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Intermediate Care
The Reset

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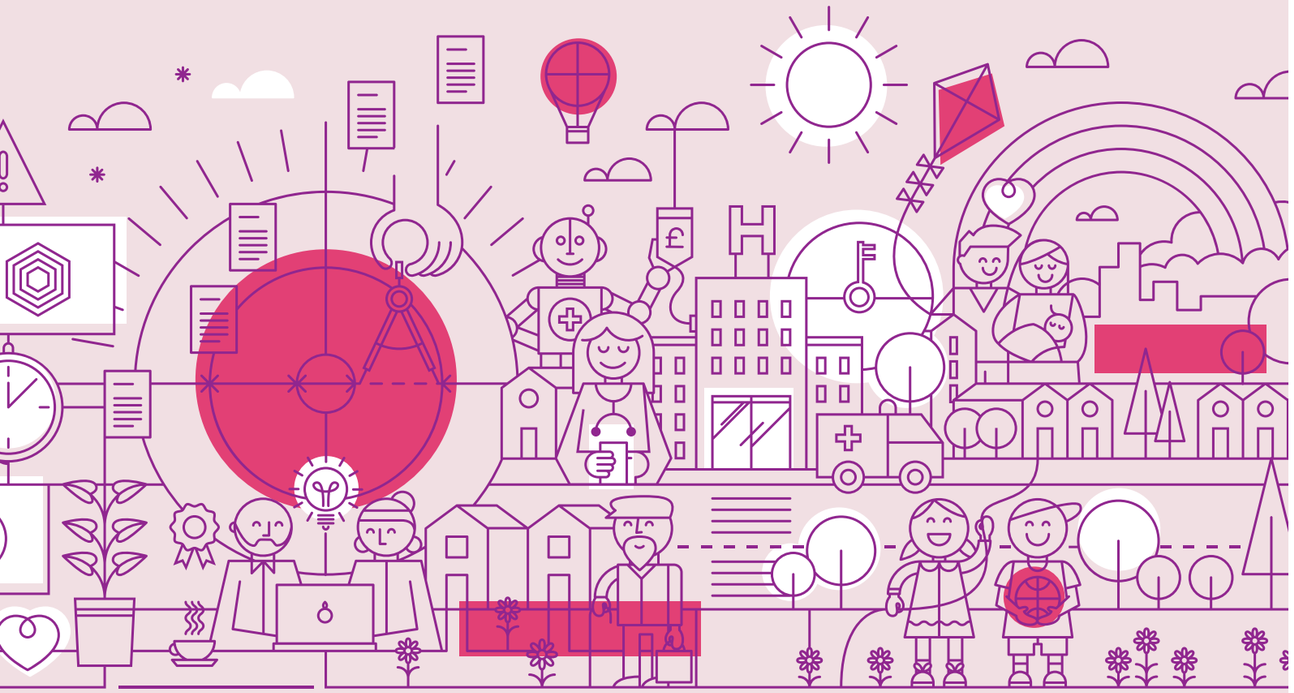


Foreword

Sarah McClinton
Immediate Past President
Association of Directors of Adult Social Services (ADASS)

Since the publication of the 'Age of Intermediate Care' report in 2021, much has happened to change the landscape. The shifting sands of increased demand and complexity of need, financial hardship, and a global pandemic with its consequences, have each brought significant challenges.

Intermediate care has never been more important, with its potential to change people's lives, to have significant impact in systems, and to improve outcomes. This report clearly shows why intermediate care that merely focuses on hospital discharge is a missed opportunity. We must recognise the role intermediate care, in its broadest sense, can play in resolving crises and offering rehabilitation to help people stay well and connected at home as well as avoiding the need for hospital care.

We highlight innovative ways we can support people to stay in their own homes with the right community support, so there is no question of 'deconditioning' in an acute bed. As a policy position, a Home First approach is vital. We know that where clinically safe and appropriate in non-acute instances, home care will increase recovery time and wellbeing. I would like to thank NHS colleagues, members of Think Local Act Personal (TLAP), and the Carers Trust for their valuable contributions in co-creating this report.

