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Effective accommodation based (care home or community hospital) Intermediate Care and Reablement: A blueprint from the National Care Forum

Introduction

Intermediate care has, for many years now, been an essential part of the journey of people who are moving from hospital back to the place they call home and offers a preventative role in reducing readmissions to hospital. Given the current pressures in local systems and the experiences of people getting stuck in hospital, it is more important than ever that we deliver the vision of effective, timely, high quality rehabilitative care in a variety of community settings.

The work of the National Care Forum (NCF), in collaboration with the wider Care Provider Alliance (CPA), to support the Intermediate Care Programme shows that there are many high quality, effective, timely intermediate/step down care services and that there are several essential ingredients that need to be in place to ensure this. This document sets out those key ingredients, through the different lens of the person being supported, the care providers supporting them and the local systems within which all of this happens.

People have the right to expect that their journey from hospital back to the place they call home will support them to be as independent as possible and that if they need it, a dedicated intermediate care service will be available for them as close to their local community as possible, with the right environment to maximise their rehabilitation. This should include opportunities for social and well-being activities that support progress in rehabilitation and recovery. In addition, research has indicated that providing areas where people can meet and discuss their various rehabilitation journeys allows a culture of motivational peer support and helps maintain people's energy and interest in the rehabilitation process. People and their families should be assured that the appropriate and relevant health professionals will be deployed to support their rehabilitative journey, both in the intermediate care service and with a seamless transition to ongoing community health and therapeutic support if needed when they return home.

Defining an intermediate care service in accommodation based services

An intermediate care service offers restorative care, including rehabilitation and recovery, to people who need it following a stay in hospital or, sometimes, to reduce the likelihood of a possible hospital admission.

NICE, the National Institute for Health and Care Excellence, describe intermediate care services like this:

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"Intermediate care services provide support for a short time to help you recover and increase your independence[1]."

Intermediate care is about supporting people's rehabilitation activities and enabling their speedy return to a baseline of independence, where possible.

Intermediate Care should be regarded as describing services that meet all the following criteria:

- support people who would otherwise face unnecessarily prolonged or inappropriate in-patient hospital stays.
- are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active and timely therapy, treatment or opportunity for recovery.
- have a planned outcome of maximising independence and typically enabling the person to return to their own home within an agreed time frame, normally between 4 and 6 weeks.
- involve cross-professional multi-disciplinary working, with a unified assessment framework, single professional records, and shared protocols.

Stages in the Process:

- **Assessment**: local systems will need to make sure that they have trusted assessment processes in place which focuses on timely accurate assessments which are shared, planning together, between the hospital discharge team/transfer of care hub and the intermediate care service lead/manager.
- **Moving into the intermediate care service**: The admission process to the intermediate care service needs to be well planned and fully supported by both the hospital discharge team and the intermediate care service team including: planning for mutually agreed admission times, having clear transport arrangements in place, clear communication with the person and their family, ensuring the person has all their essentials with them (hearing aids, glasses, dentures, medication, clothes, walking aids etc) and making sure the intermediate care service is ready to welcome them. The transfer of information about them to the intermediate care service also needs to be seamless.
- **Care and rehabilitation planning**: The person will have a clear care and rehabilitation plan which begins during their stay in hospital and continues as soon as they arrive at the intermediate care service and the intermediate care lead will be involved in planning for their return home as soon as they arrive.
- **Co-ordinating the return home**: 24/7 staffing and a safe, well-designed environment enables a focus on achieving improved confidence, mobility and functioning for independence and to discuss and make plans for returning home, discuss hopes and fears and working with the person, their family/friends (if appropriate) and other key stakeholders to support a clearly articulated plan outlining responsibility and delivery for a smooth return home and ensuring ongoing support if needed.

[1] https://www.nice.org.uk/about/nice-communities/social-care/quick-guides/understanding-intermediate-care

Key ingredients of the blueprint

This blueprint focuses on **accommodation-based services in care settings**, either within a dedicated 'unit' or an entire service, which support people out of hospital who are medically well, but need on-going therapy, reablement and 24-hour care before they can safely go home.

Key ingredient 1: Environment

Accommodation-based services provide an effective 24/7 environment staffed by an experienced care team which promote rehabilitation and optimum physical activity, social interaction, and psychological responses for individuals who are attempting to regain confidence and mobility and return to a level of functioning independence to return home. They create a place where people can immediately feel better, build confidence and improved well-being; they offer the opportunity to re-engage with others and after a short stay, return home to carry on living their lives.

A well-designed environment is key to achieving a sense of control and compensating for changes and impairments that can make it difficult for the person to understand and navigate. These can be sensory, mobility, or cognitive impairments, and sometimes a combination, which can affect functioning, behaviour, independence, and ultimately, quality of life.

Environments should reduce risks, such as falls, whilst allowing the freedom and confidence for the person to fully use their abilities, aiding memory in day-to-day living, and reinforcing personal identity. A well-designed environment can also improve the standards, practices, and behaviours of staff.

