provides the local skills and capacity required to support more people to live independently at home

4 **Funding**
Win the case for further investment and secure a long-term funding solution and single financial governance model

The next steps for these challenges are explored over the following pages.

Next steps: culture and behaviours

One of the largest opportunities is to build on the collaboration achieved since the pandemic started and foster new cultures and behaviours in health and care systems – to focus on function more than form. This is the area that has so far received the least focus and investment, probably because it is the most difficult to change in a sustainable way. But efforts to prioritise Intermediate Care which look at structure and funding but ignore culture and behaviours will fail.

The success of the strategic direction of the NHS is predicated on health and care professionals collaborating around the person within their local systems. Intermediate Care will only be able to deliver the outcomes we desire if sustainable cultural change can be affected.

To do this the sector must:

1 Create **parity of esteem** across professional groups and organisations. This requires developing increased knowledge and understanding and building confidence and trust so that all system actors have an equal voice around the person[15]. System duplications and contradictions need to be ironed out.

2 Move towards a much more **collaborative working** approach at a local system level. Once the relationship conditions are in place, actively bring different professional groups together around the person and the independent social care sector.

3 Move away from the **hierarchical medical model,** and create greater balance and opportunities for influence from social care, therapy and geriatricians within **multi-disciplinary teams**. (Medical input will still remain critical in these teams to identify and exclude acute medical problems prior to admission avoidance decisions).

4 Create more **blended roles** to work across organisational boundaries, helping to break down silo working and embed new collaborative behaviours. Challenge the constraints that have evolved over time whereby only certain professionals can make certain decisions or where data and information is not readily shared across organisational boundaries. Create greater **agility and resilience** through empowerment of staff and less command and control (Trusted Assessor roles are a good example of where this has proved successful in adult social care).

5 Create a **common language** (focused on the person) to help remove the ambiguity and miscommunication that persists between organisations and professions today.

6 Remove or **better manage referrals and handoffs** between organisations or professions. Improved collaboration will help, but much more time needs to be invested in the positive handover of patients to help optimise their recovery and outcomes. Digital solutions will also add value in terms of making sure we have consistent and high-quality information flows between professionals and organisations.

7 Recognise that delivering change in health settings (e.g. acute hospitals) is **fundamentally different** to other settings. The desire of frontline staff to hang onto 'order behind the chaos', coupled with existing perverse incentives, will take longer to change in a sustainable way.

8 Recognise that other (non-NHS) parts of the system also need to tackle resistance to change in **pace of work and working hours**, moving away from the '9 to 5' and towards a 24/7 model.

15 See IMPOWER's 2020 report 'Next steps for the VCS: The Voluntary and Community Sector in a world shaped by Covid'

One of the biggest challenges is how we can support the required cultural change through leadership, create the vision narrative and develop robust metrics to drive the right behaviours. Moving this forward has to be about getting the system leaders to support cultural change. We need to create system ownership and recognition of why this is important.
Stephen Chandler, Corporate Director of Adult and Housing Services, Cherwell District Council and Oxfordshire County Council

Even though we have a Home First service and philosophy, the issue is the culture of 'bed is safer'. In practice, delivering cultural change is so difficult. I am really interested to hear about what can be done to actually change that culture… what are the things that actually work and how can we implement them.
Dr Eileen Burns, Geriatrician, Past President of British Geriatric Society. Leeds Teaching Hospitals NHS Trust

We can all agree that the attitude to clinical risk in hospitals is unhelpful... we ultimately know that hospitals are not safe places.
Dr Jonathan Steel, Lead Fellow for Social Care, Royal College of Physicians

We need to create greater equality of esteem and value across professional groups and organisations. The mindset of 'clinicians knowing best' and 'hospitals being king' must continue to be challenged. Where this is accepted and 'lived' the person gets better support.
Kim Carey, Interim Director of Adult Services, Bromley Council

There is a significant opportunity around culture and behaviours. Creating post-discharge feedback loops, and increasing knowledge of and confidence in a whole system response are critical. We need to value experience and skill as much as professional qualification when making decisions to keep people safe. The 'trusted assessor' roles have shown how we could do this differently and to good effect.
Dr Ruth Law, Consultant Physician, and Geriatrician, Whittington Health NHS Trust

Next steps: operating model

Despite the focus on form over function in recent years, there is still no recognised best practice operating model for Intermediate Care. There is a clear need and opportunity to define one, whilst acknowledging the tension (and often frustration) that exists between national guidance and local empowerment and innovation.