ADASS is very grateful to IMPOWER for their support on this work. This report is designed to stimulate debate and discussion and as such it does not necessarily reflect the views of ADASS. The report is sponsored by IMPOWER but ADASS retained editorial control over the content.

Introduction

We have emerged from Covid needing to support higher numbers of people, in the context of ever-straightened financial circumstances.

In early 2021, ADASS and IMPOWER published 'The Age of Intermediate Care'. This report set out how an effective care offer, working with people who require short-term additional care and support beyond, can deliver wide-ranging and multi-partner benefits improving outcomes for individuals, financial sustainability and, for those requiring support, the ability to manage on a day-to-day basis.

Although it has only been two years, much has subsequently changed to impact intermediate care. Systems have emerged from Covid needing to support higher numbers of people (with increasingly complex requirements) in the context of ever-straightened financial circumstances.

Managing daily operations within a tight financial envelope increasingly comes at the opportunity cost of innovating for immediate improvement, designing and working towards a sustainable medium-term model, and, most importantly working together to deliver the best possible outcomes for the person at the centre.

The September publication of the NHS 'Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge' was a welcome codification of good practice for intermediate care at the point of hospital discharge, but it does not go far enough.

Intermediate care can, and should, be defined more broadly to include the activity support required in the community and person's home, more intensive facilities, and medical settings to provide the right input when someone's needs go beyond what is normally required, including for those at the end of their lives.

This report sets out how to reset intermediate care for the medium term, whilst taking full advantage of the immediate opportunities on offer, and how this can be measured to show the impact of effective system working driving future policy direction and local investment decisions.

Underpinning this report is the imperative of putting the person at the centre – their outcomes, experiences and expectations must be the driver of the current and future intermediate care offer.

Making this work will require small and large changes in processes, behaviours and service design, ranging from the mundane (de-jargoning language) to the challenging (fundamentally integrating services and professional roles to optimise patient outcomes).

Crucially this report demonstrates that many systems have already grasped the challenge of improving intermediate care, delivering rapid and meaningful improvements.

Addressing these challenges often feels insurmountable. National expectations and daily operational pressures can make stepping back and designing for different near impossible. To that end, we thank everyone who has contributed to this report for their time, input and optimism in outlining a better version of intermediate care.

Defining intermediate care

The exact definition of intermediate care is amorphous. Every system, and partner within that system, defines it differently and and the boundaries vary. For the general public intermediate care isn't a term that will resonate, and nor are its linked phases – step-up/step-down, reablement and so forth.

This report defines intermediate care more broadly than the recent NHS framework. For the purposes of the roundtable that kick-started this report, we are defining intermediate care as: **the period from when someone requires additional social and medical care input to respond to an adverse event or worsening of their condition, through to the point they return to a stable setting (ideally their home) able to live as they were.**

This definition enables a far broader perspective of intermediate care including community and more intensive step-up services, virtual hospital services, post-hospital discharge support and includes the role of the voluntary sector, family, carers, and communities.

What does success look like?

ADASS and IMPOWER identified the importance of driving success through delivering holistically-assessed, whole person outcomes.

Delivering intermediate care requires balancing three competing priorities: daily operations and pressures, responding to people's needs, and delivering good outcomes. All three priorities demand immediate or short-term attention, distracting from setting – let alone cohesively working towards delivering a strategic ambition. Running alongside is the consistent challenge to make the best use of available resources and respond to changing financial circumstances.

For systems, defining success shouldn't start with the design of target operating models, or workforce plans, but rather from working to a clearly articulated inclusive ambition and design principles that build on co-produced outcomes.

A recent joint roundtable facilitated by ADASS and IMPOWER identified the importance of driving success through delivering holistically-assessed, whole person outcomes. Maintaining system ownership and visibility of outcomes will enable effective short and medium-term decision making in multi-partner systems that cuts through daily operational noise.

