Department of Health

Intermediate Care – Halfway Home

Updated Guidance for the NHS and Local Authorities

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Intermediate Care – Halfway Home

Updated Guidance for the NHS and Local Authorities

Intermediate care guidance

Introduction

Since the Department of Health published initial guidance on intermediate care in 2001[1] there has been a plethora of change in terms of policy, practice and organisational reconfiguration. There is therefore a need for updated guidance that reflects these changes and sets in context the function of intermediate care in meeting the health and social care needs of individuals to prevent unnecessary admission, expedite appropriate hospital discharge and avoid long-term admission to care homes.

This guidance provides renewed clarification of intermediate care which should change the way it works in relation to other local services and indicates the way forward for the next few years. It builds on the 2001 guidance on intermediate care and adds the following.

- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood
- Renewed emphasis on those at risk of admission to residential care
- Inclusion of people with dementia or mental health needs
- Flexibility over the length of the time-limited period
- Integration with mainstream health and social care
- Timely access to specialist support as needed
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement
- Governance of the quality and performance of services

The policy landscape has moved on significantly and new models of care have been developed. There has been a shift to more personalised services that address inequalities, with greater focus on prevention and early intervention. Joint commissioning of a wide range of integrated services is required to fulfil the intermediate care function, including social care re-ablement.

1 Department of Health *Intermediate Care* 2001 Health service/local authority circular HSC 2001/001

There have been major structural changes since the initial guidance was published, which provided models for contracting residential, domiciliary and day rehabilitation services. Mergers of PCTs and the development of separate arrangements for social care for adults and children have altered local funding and partnership arrangements. Some PCTs that were formerly separate areas now have uneven service provision within their boundaries.

The original intermediate guidance has been interpreted differently in some areas, resulting in an inflexible adherence to a six-week timescale and the exclusion of some groups from services, such as older people with mental health problems and those whose discharge destination was uncertain because they were at risk of needing long-term residential care.

As part of the development of this updated guidance, a series of stakeholder events were held to obtain the views of various groups, including intermediate care managers and professional staff, voluntary and community organisations, service users and carers, older people, professional bodies, academics, commissioners and other health and social care representatives.

The views from the discussions were that the original guidance still held good in its widest sense, and although the term intermediate care is more encompassing than originally envisaged, its name should remain unchanged to maintain continuity.

Using this guidance

This guidance is part of the Department of Health's prevention package, a key component of the government's strategy for creating a society for all ages. The package aims to raise the focus on older people's prevention services and encourage their use, ultimately improving older people's health, well-being and independence.

The guidance is primarily aimed at commissioners but will also be of interest to practitioners, providers, service users and their carers.

1. Definition of intermediate care

Intermediate care is a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living.

The initial Department of Health guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The definition included services that met the following criteria.

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

2. Users of intermediate care

No one should be excluded from intermediate care on the basis of age or ethnic or cultural group, so services need to be able to adapt to a variety of needs. Homeless people and prisoners should also be eligible. Intermediate care should be available to all adults over the age of 18 who might need it. Young disabled people might benefit from intermediate care while managing their transition to adulthood, as a new configuration of support may be arranged to suit their changing needs.

The key target groups for intermediate care identified in the initial guidance – people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long-term residential care or continuing NHS in-patient care – remain the priorities.

However, those who might be facing admission to long-term residential care should be considered to be equally, if not more, important than the other two groups. All older people at risk of entering care homes, either residential or nursing, should be given the opportunity to benefit from rehabilitation and recuperation and for their needs to be assessed in a setting other than an acute hospital ward.

They should not be transferred directly to long-term residential care from an acute hospital ward unless there are exceptional circumstances. Such circumstances might include:

- those who have already completed a period of specialist rehabilitation, such as in a stroke unit
- those judged to have had sufficient previous attempts at being supported at home (with or without intermediate care support)
- those for whom a period in residential intermediate care followed by another move is judged likely to be distressing.

At the time of entry to intermediate care, people should not be in need of 24-hour access to consultant-led medical care. However, many of those for whom intermediate care may be suitable may have medium to long-term medical conditions that make them liable to relapse. This likelihood means that competent assessment on an ongoing basis is essential, so that any clinical changes can be

identified and responded to quickly. In such cases, the individual may need specialist treatment or possibly a transfer back to acute care.