Specialist Intermediate Care Providers must ensure that the physical environment reflects the purpose of dedicated rehabilitative care and the distinctive needs of the people who need short-term rehabilitative care and support to return home. The provider should plan to provide:

- ✓ intermediate care in facilities separate from long-stay accommodation so as not to cause disruption to permanent residents and to ensure that the staff providing restorative care in the intermediate care service are clear about their role.
- ✓ private ensuite bedrooms with shower facilities to develop the preparedness to go home and maintain independence.
- ✓ kitchen facilities to enable people to regain independence with food and drink preparation. Nutritional support could be provided here.
- ✓ Provide rehabilitation space, personalised programmes of training and exercise equipment to enable daily exercises and training and to enable the active involvement of key health professionals (AHPs), including specialist AHPS to facilitate independence (e.g. OTs, SALTs) in the recovery and rehabilitation programme for the people being supported.
- ✓ Designated therapy, kitchen, and lounge areas for the primary use of Intermediate Care Service users and to provide them in close proximity to the bedroom areas.
- ✓ Ensure that the décor and furniture will be of a domestic style in those areas to be used for Intermediate Care, avoiding very 'clinical' surroundings and striving for a more domestic style to promote preparedness for returning home.

- ✓ Provide standard equipment and adaptations that one might expect to find or that the person is going to need in the individuals' homes in order to develop confidence in use of those bits of kit if needed.
- ✓ Provide detailed information to relevant AHP or members of the MDT about use of equipment and adaptations to prepare for return home.
- ✓ Provide a range of opportunities for therapeutic activity.
- ✓ Provide opportunities for social and well-being activities.
- ✓ Provide outdoor facilities to access the garden.
- ✓ Provide individual medication storage to facilitate self-medication, and to provide coaching on medication management where needed.
- ✓ Provide domestic laundry facilities to enable people to regain independence with managing their laundry.
- ✓ Provide equipment to support comfort, safety, and clinical needs, to be agreed as part of the contract.

Key ingredient 2: Workforce in the Intermediate care service

The intermediate care service workforce is essential in supporting people's rehabilitation activities and enabling their speedy return to a baseline of independence. Rehabilitative care requires a different ethos and mindset from delivering long-term care and it is much more time intensive. Specific training and support will enable staff to become rehabilitation support workers, adopting a rehabilitation mindset. This training and support can be provided via a mix of in house/external care provider training and training and support from a range of therapists.

Accommodation-based services offer 24/7 staffing – this provides a real opportunity to make every interaction with the person a 'rehabilitative' interaction and increases the opportunities to encourage independence. It also offers the opportunity to begin planning for the person's return home as soon as they arrive in the Intermediate Care service. This includes a real focus on achieving improved confidence, mobility and functioning for independence and to discuss next steps, plans for returning home, discuss hopes & fears and supporting the logistics of a smooth return home with ongoing support in place if needed.

Staffing an accommodation based Intermediate Care Service

Specialist Intermediate Care Providers must ensure that they have workforce models that will deliver high quality, effective, timely intermediate care services. Workforce models will vary – here are some suggestions:

- ✓ Dedicated **Intermediate Care Lead(s)** to be employed by the specialist Intermediate Care provider to manage and co-ordinate the Intermediate Care Service. (The number of leads will vary based on the average turnaround and number of admissions and discharges managed within the unit.) This role includes:
    - managing the whole process and logistics of liaison with the discharge teams.
    - overseeing the person's whole journey through the service, with a clear focus on return home, identifying and removing barriers where appropriate.
    - ensuring effective and timely Multidisciplinary Team (MDT) meetings.

- facilitate and negotiate equitable, timely access to support from therapists, GPs, and geriatricians, according to local arrangements.
- planning for the return home.
- working with families, AHPs and other care providers to help people back home.
- Liaising with AHPs/LAs to ensure arrangements for any aids/ adaptions needed in the person's home when the return, including access to DFG assessment.
- ensuring people are rehabilitated and discharged as per agreed plan.

✓ **Rehabilitation support workers**: specialist care workers who are dedicated to the specialist service, reporting into the Intermediate Care Lead/coordinator. Specialist training, and ongoing supervision will support these roles to provide a dedicated rehabilitation focus and work creatively with people, their families and the wider group of care and health professionals supporting the person's rehabilitation and return home.

✓ **Service Lead Nursing input**: the service will need to have access to a nurse; either a nurse employed within the care setting with nursing, or in the case of care settings without nursing, a community nurse who is responsible for the person's clinical care. Out of hours arrangements need to be agreed locally at the outset of the service and be part of the contract.

Key Ingredient 3: Multidisciplinary Commitment and Collaboration to Intermediate Care

Intermediate accommodation-based care services are very different to long-term accommodation-based care services. More resource and time are needed to manage the process and logistics of liaison with the discharge teams to ensure that a trusted assessment has been done in order for the service to meet the needs of the person being referred. Once it is agreed that the service is right for the person, the care provider then needs to oversee the person's whole journey through the service, including:

- ensuring effective MDT meetings including co-ordinating support from the whole MDT – involving the therapist, GPs, and geriatricians (according to local agreements) in particular.
- planning for the return home by working with families, AHPs and other care providers to help people back home.
- Liaising with AHPs/LAs to ensure arrangements for any aids/adaptions needed in the person's home when the return, including access to DFG assessment.
- ensuring people are rehabilitated and discharged as per agreed plan.
- co-ordinate the arrangements for getting any ongoing care and support place before the person returns home and making sure it all runs smoothly.