The roundtable discussion identified a series of conditions for success to enable a successful intermediate care model including:

- **Setting a clear system-owned strategic framework,** built on trust and led by an achievable inclusive ambition, supported by robust design principles and measurable outcomes.
- **Shaping a target delivery model,** with a shared resource allocation that supports achievement of system ambitions.
- **A flexible system workforce that delivers support to where they need it most,** not where is most organisationally or physically convenient. Wherever practical the workforce will be integrated enabling the easily flexible deployment of staff in response to demand.
- **Not constraining workforce thinking to qualified staff,** but recognising every contact counts and leveraging flexibilities of blended roles and the capabilities of non-qualified staff – this must be aligned to refreshed career structures that offer clear routes for progression.
- **Supporting financial levers are in place to facilitate commissioning activity** that goes beyond organisation sovereignty. Wherever possible funding needs to be aligned to the medium-term as well as longer-term direction, with a consensus on using short-term funding streams and grants to support achieving the inclusive ambition.
- **Commissioning activity is led by medium and longer-term outcomes,** whilst achieving sufficiency to meet planned demand.
- **Establishing and using a cross-partner standard data set and dashboard** that is regarded as the single version of the truth for the system.
- **Maximising the role of technology** to make care delivery more personalised, responsive and enabling.
- **Strong national and local messaging** that gives people confidence in supporting the delivery model.
- **Ideally there will be an independent research component within the intermediate model** that is resourced to give evidence periodically on impact at individual, system and organisational levels.

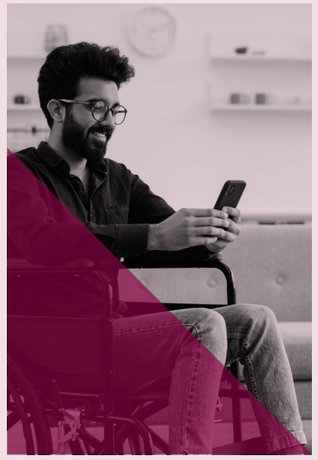
Whilst there is largely consensus to these conditions of success, in practice delivery requires sustained trust and commitment from all system partners to changed behaviours, operating, workforce and commissioning models.

IMPOWER's experience of working across intermediate care, from front line in acute hospitals to integrated commissioning, has shown that the tendency is for daily operations to be the driving determinant of intermediate care decision making for the system.

Whilst this enables acute trusts to support incoming demand, this can drive tactical and strategic opportunity costs that daily can deliver poor outcomes for the person and disproportionate operational and financial pressures for system partners. Such a mindset addresses one 'bump in the carpet' but fails to address some of the greater upstream challenges. Over the longer term, the immediacy of decision making to solve a specific challenge can drive the system direction away from target outcomes.

What should success look like?

The person's experience must take prominence in shaping service design and delivery, with feedback informing both day-to-day activity and strategic direction.



Throughout the roundtable, funding and finances were a recurrent theme. However, there was consensus, best articulated by Lincolnshire County Council's Director of Adult Social Services, Glen Garrod, that more money isn't a silver bullet for intermediate care. It's unlikely there is going to be significant new funding this winter, so systems will have to innovate using the resources they have.

In 2020-2021, there was a significant increase in intermediate care funding enabling hospitals to maintain sustainable activity levels during Covid peaks. Whilst substantive budgets have returned to pre-Covid levels across systems, there is still a substantial level of resource available; particularly the acute hospital capacity used to support medically-fit patients.

Delivering a reset future requires a departure from organisational funding silos, with commitment, trust and integrity in establishing a jointly-funded offer, which allocates system funding to where it will deliver the most impact.

The same principle applies for workforce too. Whilst recruitment challenges for some specialities are well known, many systems still have a considerable level of resource available to support intermediate care delivery. The step-change will be for staff to be placed where they can best deliver the system's target outcomes. In practice this is likely to mean a more flexible, community-based, workforce model that de-couples staff from specific organisations and buildings.