Intermediate care could also form part of a pathway for end of life care if there were specific goals for the individual and carer(s) that could be addressed in a limited time. An example might be enabling someone to move back home, establishing a suitable environment and routine, setting up a care package and helping carers to develop the skills they might need.

Intermediate care should also be inclusive of older people with mental health needs, either as a primary or a secondary diagnosis, if there is a goal that could be addressed within a limited period of weeks. Without specialist help, people with dementia are particularly likely to have a prolonged stay in hospital, due to difficulties in determining their longer term care needs, as they often recover their physical functioning more slowly. Their hospital experiences can be doubly traumatic, as the surroundings are disorientating and they are separated from familiar people and places. So providing appropriate support to reduce admissions and enable earlier discharge can have a significant impact on people's experiences and on efficiency, because of the numbers involved.

Appropriate rehabilitation therapies with people with dementia and physical health needs have been shown to be successful in enabling them to return home and to stay out of institutional care[2].

Intermediate care should be provided to people whose short-term needs can be addressed within a limited period of weeks, as part of their overall care pathway. This could include short-term rehabilitation before moving to a lower level of longer term support. Many services use a guideline of up to six weeks, while others use up to eight weeks, with flexibility for extended needs. However, stating a standard time period can lead to inappropriate expectations, as many people will need the service for only a short time, such as less than two weeks, and should move on as soon as they are ready. Others may need a longer period of therapy and rehabilitation. If those with certain conditions, such as spinal injury or brain injury are included, their intermediate care should link with longer term plans for support. Those with dementia may need an extended period of intermediate care while a physical condition stabilises.

2 Huusko et al, 2000, cited in K Read, 'Intermediate care: the new pathway to rehabilitation or widening the chasm?' in M Marshall, *Perspectives on rehabilitation and dementia,* Jessica Kingsley, London, 2005.

3. Why intermediate care is important

Intermediate care has an important function in meeting the health and social care needs of individuals to prevent unnecessary admission, expedite appropriate hospital discharge and avoid premature admission to care homes.

Older people are particularly vulnerable at transition points in care, so services need to work together and share responsibility for meeting older people's needs through access to appropriate care, in the right place and at the right time.

Properly developed and implemented, the intermediate care function will enhance the appropriateness and quality of care for individuals and help older people realise their full potential as well as regaining their health. Intermediate care should also have significant impact on the health and social care system as a whole by making more effective use of capacity and establishing new ways of working. It is an important element of recent policy development, such as care closer to home, the transformation of social care, the NHS Next Stage Review, carers' and national dementia strategies and compliance with the Mental Capacity Act (see **Annex 5** for references). Section 6 gives an indication of what a good intermediate care service should look like in order to have the desired impact.

An earlier review of intermediate care, *NSF for Older People, supporting implementation: Intermediate care: moving forward*[3], noted some of the key factors that had been shown to lead to successful development of the function, including clear leadership, good co-ordination, having a single point of access to the service and the capacity to accept risk.

This 2002 review of intermediate care sets out the guiding principles of intermediate care as:

- person-centred care
- whole system working
- timely access to specialist care
- promoting healthy and active life.

3 Department of Health, *NSF for Older People, supporting implementation. Intermediate Care: moving forward*, DH, June 2002.

But the review also identified issues of inconsistency, fragmentation, a lack of coherence and poor integration with other services. To encourage recognition of intermediate care as a mainstream function, potential partners need to understand cultural dynamics and how to interact with each other.

4. Providers of intermediate care

The services that might contribute to the intermediate care function include:

- rapid response teams to prevent avoidable admission to hospital for patients referred from GPs, A&E or other sources, with short-term care and support in their own home
- acute care at home from specialist teams, including some treatment such as administration of intravenous antibiotics
- residential rehabilitation in a setting such as a residential care home or community hospital, for people who do not need 24-hour consultant-led medical care but need a short period of therapy and rehabilitation, ranging from one to about six weeks
- supported discharge in a patient's own home, with nursing and/or therapeutic support, and home care support and community equipment where necessary, to allow rehabilitation and recovery at home. The arrangements may work well in specialist accommodation such as extra care housing
- day rehabilitation for a limited period in a day hospital or day centre, possibly in conjunction with other forms of intermediate care support.