Key professionals linking with the service:

✓ **Registered therapists'** expertise will be needed for the assessment of people and development of rehabilitation plans. Arrangements must be in place for inclusive and effective therapeutic input to include Occupational Therapy, Physiotherapy, Speech and Language, dietetics, podiatry during the person's stay in the Intermediate Care service. **It is essential that the Intermediate Care service has timely and regular access to therapists to ensure that rehabilitation plans are developed and progressed**. Therapists can come from the existing health system, be that

hospital or community (or a combination of both) or intermediate care services could be resourced within the commissioning process to employ their own registered therapists.

- **Where commissioners contract directly with private therapists**, they should ensure those individuals have up-to-date registrations, mandatory training and CPD and expertise in the rehabilitation of frail older people. NHS Professionals, bank or locum agencies should provide those assurances. Where private therapists are unfamiliar with the local health system, there needs to be some form of induction and access to relevant technology and systems, including electronic care planning systems.
- **The clinical lead and the Intermediate Care service lead/manager** will have responsibility for overall clinical governance and will need to be satisfied with the competence and performance of therapists and other staff. MDT meetings must be scheduled on a regular basis (no less than weekly) to ensure people's progress is reviewed and individual treatment/therapy changes or discharge home in a timely manner.
- Work is underway on developing a wider workforce model to support the intermediate care programme development as there are pressures on and shortages of the registered therapy workforce. Delegation of health care activities to care workers and other staff must be undertaken in line with Health and Care Professionals Council (HCPC).

✓ **GPs and pharmacists:** Local systems must ensure that suitable support is in place for the specialist Intermediate Care units, including GP and medicines access. Wherever possible the onsite service should coordinate remote access to a person's registered GP practice for advice and consultation where needed and to ensure access to prescribed medications, e.g., by agreeing and informing of a nominated pharmacy who can deliver medicines to the site. This could be the pharmacy with a contract to supply the Care home. Where the individual receiving care in the intermediate care service is not a registered patient of the GP, commissioners should agree on an approach with the PCN to proactively support temporary registration and management of all patients discharged to rehabilitation beds. Advanced Care Practitioners (ACPs) may be able to carry out some of the responsibilities of GPs as per existing practice. All clinical information should be recorded and transferred to the patient's substantive GP record.

✓ **Out-of-hours cover**: a clear arrangement for out of hours medical support must be in place. Arrangements may vary locally, in some areas it may be an on-call geriatrician, in others it may be that this aligned as part of virtual wards/Hospital at Home implementation and in others it could be a different advanced clinical decision maker. As it is likely to be outside the normal GP arrangements for that care setting, then there must be clear out of hours medical cover, which must cover routine proactive support as well as urgent crisis response to ensure out of hours cover. It is essential that there are clear pathways and assessment to support early recognition of deterioration and appropriate escalation processes in place to maintain the person's safety. Training on escalation processes should also be provided to support workers as necessary.

✓ **Geriatricians:** local systems must ensure that that there is an identified Geriatrician for support and escalation to support intermediate care services in dealing effectively with deterioration or escalation of need. Local arrangements may vary but having remote on-call geriatrician support

will provide real benefits by providing primary, community and care home professionals specialist advice, and intervening where there is deterioration or urgent escalation of needs. Along with the beneficial outcomes for the person, systems should consider the cost-benefit advantages of this support in avoiding emergency hospital admittance and identify how it can be provided. It should include out of hours cover.

- ✓ **Support from an Admiral Nurse**[2]: if the focus of the Intermediate Care services is supporting older people, then access to an Admiral Nurse would be hugely beneficial for those people who have a diagnosis of dementia. The Admiral Nurse will provide advice and support for carers of people living with Dementia in the facility and on return home.
- ✓ **Support from Specialist Learning Disability or Mental Health Nurses**: if the Intermediate care service is likely to be supporting people with a learning disability or autistic people or people with poor mental health, then access to specialist LD or MH nurse will be hugely beneficial.
- ✓ **Social workers**: as well as the initial assessment, social work input will be essential in achieving a prompt return home for people who are deemed able to leave the specialist Intermediate Care unit (with a package of domiciliary care if needed). Ideally a specific Social Worker would be allocated to the intermediate care service to build relationships and be part of the wider MDT.
- ✓ **Family members, friends, community support and advocates**: it is important that, in line with the wishes of the person being supported, family members/friends/those nominated by the person should be central in conversations and decisions. They are a useful resource in supporting individuals in actioning their rehabilitation plans, with some instruction from registered therapists. They may also be able to continue this role once a person returns home. It is important to recognise that family members are often a huge asset.
- ✓ **Other workforce resources:** There are a variety of additional or alternative workforce resources that commissioners could call upon to support rehabilitation activities in the specialist Intermediate Care units. Opportunities include but are not limited to:
  - Therapy Support Workers and Therapist students on placement with local providers.
  - Physical activity specialists, such as those potentially already employed by Local Authorities to provide group exercise classes.
  - Local volunteers from charitable and independent organisations that already work with older people.
  - Workers in private sector and retirement housing settings, such as gyms, for example personal trainers.
  - Family members, carers, advocates.