The recent NHS white paper references a 'Plan to put in place a legal framework for the discharge to assess model, which will allow CHC, NHS funded nursing and Care Act assessments to take place after an individual has been discharge from acute care.' This is helpful and a key component of any future Intermediate Care model, but once again highlights that national guidance continues to be too narrowly framed on discharge and is playing catch up with the thinking at a local level.

The consultation panel for this report discussed this specific challenge in some detail and felt that the following activities would be welcomed by the sector:

National level

1 **Research best practice** - conduct further research into what works best within existing Intermediate Care models, focusing on evidencing the improved outcomes achieved for the person

2 **Develop guiding principles** for the design of an Intermediate Care model, to achieve some commonality of approach across the country

3 **Prioritise prevention of unnecessary admissions** - create an equal focus and investment in preventing unnecessary admissions by shifting the immediate priority focus to admission avoidance, getting the Intermediate Care model to work effectively at the point of crisis pre-admission

4 **Shared data** that measures outcomes for the person and overall system performance is essential. This will require local systems to share data around the person and to embrace a broader range of whole system performance measures rather than narrow framing success to a few individual key performance indicators

Local level

5 **Conduct local needs analysis**, recognising that this will lead to some necessary local variation

6 **Design an Intermediate Care service suite** - create a blended mix of services to meet local needs, across organisational and professional boundaries (in other words a community solution blended with acute, primary and social care services)

7 **Design local Intermediate Care operating models** - consider local geography and local health and care system make-up (i.e. each area has variation in make up of health, local government, voluntary and community services, housing services and other organisations, footprints, PCNs, ICSs etc). Blend national policy and guiding principles with local needs and structures. Develop form to follow function. Position Intermediate Care front and centre within the local ICS

8 **Implementation:** the Intermediate Care model should be a priority implementation within any emerging ICS. It will be the acid test of positive collaboration and working across organisational interfaces. In effect it is a microcosm of the entire strategic ambition of the Department of Health and Social Care for the sector. If we can get Intermediate Care working effectively, there is hope for the wider ambitions for ICSs

Services have not kept pace with the needs of the population we're trying to serve – and my view is that prevention of admission to hospital is equally, if not more important, than expediting that transfer or discharge at the other side.
Iain MacBeath, Strategic Director, Health and Wellbeing, City of Bradford Metropolitan District Council, and Honorary Treasurer, ADASS

We know that we need to be focused around primary care, communities and social care, but the national direction keeps taking us back into acute hospitals – and prescribing what we should be doing.
Julie Ogley, Director of Social Care, Health and Housing, Central Bedfordshire Council

We could do a huge amount more on Intermediate Care step up and avoiding admissions. It's complex, at point of crisis, and requires health and adult social care to work together.
Dr Eileen Burns, Geriatrician, Past President of British Geriatric Society. Leeds Teaching Hospitals NHS Trust

Next steps: workforce

The Age of Intermediate Care will also need to be the age of the physiotherapist and occupational therapist, complemented with nursing and care services and technology. There is a significant opportunity and urgent need to realign existing skills to the needs of the person, whilst investing in the development of additional skills where there are deficits.

To achieve this the sector would need to:

1 Create a baseline understanding of the national and local workforce - its skills, capability and capacity across organisational boundaries.

2 Map this workforce capability and capacity against national and local needs.

3 At a national level, work with Health Education England to invest in increasing the number of specific skills (e.g. therapists and geriatricians) to meet the demands of the aging population the sector is supporting.

4 At a local system level, build inclusive ambition to solve this challenge together. Create a single, local workforce strategy across the Integrated Care model, bringing the power of multiple organisations together around the person.

5 Collectively invest in additional skills, capability or capacity where gaps exist, in order to fill those gaps but also to help drive the required cultural change. This includes thinking about creating more blended roles across organisations to help improve collaboration and embed new cultures and behaviours across organisational interfaces.

6 Create greater flexibility of working practices. For example, encouraging more clinicians and consultants to work within communities and homes as well as in hospitals, taking their skills where they are most needed to help people with higher levels of acuity remain at home. Alternatively, encouraging GPs to work across the interface into adult social care and hospitals to provide a more holistic view of people and effect shared decision making and outcomes around hospital admission and discharge. Providers should be encouraged to upskill domiciliary care staff so that they are able to provide reablement as well as care.

7 Invest more in support at home and integrate health and care services, in order to address the challenge of getting people directly home rather than into a bed. This would reduce the delays for home support and consequently the number of people being transitioned into beds at discharge.

8 Work with the leaders of occupational therapy across the sector to increase the strength of their voice and influence, in relation to the role they need to play in the Age of Intermediate Care.