Arrangements for providing local authority home care, day care and residential care free to the user, where they are an integral part of an intermediate care package, remain unchanged from the guidance issued in 2001.

The core service should generally be provided in community-based settings or in the person's own home, but a range of services is likely to be needed, including beds in residential settings, some with nursing care. It may include a rapid response team to provide assessment and immediate intervention in people's homes (or care home, if this is where they live), to reduce inappropriate admissions to hospital. It could also include more intensive support and treatment in the person's home to avoid admission or to facilitate discharge, sometimes described as 'hospital at home'. Part of the service should be available on a 24-hour, seven days a week basis, with access to assessment.

Some services make greater use of residential beds, while others provide more care at home or in day care settings or resource centres, with therapies available. In some areas the service might be able to manage with fewer beds if it employed

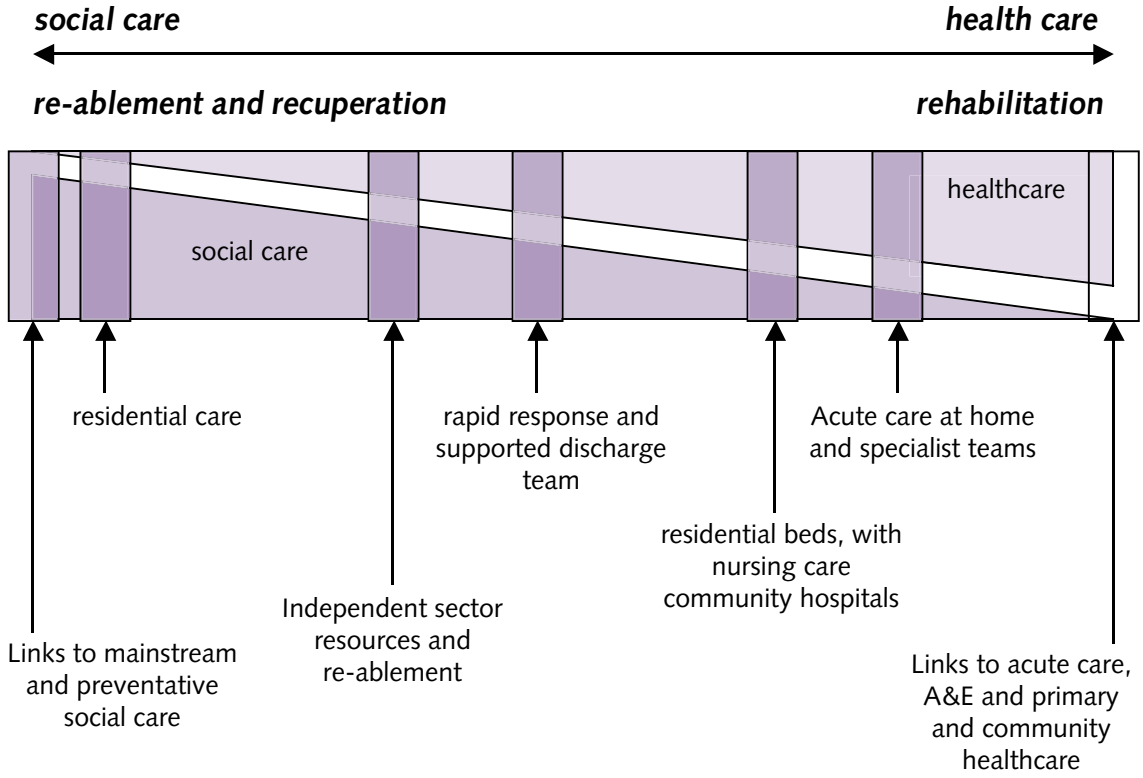
more 24-hour community-based staff. Some beds may be provided in care homes, possibly linked to long-term placements, but the intermediate care function should be distinct and be related to short-term goals.

Sheltered or extra care housing can be part of intermediate care, providing a range of options with input from the core team. Rapid care and repair services can also enable people to move back home who might otherwise have remained in hospital or a residential setting. Technology such as telecare can also enable people to remain at home safely and independently who might otherwise have needed either residential care or more intensive home care.