How does an intermediate care service fit with Enhanced Healthcare in Care Homes (EHCH)? EHCH takes a multidisciplinary approach to proactive planned care with people living in a care home for the longer term; it is not geared up to support an intermediate care service.

If the person in the intermediate care service is registered with the GP that covers the service routinely, then ECHC can apply. If the person is registered with a different GP, then it doesn't.

[2] https://www.dementiauk.org/get-support/what-is-an-admiral-nurse/

A shared view of key outcomes: NHS colleagues have suggested that it will be important for the intermediate care service to be ready to engage in agreed shared key outcomes that the MDT might want to capture/ monitor. Suggestions included:

- Delays - understanding any delays to admission to the service / delays in leaving hospital / delays in leaving the intermediate care service (useful to see where the bottlenecks are locally)
- length of stay in the intermediate care service (useful to see if the original estimate of rehab & recovery proved accurate)
- outcomes of the care delivered by the service (both the personal outcomes sought for the individual and and the outcomes anticipated by the referring team)
- total overall cost of that rehab & recovery package of care
- any readmission to hospital during the stay in the intermediate care service.

These will need obviously need to be discussed and negotiated locally and will need to be reflected in the contractual arrangements.

Key Ingredient 4: Technology

Digital technology will be essential to support the rehabilitative journey.

Digital systems in the local health and care system will need to communicate securely with the intermediate care service and systems should consider how this will be achieved whilst meeting the requirements of data protection legislation and other regulations.

As a minimum, intermediate care services will need to ensure that they have the following:

- ✓ NHSmail, or an alternative email which is accredited as meeting the secure email standard (DCB 1596), so that information can be shared securely via email.
- ✓ To achieve "standards met" annually on their Data Security & Protection Toolkit submission. This is a mandatory requirement for all health and care settings which access NHS data and operate under an NHS contract.
- ✓ Internet access to support the use of digital tools in the care setting and to facilitate the individual receiving support in improving their digital confidence.
- ✓ A digital social care records system: A Digital Social Care Record (DSCR) allows the digital recording of care information and care received by an individual, within a social care setting, replacing traditional paper records. DSCRs are person-centred and enable information to be shared securely and in real-time with authorised individuals across the health and care sector. While this is not currently a mandatory requirement, it is an incredibly helpful step on the digital journey. [The assured supplier list for digital social care record suppliers can be found here. Information about the Adult Social Care Digital Transformation Fund can be found here]
- ✓ While we await the creation & roll out of shared care records, access to data across the various system partners is essential for the effective 'flow' of people through the intermediate care service. Some intermediate care services are using national solutions such as the Summary Care Record application (SCRa), Proxy Access to the GP record or GP

Connect to improve data access and outcomes for the people they support. In other areas, local solutions or fledgling shared care records are in place to improve access to data from primary and secondary care and local authorities.

Key stakeholders across the local system will need to champion shared access to the relevant health and care data to support the intermediate care delivery and create a culture of trust in data sharing. In one of our case studies, we show the effectiveness of assessment data from a trusted assessor going directly into the electronic care planning system of the intermediate care service which sped up and streamlined the process of discharge from hospital. Access to GP data & prescribed medication data is also key.

As this data is shared across the system, it will be important for local data sharing agreements to be developed and agreed to ensure that the risks to individuals are mitigated and legal requirements are met. The National Health and Care Information Governance panel have created guidance on information sharing for MDTs and a website dedicated to information governance guidance and information sharing more widely.

Other technology to aid independence and assessment can be considered such as bed sensors, light sensors, cameras with permission, acoustic monitoring. Supporting people with their digital confidence is also important as they plan to go home, exploring technology that can support independence when back in the community, such as personal alarms, other potential sensor tech and smart devices. The intermediate care service will need to provide wi-fi access.

Technology is increasingly being used to aid independence and assessment. Some of these are fitted within the care service itself. A non-exhaustive list of solutions is below:

- Acoustic monitoring
- Cameras
- Bed and lighting sensors
- Circadian rhythm lighting

In addition, assistive technology can be introduced in the intermediate care service and then used by the individual when they return home. Where the individual in the intermediate care service is not digitally confident, this is likely to require additional support from the intermediate care team. At a minimum this would include,

- Understanding the hardware, software and connectivity requirements of the individual in their home. Do they have access to a smart phone, tablet or PC? Do they have internet access? If they don't, the intermediate care team should work together to support the individual with digital access.
- Supporting the individual to understand how the technology works and to feel confident using it. For example, smart home assistants such as Amazon Alexa or Google Nest can function as helpful communication tools, alarm reminders and more. Where an individual can use these technologies in the intermediate care setting, they often feel more confident in their capability to return home and maintain independence.

- Supporting the individual to understand who has access to their data and how the technology works. Some technologies, particularly any camera or monitoring equipment, can cause anxiety and alarm in individuals. Staff will need to be able to discuss and allay any concerns with an individual should they decide that they would like to use technology to support their independence. Where an individual chooses not to use technology, the MDT should be able to plan how to ensure that this doesn't impact care quality and outcomes.