From these themes, it's possible to articulate a successfully reset intermediate care system; working towards a clearly-defined inclusive ambition, using this ambition and design principles to support daily decision making and allocating system resources beyond organisational boundaries.

At the forefront of the reset system is delivering for the people passing through it and their families. The person's experience must take more prominence in shaping service design and delivery, with feedback informing both day-to-day activity and strategic direction.

Case study:
United Lincolnshire Hospital Trust

£3.2m
TOTAL ANNUAL COST AVOIDANCE evidenced across United Lincolnshire Hospital participating wards in 2022

4 ADDITIONAL PEOPLE are being discharged home per day in the Medical Emergency Assessment Unit compared to this time last year - a potential cost avoidance of up to £2.3m

120 SURGICAL ADMISSIONS AVOIDED in 1 month due to early intervention - an annual potential cost avoidance of £0.5m

£402k POTENTIAL COST AVOIDANCE from increasing discharges by 1 patient per day at midday board rounds in 2022, compared to the same time in 2021

Achieved system-wide agreement on a new model for bed-based services to support discharge that's now implemented

Source: IMPOWER Annual Impact Report 2023

IMPOWER worked with United Lincolnshire Hospitals Trust (ULHT), one of the biggest acute hospital trusts in the country, to relieve pressure on wards and ensure patients who can go home, do so.

When IMPOWER carried out an initial review commissioned jointly by ULHT and Lincolnshire County Council in early 2022, the team found a significant number of patients, with the right support, could – and should – have gone home.

Through identifying targeted interventions to bring about immediate and longer-term improvements, and developing a different approach and culture that embedded new ways of working, IMPOWER's work helped ULHT to deliver better patient outcomes.

Case study:
Manchester and Trafford Local Care Organisations

1.5 DAYS
Average length of stay for patients on intervention wards has fallen by 1.5 days

49% INCREASE
in ward staff's understanding of strengths-based practice

25% DECREASE
in Pathway 3 (higher cost intensive support, usually in a care/nursing home) discharges

5 PATIENTS A WEEK
Hospital at Home offer introduced is supporting 5 patients a week to be discharged from hospital

Achieved system-wide agreement on a new model for bed-based services to support discharge that's now implemented

Source: IMPOWER Annual Impact Report 2023

Manchester and Trafford each have a Local Care Organisation (LCO), which play a leading role at key points in the health and care interface, particularly in discharging people from hospital settings.

In March 2022, the two LCOs jointly commissioned IMPOWER to design and implement the Resilient Discharge Programme (RDP) on behalf of all partners in the system. The task was to embed improvements made in response to the pandemic as part of a whole-system transformation programme to fundamentally alter the approach to patient discharge.

The key issue was too many patients were in hospital beds when they didn't need to be, resulting in inefficient use of resources and poorer outcomes for those individuals. The programme is enabling the LCOs to reduce delays and ensure patients consistently get the right support at the right time, and that as many as possible are discharged home.

Anonymised patient experience example from Manchester and Trafford LCO's Resilient Discharge Programme

James, who has dementia, was admitted to hospital after having a fall.

His daughter was concerned he would have another fall with the dementia progressing and the family felt James would be better off in a care home.

Through strengths-based practice, introduced via the Resilient Discharge Programme, therapists worked with the family, ensured he still was able to live independently, and reassured them that supporting James to stay at home for as long as possible was better for his health and wellbeing.

James wanted to stay at home where he's most comfortable and the community could help support him. That outcome was achieved.

Source: IMPOWER Annual Impact Report 2023

What can be done now?

We have consistently seen that people using intermediate care, and those delivering support, benefit from dedicated resources delivering tactical improvements.

As set out in the previous section, it is a multi-year journey, requiring significant commitments and changed behaviours to deliver an intermediate care reset.

Given the step-change required this cannot be delivered through a 'big bang' moment, but rather iteratively through a progressive series of small wins. Not only does this make for a more manageable change journey, it enables systems to regularly demonstrate the benefits of change and, more importantly, realises substantial wins to support daily challenges.

