Bradford District and Craven
Health and Care Partnership

ACTasONE

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Intermediate Care Programme of Transformation and Change

January 2022

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1. Re-set of Intermediate Care

A rapid review into the provision of intermediate care services was concluded in December 2022. The recommendations have been accepted by the Partnership Leadership Executive. The implementation of the recommendations and a re-focus of the service offer has been accepted as a workstream of the Healthy Communities Programme Board. This paper offers an initial structure to inform the ongoing transformation of the Partnership's intermediate care services.

Recommendations from the review – The Partnership should:

1. Aim to reduce the current bed base to a level more in line with the national average.
2. Formalise the integrated commissioning of services to work as a joined up model.
3. Realign the Better Care Fund to reflect service delivery, with the addition of all services that support people to stay well at home as schedules to the fund.
4. Take a cohorting approach to care in the bedded facilities with a fair balance of access to therapy services.
5. Increase capacity and uptake in the home-based pathway, refocusing on prevention and admission avoidance.
6. Empower decision making through the consistent use of data and intelligence to inform operational and strategic planning, moving to one data set and dashboard.
7. Formalise the leadership arrangements for the Intermediate Care offer and set out accountability and lead provider arrangement with a pooled budget.

The Partnership would best focus its current and future available resource on reducing the number of people being admitted to hospital as well as discharging to assess. This includes:

8. An Integrated Community Recovery Service with a 'Home First' ethos and strategy.
9. An integrated community model incorporating the Virtual Ward, 2-Hour Urgent Community Response, 2-hour Social Care Rapid Response and Community Collaborative Teams.
10. An increased digital care and technology enabled care (TEC) offer to allow people to manage their own health and care at home.
11. Increased partnering with the Voluntary and Community Sector to support people on Pathways 0, 0+ and 1, with the clear objective of reducing the need for Pathways 1, 2 and 3.

12. Investment in therapy, therapy assistants and enhancement of the skills of home care staff to work with people on a therapeutic plan of care.

13. The Trusted Assessor and MAIDT models leading discharge to assess from all beds including those classed as Intermediate Care Community Hospitals and Assessment Beds.

14. Community reablement that is available within 24 hours of a person being determined medically fit to leave hospital.

15. A significantly reduced number of short stay Community Hospital and Social Care assessment beds, managed as a whole, with therapy input available consistently in all units.

Structure

Looking forward, NHS England is working on a re-set of Intermediate Care with a National Integrated Planning Framework for Intermediate Care. This is scheduled for publication in 2023, with a 12 month implementation period. This will include:

- Accountability for system and lead provider arrangements defined and agreed;
- Roll out of 'Community Recovery Services'; and
- Standardised national reporting of all metrics and outcomes across the whole of the ICS service from 1st April 2024.

The national re-set offers a framework to consider the transformation work to be undertaken by the health and care partnership.

Governance and Assurance

Accountability and leadership for the Intermediate Care workstream is held by the Healthy Communities Programme Board. The Board reports to the Partnership Leadership Executive.

Transformation and Change

The Intermediate Care Transformation Task and Finish Group is responsible for the prioritisation and implementation of the recommendations to deliver a Community Recovery Service. .

Intelligence and Analysis

Data to inform decisions and monitor impact is essential in any change programme. The Partnership's business intelligence teams will support the development of relevant measures and reporting to inform transformation and mitigate risk.

2. Supporting people's wellness and wellbeing at home

The case for change

Evidence from a range of sources shows that a well-designed intermediate service care can:

- Improve people's health and wellbeing outcomes
- Reduce unnecessary admissions and readmissions to hospital
- Reduce delayed discharges, length of hospital stays and free-up NHS capacity
- Reduce premature long-term social care provision

Intermediate Care comprises short-term, multidisciplinary services that provide support to people who have been in hospital or who are at risk of hospital admission.

Intermediate care helps people to recover or rehabilitate at home and is underpinned by the Home First principle that the vast majority of people recover best at home. Intermediate care helps people to be as independent as possible after a stay in hospital, or a crisis in the community, and helps people to avoid people going into hospital or residential care unnecessarily. Intermediate care services are sometimes known as 'step down' or 'step up' services and can be provided in different places (e.g., people's own home, care home, community hospital).

Our vision is that within 2 years all people in an acute or community hospital, who need further support to recover, will have access to high quality therapeutic community recovery services in an appropriate setting within 1 day of no longer requiring acute or community hospital care. People should be able to access the right level of high-quality service provision they need in a timely manner. Services should additionally enable people to assess their needs, review their options, and plan for their futures.

Our aim is to facilitate a steady rate of improvement towards the vision, reporting progress at regular intervals.

The Intermediate Care Programme will look at home-based and bed-based rehabilitation and reablement; linking with the urgent community response programme.

Intermediate care services are crucial to helping more people recover their independence, reduce deconditioning and improve outcomes. We will work to develop a new community recovery service that will decrease delays in people being discharged from hospital, improve their functional outcomes, and reduce or delay long term care needs.

Objectives

The change programme will have the responsibility for the development of timely, high quality intermediate care services to:

- Promote faster recovery from illness or injury and therefore improving functional outcomes
- Prevent unnecessary acute hospital admissions and readmissions
- Support people's self-esteem, dignity and choice and reduce a person's risk of deconditioning
- Reduce the need for long-term care (home-based and bed-based)
- Reduce the amount of time people have to spend in acute or community bed-based care
- Promote more efficient patient flows (right care, right place, right time) through the health and social care system, involving and supporting carers
- Maximise independent living

Challenges

We need more information and evidence to determine the best service models for the future. This means that there are a significant number of areas we will need to understand better through the work of the programme, for example:

- Supporting people with mental health needs, notably cognitive impairment
- Optimal activities for length of stay to achieve the ambitions of intermediate care
- Understanding best practice and people's experience for transfer to long term care
- How intermediate care can support unpaid (family) carers to continue to care,
- Workforce challenges
- Effective measures of performance and outcomes
- Innovative changes to service delivery models to respond to further demographic demand increases
- Cost benefit analysis and finding 'what works' for us locally