Dependent on the health and care needs of the individual, some pathways use specialist technology and apps to support someone with their healthcare needs remotely. For example, diabetes, frailty and falls pathways all use specialist apps and software. In addition, people's wellbeing can often be supported by the positive use of technology.

How does an intermediate care service fit with virtual wards? It is possible that an intermediate care service could benefit from the virtual ward approach as it could be helpful to support a person discharged to the intermediate care setting to avoid a return to hospital.

Key Ingredient 5: Sustainable Commissioning and Funding

It is essential to develop mature partnership commissioning and contracting arrangements for Intermediate Care services across local systems. Work from SCIE highlights[3] the importance of a joint or integrated commissioning function for the service in which health and social care resources are aligned, if not pooled. If providers are to invest in creating specialist environments, then they need sustainable long-term funding and resourcing to deliver these.

Local systems will need to invest in secure long-term funding for intermediate care services – a well-designed rehabilitative environment is a key element in the funding needed to deliver an effective intermediate care service and must be addressed in the future Community Recovery model. It is not possible to deliver an effective intermediate care service with short-term emergency pots of money. Care providers need confidence and certainty to invest in the design & delivery of intermediate care services. In addition, there is a need to properly fund and integrate the technology required to effectively deliver intermediate care.

Funding the intermediate care service workforce properly: The local system will also need to ensure that it resources the care workforce in the intermediate care service properly. Intermediate care is very different to long-term care and requires a more intensive staffing model, a different set of skills and expertise and the delegation of a range of activities. The staffing required may change based on the turnaround time of people's stay and the number of admissions and discharges but overall, staffing at the right level with the right skills is a key element in determining the funding needed to deliver an effective intermediate care service and must be addressed in the future Community Recovery model. Places in a specialist Intermediate Care service will cost significantly more than the average local rate due to additional care worker hours to support rehabilitation activities and other cost pressures.

[3] https://www.scie.org.uk/prevention/independence/intermediate-care/highlights

Case Studies

Case study: WCS Care

Since 2017 WCS Care, a not-for-profit care provider in Warwickshire, has worked alongside South Warwickshire Foundation Trust to deliver a discharge to assess therapy service at their residential care home, Castle Brook in Kenilworth, for people who are medically fit for discharge from hospital but need additional therapy before returning home. The service has delivered significant impacts for patients and the wider health service - one patient journey, two services.

Their SWFT video can be found here: https://youtu.be/eZMCEjc2zjA

Case study: Belong Villages

Belong is a not-for-profit care provider, operating care villages which provide 24-hour care, including specialist nursing and dementia support, in secure households for 12 people. Households are arranged around a village centre with a range of facilities, including a bistro, hair salon, activity rooms and a gym providing a specialist exercise and rehabilitation service. Villages also include independent living apartments and operate a home care and day care service. This ensures a range of services to support people's changing needs, a feature which, combined with the self-contained nature of the households, lends itself to providing an intermediate care service.

Belong has operated an intermediate care service at two locations; most recently, at Belong Morris Feinmann in Didsbury, Greater Manchester, where Manchester City Council commissioned a household to be allocated as a 'Discharge to Assess' (D2A) service during the Covid-19 pandemic. This ran from December 2020 to September 2021 and built on Belong's earlier experience at Belong Macclesfield, which spanned over six years.

Objectives
Manchester City Council aimed to accelerate hospital discharges by working with Belong to provide a step-down facility for people coming out of hospital. Objectives included:

- Enabling people to leave hospital faster to free beds, while at the same time ensuring older people are in a setting that is conducive to recovery and return to their usual abode.
- Enabling people to return home in a timely fashion, with a target set of six weeks maximum stay in Belong.
- Enabling people to be assessed for longer-term needs in an environment that is more reflective of 'home' therefore giving opportunities for people's daily living abilities to be assessed.

Response
Belong's care model is based on smaller households of 12 people who live together, each with their own communal dining room lounge. There are usually six households in each village and in addition, their villages comprise of independent living apartments and a range of communal facilities including a bistro, entertainment venue and exercise studios, all of which are open to the public as well as people that live within the village.

Belong Morris Feinmann provided 'Olive' as a dedicated household, giving Manchester City Council 12 en-suite rooms that were allocated as a D2A facility.

Referrals from the hospital arrived with a care assessment and a complete care plan prepared on arrival using Belong's electronic care planning software, Person Centred Software.

Belong's use of electronic care records and medicine management software assisted the move-in process and set-up in the residential care setting. It ensured managers had visibility of all resident needs and it also made it easier to share information with the wider multi-disciplinary team (subject to consents being in place).

Those arriving in Belong benefited from a homely, non-clinical environment, designed to maximise independence, with use of an open plan living, dining and kitchen area, where people could make

their own drinks and get involved in meal preparation as they wished. They also had use of a small laundry and secure access to a garden.

Nutrition and hydration were supported and monitored carefully. As meals are prepared in the household, there is a home-like aspect as the appetising smells of cooking helps to signal approaching mealtimes. Intake was recorded using the PCS system and this was also used to set alerts for necessary care interventions and to record residents' wellbeing and progress in a broader sense.

There were also social opportunities in the village, which took place within the households, due to the impact of Covid-19 regulations preventing mixing between different households. Under normal times, the range of activities would have been even greater.