5. Types of intermediate care provision

Intermediate care is a function rather than a discrete service, so it can incorporate a wide range of different services, depending on the local context of needs and other facilities available. It should support anyone with a health-related need through periods of transition, operating between other service units, so will need to adapt in response to any changes in the surrounding services. It is part of a continuum, as illustrated below, spanning acute and long-term care, linking with social care re-ablement.

Figure 1.
The continuum of intermediate care (adapted from Brophy 2008)



Since the components of the intermediate care service vary, depending on the context of other local services, it should provide the function of linking and filling gaps in the local network. For example, a crisis response service for older people who fall, resulting in minor injury, might be provided by the intermediate care service in some areas, but in others it might be provided by primary care or by the ambulance service. What is important is that the service is available and all agencies know about it.

See **Annex 1** for examples of interventions that may contribute to intermediate care.

Intermediate care should also encompass a wider preventative role, aiming to promote confidence building and social inclusion, thus avoiding the need for institutional care or intensive home care at a later date. It should link closely with social care re-ablement, acute or urgent healthcare (including out of hours primary care services), A&E, community health services and management of long-term conditions, primary health care, domiciliary social care, day care and residential or nursing care homes.

Effective links are necessary so that potential users are referred into the service from any of these services as soon as the need arises, so the staff of all health and social care services need to be given good information about it. It can be useful to have some staff located close to A&E. GPs in particular need to be well informed about the service, as well as acute trusts.

The intermediate care function should be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management. This might be best achieved with a single manager, although it may consist of a number of multi-agency teams and facilities.

6. What intermediate care should look like

The emphasis of intermediate care should be on active enablement, which is likely to require any one of a range of therapeutic skills, including support for the social and environmental adjustments that users and their carers may need to make in response to reduced functional capacity.

Those with all types of conditions should be potentially eligible, so inclusion should be based on individual need rather than diagnostic group.

Care should be arranged on the basis of a holistic assessment, in which the individual's wishes and those of their carers are fully considered. Using a shared assessment framework is essential, as the service has to make links between different professions, agencies and facilities. This can help to avoid the person undergoing multiple assessments in different settings or by different professionals. An example of a service with shared assessment and access to resources is illustrated in **Annex 2**.

The assessment should lead to an intermediate care plan for each individual, with a team member making sure that it is carried out. The individual and their carers should be key participants in any decisions made. The responsible team member could be a member of any of the professional groups involved. Assessment undertaken during the intermediate care episode may contribute to decisions on personal budgets (and personal health budgets where they are being piloted – see http://www.dhcarenetworks.org.uk/PHBLN for a list of pilot sites) after the intermediate care is completed, although the care provided during this period is free of charge to the user.

Shared working protocols and performance management between services will be necessary to ensure timely transition in and out of intermediate care with other social care or health services. Differences of interpretation or priorities are inevitable but are best managed by collaborative review of the service operation rather than by case-by-case negotiation, which causes delay, reduces the quality of care for users and wastes staff time.

All individual care plans for people receiving intermediate care should include a review at regular intervals within six weeks or less. If their care needs to last longer, reviews should take place at regular intervals, such as every two weeks.

Some evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. It has been shown to reduce the use of acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life.

Key findings have included the following.

- Intermediate care projects within the Older People's Use of Services (OPUS) research programme found improvements in people's quality of life and abilities but needed to be clearly targeted if they were to reduce admissions.
- Systematic reviews of hospital at home schemes and supported early discharge, which can form elements of an intermediate care service, concluded that these can provide satisfactory alternatives to treatment in an acute hospital.
- Community rehabilitation teams, which can form part of an intermediate care service, have been shown to be beneficial for some groups of patients, such as those recovering from stroke.
- Community hospitals have been found to be a more effective setting for rehabilitation of older people following an acute illness than acute hospitals, although the costs were similar.
- The evidence from experimental studies is mixed. Although intermediate care may have contributed to a fall in delayed discharges, an evaluation of a well resourced city-wide service found no improvement in patient outcomes and a greater subsequent use of hospital.
- The evidence for the effectiveness of residential nurse-led units or nursing home based intermediate care is limited. While they may be safe and effective, they may also be inefficient.
- Local authority-led partnership for older people projects (POPPs), which provided practical support to older people to help them maintain independence, or intermediate care to those at risk of admission, were found to improve users' quality of life and contributed to a significant reduction in emergency hospital bed days. The projects were judged to be cost effective.
- Intermediate care services in which patients saw a smaller number of practitioners, some of whom could be support workers, led to better outcomes.
- A pilot programme to provide training and career development to support workers in intermediate care demonstrated positive effects on the work of the teams and benefits for the workers.