IMPOWER's experience demonstrates that there are levers that can be utilised to deliver rapid improvements within intermediate care, even within the parameters of locked-in components, such as: acute footprint, short and medium-term funding, and workforce allocation. These can both target elements of the person's journey, but also be viewed through a functional (organisational model, financial, etc) lens.

We have consistently seen that all system partners and people using intermediate care will benefit from allocating dedicated resources to support tactical change in intermediate care. These benefits can be financial (reallocation of acute capacity for elective care, lower ongoing social care costs, etc) and operational (fewer day-to-day delivery crises). Crucially, this delivers improved outcomes for people, supporting their recovery, independence and wellbeing. A multi-disclipinary focus is imperative to supporting people's outcomes.

This capacity will enable breathing space and the ability to step-back from day-to-day operational challenges and escalations which frequently divert resources and attention from supporting progress.

Early in a person's journey there are four constructive steps that can be taken at speed:

- Allocate and ringfence a level of dedicated community and additional support for step-up capacity. This will enable the system to best support people at the start of their journey even at points of escalated discharge challenge.
- Establish an agile referral and allocation hub that has the ability to deploy resources at speed to respond to demand. Publish and update one electronic list of people waiting for intermediate care resource, to enable prioritised access to available resources.
- Ensure multi-disciplinary board rounds, including social care representation, are in-place for all pre-admission acute units. This facilitates more holistic discussion aligned to the person's desired outcomes and baseline position, mitigating the observed tendency to over-test and over-diagnose when solely clinically driven.

Focused multi-disciplinary working, aligned with holistic good practice (e.g. planning discharge from date of admission) can have a substantial impact on operational outcomes and quality within a few weeks.

During an episode requiring additional support, aligned and outcome-focused, multi-disciplinary working can have a rapid positive impact. Core to this is working with the person and their family, representative or advocate, as well as with hospital and community staff. Working collaboratively towards a target discharge date and outcome from the point of admission enables the overall system to: reduce length of stay, discharge to lower-intensity support, and reduce medium-term support requirements (and costs).

Setting clear discharge expectations with community providers and families helps ensure that any modifications or equipment can be put in place in a timely fashion, and that the support required (formal and informal) to make the discharge a success is in place. Combining these factors, together with pre-ordering pharmacy or storing the most commonly required medicines on ward, helps minimise the number of discharge delays once a date is set and medical treatment completed.

Once someone has been discharged from an acute setting, the next stage of their intermediate care support is essential to achieving the best outcome. All too frequently following discharge people do not receive the input, support and longer-term planning they require. Allocating dedicated resource within the system to coordinate inputs and review is likely to deliver significant capacity and financial gains.

Overall system resource levels are set, so even if short-term funding is made available, it is challenging to stand-up the right resource. However, there are options to deploy resource flexibly – either tying facility-based capacity (e.g. physio and occupational therapists in a community hospital) to tight eligibility criteria or releasing some staff into community facing roles, helping to increase the number of people who can be supported in their own homes.

A reflection from the ADASS/IMPOWER roundtable is that it is easier to describe success than deliver it, but the delivery of a range of interventions can rapidly demonstrate the benefits of system working and make bigger strides towards the delivery of a new model than would initially seem the case.

Case study:
East Surrey Hospital

16% INCREASE
in ambulance handovers within 30 minutes, achieving a 96% success rate and maintaining national targets for the first time since January 2022

13% IMPROVEMENT
in Emergency Department 4-hour performance across admitted and non-admitted pathways

70 FEWER PATIENTS
per week residing in hospital for over 14 days, attributing to a 32% reduction in long length of stay patients

42% REDUCTION
in bed occupancy by patients who do not have a criteria to reside, moving from Third to First quartile nationally

58 BEDS SAVED
(equivalent) annually through a 0.5 days reduction in length of stay across non-elective bed base (1.8 days lower than last year)