Outcomes

- 41 patients came to Belong for intermediate care.
- 19 people were able to return to their own homes.

Learnings

Dedicated project leads

Although intended as a step-down facility, the nature of hospital discharges meant that needs at point of arrival were often sub-acute and included some who were in fact on end-of-life pathways due to co-morbidities.

As turning people away is always a very last resort, only for scenarios where a move-in would be considered unsafe, careful planning and dedicated resources are needed to minimise the likelihood of this happening.

Specifically, a named discharge coordinator with knowledge and experience of the Belong setting and team would help ensure hospital assessments were informed and suitable referrals made. A dedicated coordinator would also be able to monitor the time of move-ins, both in terms of allowing time between move-ins to settle customers in and considering the time of day to make for an easy transition.

Equally, a dedicated point of liaison in the care setting, bringing clinical knowledge and expertise to the relationship, is key to day-to-day smooth running of the contract. At the time of the D2A contract, consistent nurse support was provided by Belong's Village Nurse Manager, which ensured a high level of expertise to oversee the care provided. For a longer-term contract, a dedicated nurse would be needed, as was in place during our Macclesfield experience.

Joined up working

Dedicated project leads on both sides contribute to closer collaboration, regular communication, and higher quality information, decision-making and therefore outcomes. The ultimate goal would be for NHS and social care systems to be integrated so that patient information is readily available to care teams without the need to manually re-enter extensive datasets.

Multidisciplinary approach, including a well thought-out medical model

Another pre-requisite for intermediate care is close working with a GP practice to ensure continuity of care and medical attention for those moving to Belong. In some cases, including in Belong Morris Feinmann, this may not be the same GP practice attending to other residents, as given the higher needs, not all practices are able to absorb this, making an aspect that needs to be carefully planned.

A real strength in terms of their experience in Didsbury was the close working relationships between the multi-disciplinary team (MDT) including care colleagues, GPs, occupational therapists and physiotherapists, contributing to better outcomes for the individual.

Regular meetings between the MDT ensured progress was reviewed at agreed intervals and the focus on reintegration to the community maintained. During the Covid-19 pandemic, these meetings took place online, pointing the way to a sustainable way of maintaining regular communications.

Equipment and technology

Whereas typically a Belong household would seek to have a blend of levels of need, the D2A household saw a higher than usual number of residents requiring specialist equipment, including profile beds, standing frames and hoists. Making provision for this from the outset helped with smooth day-to-day provision of care.

Where possible, use should be made of specialist technology and expertise to aid rehabilitation and contribute to faster discharges.

For example, in Belong Morris Feinmann, there is access to a qualified exercise specialist to support in creating a personalised exercise programme. Although gyms could not be accessed at the height of the pandemic, some of the specialist equipment (including specially adapted exercise bikes) is mobile and could be used in households.

Exercise programmes were designed to target mobility, falls prevention, rehabilitation, for example following a stroke, and a range of other outcomes specific to older people's health needs. There are several examples where the exercise service has contributed to customers' ability to return home from 24-hour care settings. This is achieved by maintaining a core strength and skill base - key to older people's ability to maintain the basic skill of standing up from a chair and walking. Other outcomes include seeing an increase in muscle strength, flexibility, balance and co-ordination, and maintenance of everyday skills. This level of input to supporting daily exercise is something that is difficult to replicate at home or in other settings.

Integration within the wider care setting

As this contract was in part in response to the pandemic, opportunities for patients to mix with other residents were limited, largely due to the regulations governing movement between care settings at the time. Under normal circumstances, residents would also have been able to access village centre facilities, such as a bistro, hair salon, entertainment venue and the gym, creating further opportunities to promote wellbeing and accelerate recovery.

Conclusions

Belong's experience showed that residential care settings can play a valuable role in intermediate care, particularly in providing a homely setting where preparation can be made for the transition to

return home. The patient experience is positive compared to extended and indefinite hospital stays and individuals typically return home in a stronger position, particularly where they have been able to take advantage of rehabilitation and exercise support.

Belong received excellent feedback from individuals on the support provided, including a letter from one gentleman who described it as ‘magic’, ‘something special’, due to the difference made in ‘turning my life right around’ and nursing him from ‘sickness’ back to ‘good health’.

Achieving these outcomes, maximising the opportunity presented for joined up working between health and social care and making a success of intermediate care arrangements requires good communication. This includes operationally at the MDT level and with the contract monitoring/commissioning team to ensure KPIs are clear and mutually agreed, and that these are reviewed and discussed, along with emerging practice and operational challenges and successes.

Another crucial element of this is ensuring a forum is in place to monitor and review resources needed and ensure that the true cost of care continues to be met, which is key to ensuring the long-term sustainability of intermediate care contracts.

Case Study: Somerset Care & Yeovil District Hospital 2015

Please click here to watch a short video about the collaboration.

1. The wider context for the scheme/the issue or situation it was set up to address

1.1. Background

Pressure on hospitals is well-documented. So, too, is research evidence indicating that for every 10 days an older person remains in a hospital bed, they lose 10 years of muscle strength and associated function. Moving people out of hospital as swiftly as possible thus has the potential to improve health and well-being outcomes and to save money for the health and care system.