See **Annex 1** for details of research evidence to support intermediate care interventions and effective approaches to delivery.

7. What intermediate care should achieve

Commissioners should set performance goals for the whole of the health and social care system on which intermediate care should have an influence, and ensure that these goals are measured. Some goals may be quite specific, such as reducing the average length of stay for certain conditions, reducing repeat admissions and admissions to long-term care by a given percentage. They should estimate the numbers of people likely to be in need, with known vulnerability or long-term conditions.

They should also aim to set goals that reflect the quality of the service and the users' experiences, using techniques such as surveys and standardised tests for assessing ability levels. The specifications for services should be sufficiently flexible to allow access for all those who may need them and to allow service development as situations and ideas change.

Although the individual user goals of care and treatment vary widely, these are often in the domains of mobility, self-care, continence, and activities of daily living such as food preparation and participation in leisure activity. The widely used measures of ability in these domains are useful both to assess needs and agree goals and sometimes to monitor progress. Routine collection of such data through ability measurement systems such as the Barthel index, timed up and go (TUG) tests and Nottingham extended activities of daily living (EADL) index may be useful to describe the case mix of users (as suggested above) but may be less useful as outcome measures, as they can be insensitive to the specific gains achieved by individuals. Using validated tools and scales is important but they should be used in the context of the individual goals and service objectives, not as independent success measures. Outcome measurement through goal attainment scaling (GAS) can be useful for assessing the progress of individuals, as it is not specific to diagnosis or discipline and can track changes in client functioning in a quantitative way, while being patient-centred.

In health services, clinical governance (including risk management, clinical audit, critical incident reporting and staff training) is an essential part of maintaining and improving service quality. Although this term is not used in social care provision, the principles apply equally. The key issues and the best approach will need to be decided locally. Managers and staff working in intermediate care will need to be satisfied that an appropriate governance framework is in place. For health

professionals this will need to satisfy the clinical governance obligations that are generally set out by their relevant professional body. The issue of safeguarding also needs to be addressed locally. Clinical governance should be incorporated into any new service from the start as this promotes a culture of reflection, discussion and incremental quality improvements. Acting on the views of service users is a particularly powerful approach to ensuring a high-quality, patient-focused service.

8. Developing intermediate care

Commissioning

Depending on the complexity of the intermediate care service, it may be necessary to have a specialist commissioner for the service who is closely involved in its development. Even if not specialist, anyone responsible for commissioning intermediate care services should have a good knowledge of the area and of multi-agency work.

Commissioners should base their investment decisions on knowledge of the demographic characteristics of the local population. They should aim to compare their provision and activity with areas that are similar in terms of age and economic profile, on measures such as:

- the number and occupancy of beds in acute, community and care home settings
- the rates (per base population) of emergency admissions to hospital for people over 75
- the costs of occupied bed days
- the average length of stay for certain conditions
- the rates of new admissions to care homes
- the number of repeat admissions of people over 75 to hospital and care homes
- discharge locations from acute care of people over 75
- the locations of people three and six months after leaving intermediate care
- the number of people receiving intensive home care.

A new resource pack for commissioners of community services was published in January 2009.

Needs assessment

As suggested in the first phase of the Department's world class commissioning cycle, strategic planning for intermediate care should be undertaken jointly by health and local government, with a shared vision, even if the budgets are not pooled. It should be planned as a multi-disciplinary and multi-agency service,

ideally with one overall manager, and closely linked to re-ablement services in social care. Where any health care is involved in a social care re-ablement package, this should be commissioned as part of intermediate care.

Commissioners should be working together, with PCTs and local authorities in partnership, making sure that their strategies are aligned. They should share any available information about the needs of the local population, through a joint strategic needs assessment (JSNA) and work to address gaps in the data.