88% MORE DISCHARGES HOME
on Pathway 1 delivered through a 39% reduction in discharges to long-term placements on Pathway 3

Statistics approved in October 2023 by Karen Breen, Chief Operating Officer at Surrey and Sussex Healthcare Trust, and Paul Richards, Deputy Director of Adult Social Care at Surrey County Council

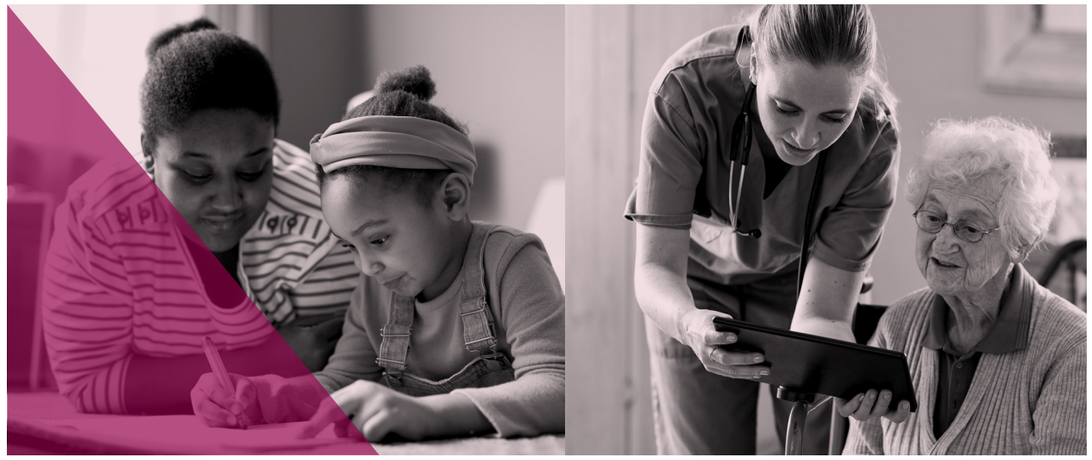
East Surrey Hospital, part of Surrey and Sussex Healthcare NHS Trust (SASH), is one of the major acute providers in both Surrey and Sussex. Such pressures, along with those faced across the country, resulted in more patients staying in the hospital longer, which put extra strain on the emergency department and frontline staff across the hospital.

Following an initial commission from Surrey County Council in November 2022, SASH and East Surrey Place commissioned IMPOWER to provide discharge and flow support in East Surrey. The work focused on ensuring patients are discharged in a safe and timely way with the right care and support that maximises their independence, reducing avoidable pressure and costs to health and social care – improving patient outcomes.

With health and care partners, the 'Let's Get You Home' hospital-wide improvement programme was implemented, enabling frontline staff on acute hospital wards to bring greater clarity and consistency to patient journeys.

How do we evidence success?

Now is the time to reshape this, using direct delivery evidence to inform national direction and funding decisions.



Recent central intermediate care policy and funding direction has suggested a disconnect between policy makers and front line delivery – with the conditions attached to recent winter funding not consistently aligning to system priorities.

The link between innovation, success and policy direction is not fully formed for intermediate care. Now is the time to reshape this, using direct delivery evidence to inform national direction and funding decisions.

Currently successes are hard to measure as reporting is configured to meet two main requirements; spot process activity for central reporting needs, and identifiers of system escalations. This means that effectiveness in consistently delivering good outcomes, avoiding readmission, or managing length of stay, often goes unreported and uncelebrated. This is amplified by system leaders rarely having the time to reflect or review recent delivery trajectories.

In a person-centred system, central to understanding success must be the outcomes, experiences and testimonies of those using, or caring for those using, the system. This can be captured at scale through the more expansive and extensive use of user surveys, together with systematically capturing experience testimonies.

Indicative system balanced scorecard

Most systems have almost all the data needed to give an end-to-end view available, the challenge is how this is shared and utilised to shape a compelling overview. An impactful first step is to create a core dashboard that fully reports system activity, enabling targeted identification of system challenges, supporting effective mitigations.