Somerset was one of the poorer performing local authority areas with respect to delayed discharges from hospital, particularly for reasons ascribed to social care. Somerset County Council had a £22m deficit, and therefore needs to cut costs. Doing more of the same was not an option.

In March 2015, Somerset Care approached Musgrove Park hospital in Taunton with a proposal to provide intermediate care rehabilitation beds in one of our Taunton nursing homes to help reduce delayed transfers of care. Discussions progressed to quite an advanced stage and then financial pressures at the hospital and a change of Director of Nursing led to abandonment of the project.

Meanwhile, Yeovil District Hospital (YDH) had heard about the proposal and said they would be interested in doing something similar. At the time, Somerset Care were building a brand-new nursing home in Yeovil, Cookson's Court, and a few weeks after it opened at the end of September 2015, we started an intermediate care collaboration with YDH.

1.2. Aims

The aims of this collaboration are to:

- ✓ Improve patient flow at YDH.
- ✓ Reduce unnecessary length of stay at YDH.
- ✓ Enable reablement in an appropriate environment.
- ✓ Maximise patient clinical outcomes.
- ✓ Reduce ongoing costs of care.

This project was an example of true collaboration and integration of services between an NHS acute trust and a not-for-profit provider of social care for older and disabled people.

2.1. Funding: Initially Somerset Care approached Somerset CCG and Somerset County Council commissioners for funding for a pilot project, to evidence that they could achieve the aims listed above by working in a different way across the health and care system. Both declined. So YDH decided to fund the pilot itself using some of its "winter pressures" money. YDH block purchased all 18 beds on the top floor of Somerset Care's nursing home in Yeovil, Cookson's Court.

2.2. Who was involved? YDH placed members of their Rehabilitation Team, including Physiotherapists and Occupational Therapists, on the top floor of the nursing home, working alongside Somerset Care's nurses, Advanced Healthcare Practitioners (Nurse Associates) and care staff. The YDH Rehab Team was on Somerset Care's nursing home floor from 8am to 8pm, 7 days a

week. Somerset Care and YDH staff work together as a single team, benefiting from each other's skills and experience, for the benefit of the people we care for.

2.3. How did it work? YDH Physiotherapists controlled admissions to Cookson's Court and ongoing discharge to the person's normal place of residence.

2.3.1. Criteria for admission: Physiotherapists trawled the hospital daily looking for patients who meet the following criteria:

- ✓ Documented confirmation by Medical Consultant that patient is Medically Fit for Discharge.
- ✓ Patient signed up to intensive reablement ≤ 10 days.
- ✓ Discharge destination is usual place of residence.
- ✓ Demonstrate ability to actively engage with rehabilitation (physically and mentally).
- ✓ Evidenced potential for rehabilitation Holistic therapy requirements identified.
- ✓ ≥ 18 years.
- ✓ Discharge summary completed and medications ready.
- ✓ Treatment Escalation Plan in place.
- ✓ Ongoing care plans completed for patients with specialist involvement.
- ✓ Emergency escalation plan agreed to avoid readmission to YDH.

Some exclusions applied: Stroke patients; Chest pain within last 24 hours; Intravenous therapy; No fixed abode; ≤ 72 hours post myocardial infarction; Medically unstable; Dorset GP (Somerset GPs only).

2.3.2. Assessment: Physiotherapists and Occupational Therapists assessed patients in hospital to determine outcome goals. For the purpose of the pilot, they also assessed levels of care and support that would have been needed if the patient been discharged straight home from hospital.

When suitable patients were identified, they were transferred to Cookson's Court, with their consent, for a 10-day period of intensive reablement. At the end of the period of reablement, they were assessed again and discharged home, with or without home care and support, as required. Care needs before and after admission to Cookson's Court were then compared.

2.3.3. Reablement at Cookson's Court: When patients arrived at Cookson's Court, they had a care plan for their reablement and clear individual goals to achieve, which they were involved in setting.

Both YDH and Somerset Care staff were trained to promote independence, encouraging people to perform activities of daily living themselves. Doing everything for people has a tendency to "dis-able" them, so instead we demonstrated how to perform tasks safely and then support people to do them independently. Where possible, and with help from families, we adjusted furniture height and position to most closely resemble a person's own home. When a person was ready to go home, we ensure they have appropriate care and support in place if necessary.