> **The future has to be a 'therapy-led' service to transfer people from hospital.**
> **Paul Cooper, Lead Professional Adviser, Royal College of Occupational Therapists**

> **How do we help acutes understand the important role they play in discharge? Have we really explored the workforce that can support this – as opposed to the organisation that leads it? Do we have a discharge expertise skills gap?**
> **Dame Barbara Hakin, Former Deputy Chief Executive of NHS England, IMPOWER Advisor**

Next steps: funding

- It is irrefutable that the sector requires continued significant levels of investment, yet the sector has so far failed to win this argument.
- The injection of Covid-related funding demonstrated what can be achieved by the sector when funding constraints are removed.
- A single pot of money is key to removing unhelpful organisational and individual behaviours in the system, because it shifts the focus from a question over who is paying to asking 'how do we best support the person?' This ultimately leads to delivering better outcomes that cost less overall.
- The sector must now build on the collaboration seen during the pandemic and come together to evidence the case for continued investment in intermediate care. The alternative is that we will see an expansion of investment in hospital beds to accommodate ever-increasing demand in the system - but the trade-off will be that fewer people are successfully supported at home or in their communities.

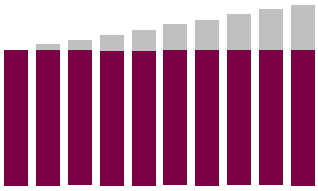
The money that was given to the NHS to spend on getting people out of hospital was the best £1.3billion the NHS has ever spent. It provided real value for money - but we need to prove that this was the case, and fight for this approach to be permanent. Otherwise, we will just move onto the next new thing.

Iain MacBeath, Strategic Director, Health and Wellbeing, City of Bradford Metropolitan District Council, and Honorary Treasurer, ADASS

What is the scale of the opportunity?

Intermediate Care provides the opportunity to optimise outcomes for people at less cost to the system. Furthermore, it drives early delivery of the strategic ambition of the sector – to move towards a community / home based model of care less focused on acute hospital settings. There is no other part of the health and care system that transcends so many organisations, professions, interfaces, processes, systems, cultures and behaviours. The Age of Intermediate Care is about managing a highly complex problem.

The significance of the challenge facing health and care at a national level is worth reiterating:



33%

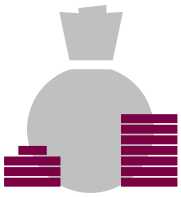
increase in number of people aged 85+ over the next 10 years[16]

1.3m

people living with dementia by 2025[17]

9 times

differential across the country in the number of people still at home 91 days after being discharged from hospital to a reablement service[18]



£3.5bn

funding gap in adult social care just to maintain services[19]

16 Estimates from 2017. https://www.scie.org.uk/prevention/independence/intermediate-care/highlights

17 Ibid.

18 Ibid.

19 https://www.local.gov.uk/about/news/lga-launches-own-green-paper-adult-social-care-reaches-breaking-point

Somerset case study:
What difference can Intermediate Care make at a local level?

This work involved Somerset County Council, Somerset Foundation Trust (including Musgrove Park Hospital and Yeovil community providers) and Somerset CCG, in partnership with IMPOWER.

At a local level the evidence that prioritising Intermediate Care produces impressive results is clear. In Somerset - which has invested in this area in recent years and is widely recognised as a high performing system - the design and implementation of the new Intermediate Care model in March 2020 (with support from IMPOWER) had a positive impact. This was largely delivered through: improving and increasing capacity and uptake in the home-based pathway, embedding discharge to assess principles across the system, and refocusing on prevention and admission avoidance.

- Demand for Intermediate Care as a percentage of all discharges increased by 8% during the pandemic (an additional 800 people by comparison to the year previous 2019/20). 94% of this additional demand was met by the enhanced home-based pathway 1 ('D2A'), and the proportion of supported discharges going to bedded settings reduced from 60% to 50% over this period
- Long term placements to residential and nursing homes reduced by 86%, and now account for 1% of all discharges (compared to 6% before March 2020)
- 62% of people who interacted with co-located adult social care staff when presenting at A&E avoided unnecessary admission, with 74% returning home or to their usual place of residence. Just under half of these received support from Rapid Response or D2A
- The length of stay on the home based pathway reduced by 2.5 days to 9.61 (year on year) and discharging via D2A saved an average of 1.1 bed days post referral by comparison to hospital average discharge wait times, relieving the pressure for beds and preventing further deconditioning[20]