Accurately reporting system outcomes will need to reflect the inherent complexity of the intermediate care system, reflecting the interplay between several metrics to point to an overall successful outcome – for example, a lower length of acute stay may not necessarily be a positive indicator if means someone has been offered Pathway 2 support when they were suitable for home-based reablement.

An example of a live project dashboard

Strategic metric 1: NRTR – average daily number by site/ consolidated group level on a weekly basis	**Strategic metric 2:** ALOS by site/consolidated group level for people who have left the acute setting in that week
Strategic metric 3: Discharge pathway breakdown – % of people discharged to P3, P2, P1 and P0	**Strategic metric 4:** % of people leaving P1 without Adult Social Care support and P0
Strategic metric 5: % of people in bedded care being discharged to home (proxy for quality)	**Additional with HIVE:** Criteria to reside assessment for patients currently admitted as number and % of current admitted patients
Additional with HIVE: EDD recorded that day for same as above metric	**Additional with HIVE:** Failed discharges - daily figure
Additional with HIVE: Proportion of previous snapshot Super PTL list that were removed	There are different filters enabling site, ward and local authority level views, within a set date range

Key:

Recorded as part of HIVE dashboard

LA to provide, data not on HIVE

National intermediate care leaders must establish a measurable consensus of 'what good looks like'.

The recommendation coming from the ADASS/IMPOWER roundtable is that national intermediate care leaders establish a measurable consensus of 'what good looks like'. The aim of this work would be two-fold – firstly, to have a clear steer on the combination of measures that point to consistently delivering good outcomes, and secondly, to introduce new data points (e.g. has a target discharge date been set at point of admission?) that would provide a layer of qualitative richness going beyond process activity.

For key community trusts these measures would likely include: proportion of community hospital resources being used for step-up patients, length of stay in community hospitals, proportion of patients discharged from acute with no rehab potential regaining independence.

Target local authority measures will include: twelve-week service requirements and changes in package for current clients following an intermediate care episode.

Acute trusts in the intermediate care cohort measures are likely to include: proportion of A&E presentations resulting in admission, average length of stay, and proportion of patients with no medical right to reside.

As the ADASS Autumn Survey Report 2023 highlights, delivering good outcomes through intermediate care should enable far-reaching housing and care benefits.

Conclusion

Intermediate care isn't broken, there are a number of examples where systems are working well. But, now is the time to reset.

From its definition onwards, intermediate care is and will always be imperfect – passionate staff are daily committed to delivering good outcomes in noisy, chaotic and frequently reactive environments, where delivering tactical, let alone strategic, change can feel near impossible.

As this report highlights:

- There is a consensus about what success looks like. Defining a destination, articulating the steps to deliver, and even having the right level of funding and resource, isn't the big challenge for systems – it is about being able to deliver it. However, whilst challenging, it's not impossible work towards a new, better-integrated, person-led way of delivering intermediate care.
- Despite the daily operational challenges there is lots that can be done now – ranging from changed behaviours on acute wards, through to a more agile deployment of community resources that delivers big and sustained changes to system activity and outcomes.
- These successes are real, measurable and deliver meaningful impact – reduced lengths of acute stay (to the extent where entire wards can be repurposed for elective activity), reduced diagnostic and pharmacology spend, lower intermediate care costs, and reduced longer-term adult social care package expenditure.
- Local systems should feel empowered to use the impact and successes to influence policy – ensuring that priorities and funding aligns to where it will make the most meaningful difference.

Intermediate care isn't broken, this report shares a number of examples where systems are working well, or have taken tactical steps that have delivered a significant level of impact.

But, now is the time to reset; commit to taking opportunities throughout the system, genuinely integrating where possible, and using a common data set to target system activity. Making these changes will not only mitigate some day-to-day frictions, but crucially allow activity to consistently be delivered around the person.

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