3. The impact it has had and any key learning

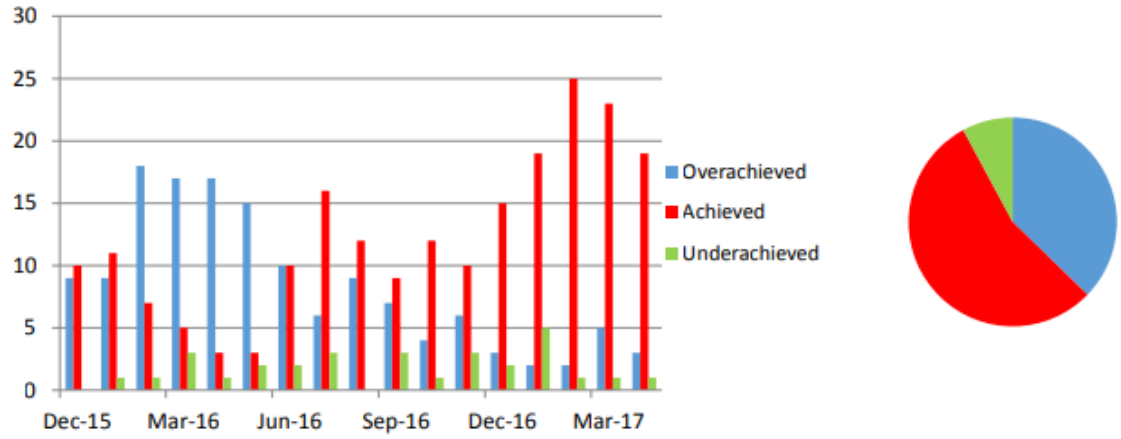
3.1. Admissions: Since the project started until April 2017, there were 402 admissions into the 18-bed unit.

3.2. Average length of stay: The aim was for a length of stay of 10 days. In practice, the length of stay ranged from 7 to 14 days, with an average length of stay of 11.63 days.

3.3. Discharge destination: The aim was for people to be discharged to their normal place of residence. Our data showed that more than 95 per cent of people went straight home from Cookson's Court. A few people had to be readmitted to hospital, which is almost inevitable if taking a positive approach to risk.

3.4. Clinical outcomes: Goal Attainment Scaling (GAS) is a method of scoring the extent to which patient's individual goals are achieved in the course of intervention. In effect, each patient has their own outcome measure, which they help to define, but this is scored in a standardised way to allow statistical analysis.

Figure 4 Goal Attainment Scaling (GAS) Scores



As the evidence shows, the vast majority of people achieved or over-achieved the outcome goals set. **Encouragingly, 42 per cent of patients required a reduction in their predicted home care packages upon discharge from Cookson's Court. We estimated that this saved the local authority c. £1.6 million in ongoing care costs.** The project has also resulted in reduced elective cancellations, and income protection of an estimated £1.9m in 17/18.

3.5. Patient Satisfaction Examples of feedback from people who have experienced this service is below:

- ✓ "The world is a better place because of people like you".
- ✓ "Wonderful staff, highly efficient, compassionate and very caring".
- ✓ "No praise is high enough".
- ✓ "A total credit to the service".
- ✓ "Dad returned home with renewed confidence".
- ✓ "Thank you for the advice and help you have given to us all. We will be able to care for Mum so much better now".

3.6. Key learning

- ✓ **Collaboration and integration** of services does not require a change in organisational form or complex rearrangement of budgets, it **depends on relationships** between people at different levels in the collaborating organisations.
- ✓ Provider organisations across the NHS and social care **can work together to challenge traditional boundaries and ways of working.**
- ✓ The value of this collaboration is the **true partnership and integrated working between the hospital and care home, sharing skills and experience for the benefit of the people we serve.** The presence of hospital staff in the care home every day from 8am to 8pm helped to build trust and confidence quickly – as soon as positive relationships were created, the rest was easy.
- ✓ Physiotherapists, OTs and rehab workers **rotate shifts between hospital and care home**, so they keep information flowing between the two locations.
- ✓ Central to the success in achieving a relatively short length of stay is the fact that **Physios/OTs from the hospital control admissions to and discharges from the reablement service in the care home**. One initial objection to this proposed collaboration raised by the local authority was that "once people are in a care home, they remain there". These data provide clear evidence that this is not the case.
- ✓ **Reablement requires a culture change**, and staff need training and supervision, so they learn to promote independence and encourage people to perform tasks themselves, rather than doing things for them.
- ✓ Most people had only positive words to say about their experience in hospital, but really noticed the benefit of moving to a quieter and more homely environment, more suited to their ongoing reablement and recovery. Some people made quite dramatic recoveries in a few days, simply due to the change in environment. **An appropriate environment really matters for reablement and facilitates a more rapid return to health and well-being.**
- ✓ **An intensive period of reablement in an appropriate environment** like Cookson's Court **may enable faster recovery than if people go straight home, though more evidence is required**. At home, people do not have access to Physios/OTs and rehab workers for 12 hours a day, 7 days per week, and thus it takes longer for confidence and physical strength to be restored. Home care reablement, which is typically funded for up to 6 weeks, is not necessarily a cheaper option than a short-term spell of intensive reablement in a care home, and may be less effective and more expensive in the long run.
- ✓ **The administration of a collaboration like this takes more time than we had originally anticipated due to the relatively fast flow of patients/residents through the care home,** compared with a typical care home where people typically stay for much longer.
- ✓ **More work is required to ensure all parties understand governance arrangements.** Regulatory accountability for services operated in a care home lies with the Registered Manager of the care home; this was not always respected by NHS colleagues.
- ✓ **Cost-benefit analysis needs to be performed on a system-wide basis**, with a recognition that investment in one area may benefit another, but the people receiving care and the

system as a whole benefit. Joint commissioning across health and care and a focus on outcomes would be helpful.

- ✓ Sustainability and Transformation Plans (STPs) have thus far excluded social care providers from discussions, limiting opportunities to build relationships and to develop new collaborations.

NCF in partnership with the Care Provider Alliance

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