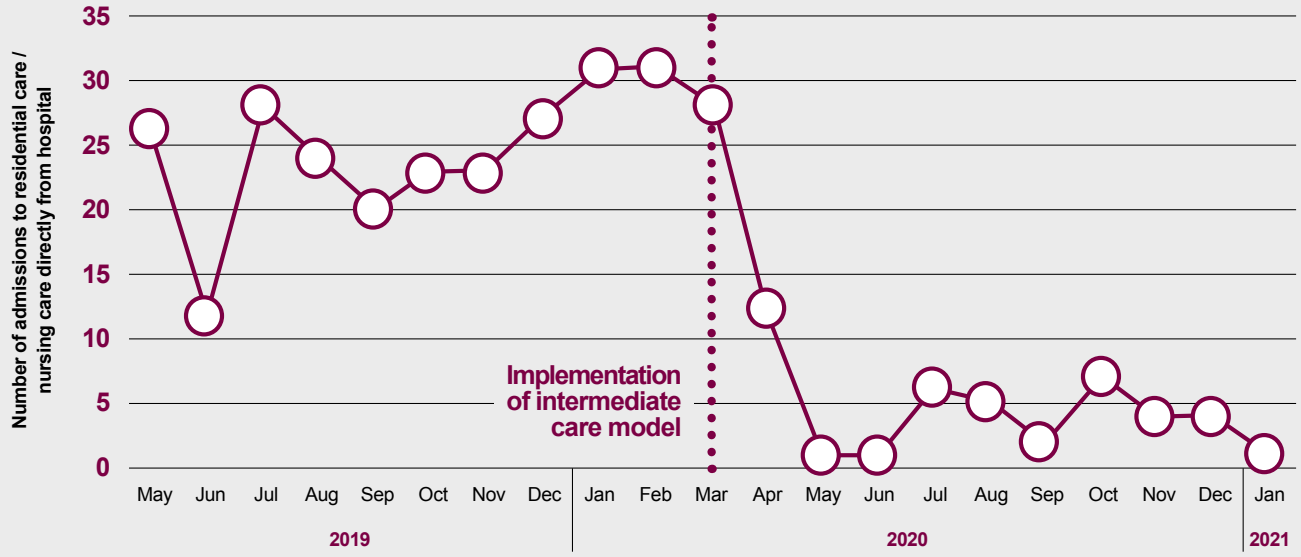
We can therefore have confidence that the level of opportunity that exists across the country, and particularly in systems that are less mature, is significant enough to justify continued and sustained investment. Over time, with a focus on resolving the challenges outlined in this report, we will deliver better outcomes for people that cost less.

Where we have worked together as a system, focused on individual outcomes, owned the cultural change together, created blended roles and made sure the community and voluntary sector is fully integrated and part of the solution, better outcomes and financial savings are achieved. To continue this, we need long term funding.

Mel Lock, Director of Adult Social Care, Lead Commissioner for Adults and Health, Somerset County Council

20 Data only from Musgrove Park Hospital

Admissions to residential and nursing care directly from hospital



Concluding comments and recommendations

The Age of Intermediate Care is, above all, an opportunity. It is at the coal face, cutting across the interface of professions and organisations, where most of the complexity exists. It is where the majority of improved outcomes and financial savings can be realised, where system pressures will truly test system relationships, and where function is more important than form.

In delivering this opportunity there is a role for:

1. The system to clearly demonstrate the value and benefits from continued long term investment in Intermediate Care.
2. The sector to embed more person-centred and preventative approaches including a significant step up in support for carers.
3. Central government to resolve the long-term funding challenge and invest in this critical part of the system.
4. NHSE to come up with different policies, models and research into what is working to best effect. There are virtually no recent cross-country comparisons to learn from.
5. ICSs to foster effective partnership working at a local level and grip the opportunity that Intermediate Care presents by empowering the leadership role that adult social care and the community solution can provide.
6. Health Education England to increase the number of therapists and geriatricians to meet the demands of the aging population the sector is supporting.

Whilst ICSs continue to form, Intermediate Care has the opportunity to pioneer local ambition and deliver real impact and improved outcomes for people and their carers. Arguably it will act as the acid test of all ICSs, shining a light on how well a local system is working collaboratively for the benefit of its people.

The scale of the opportunity for Intermediate Care to contribute to positive change across the sector – and improve thousands of lives every year - is clear. But it is also clear that the opportunity needs to be seized without delay. The pandemic has created a moment for change. But if change is not forthcoming over the coming year – across the four key challenges of culture and behaviours, operating model, workforce and funding – that moment will be lost as things transition back to 'business as usual'. It is crucial those working at both national and local levels take on the responsibility to proactively push Intermediate Care forwards, to promote it and commit to it. In doing so, local health and care systems can finally be brought together around the needs of local people, once and for all.