Market development

Commissioners need to be working closely with providers at all stages, as these relationships are crucial to the development of effective services. Each PCT should lead a multi-agency board for intermediate care and oversee the development and publication of a local intermediate care strategic plan.

The strategic plan should include:

- a clear statement about investment and disinvestment intentions to achieve better outcomes and greater efficiencies;
- a medium to long-term perspective, with contracts ideally awarded for periods of more than three years, possibly five to six years, to allow greater stability;
- consideration of some contracts awarded to independent sector providers, with their work integrated with statutory providers and monitored in a similar way; and
- contracts with housing providers.

The board should actively seek the views of patients and their carers on the current services and any plans for future service development. Local GP commissioners also need to be fully involved in discussions about service design.

Workforce

A core intermediate care team is likely to include support workers, nurses, physiotherapists, occupational therapists, social workers and community psychiatric nurses. It should be led by a senior clinician, who should ensure that the team's competence and knowledge of good practice and research are kept up to date. Nursing skills are likely to be needed for those with complex or long-term conditions and for short-term treatments, such as the provision of intravenous antibiotics at home.

The role of support workers, especially those undertaking both health and social care tasks, can be particularly valuable in helping people to regain skills in daily living. Staff from voluntary sector organisations may also be team members. All staff members need to be trained in recognising and responding to risk, although the detailed assessment may fall to specific staff members, depending upon the issue. The impact of dementia on need assessment and provision of care requires particular attention.

The core team members should be encouraged to share skills and learn from each other, to enable each of them to take on a wider range of professional tasks and promote flexibility. Health and social care professionals can gain by learning more about the value of other people's contributions. Joint training is desirable. Team members also need to retain the core skills of their own profession, so arrangements such as shared posts between intermediate care and mainstream services or rotation of posts may be useful. Spending a period of time working in an intermediate care team may be a valuable experience for therapists employed by acute trusts, for example.

Depending on the nature of the intermediate care scheme and the medical needs of users, a GP or geriatrician may be a member of the core team or available for selected individuals only. In practice, older people are the most frequent users of intermediate care. Ongoing clinical responsibility for medical care is likely to remain with the user's GP unless there is a clear alternative arrangement, eg as part of a commissioned service level agreement. If the person is cared for in their own home, it will remain the GP's responsibility. The team may be attached to a GP cluster.

In addition, the team should have ready and quick access to specialist skills such as speech and language therapy, mental health and dementia care, geriatrics, podiatry, dietetics, continence advice and pharmacy. Team members need to have good knowledge of local services, so they can refer or signpost people to them. Specific training may be needed to enable them to carry out certain healthcare or therapeutic tasks.

Competency in dementia and mental health care

All teams need to have competency in mental health and dementia care and ready access to specialists. Models of care can involve:

- recruitment of mental health professionals as core members of a generic intermediate care service, to enable members of the team to accept people with dementia or mental health needs with confidence

- close links with a community mental health team (CMHT)
- provision of a specialist service for assessment and care.

Some services have a combination of these and provide their specialist service mainly to those with a primary mental health diagnosis.

Specialist members of generic teams should not be expected to take on all the dementia or mental health cases themselves but should provide support and training to colleagues. In any case, all members of intermediate care teams should receive some training in mental health and dementia care. If specialist teams are available, they can support people intensively in their own homes to prevent avoidable admission or to facilitate discharge. Specialist beds may be designated for people with mental health needs in a care home or a special unit might be developed in a resource centre, for example. It is also important to have access to community psychiatrists and to liaison teams working in acute hospitals.

See **Annex 3** for illustrative examples of intermediate care services specifically aimed at people with dementia and mental health problems.

Capacity and resources

Provider agencies should map the current intermediate care service system, in discussion with key hospital, community health and local authority staff. The map should include the current activity of the different services, including the number of places, their occupancy and the average length of stay in each. All intermediate care beds and places should be mapped in this way. If there are multiple points of entry to the system, the map should record the numbers in each part.

If the current service does not have a single point of entry from where individual needs can be assessed comprehensively, providers should consider whether changes are needed and propose a new model, in consultation with commissioners.

They should estimate the future service capacity and resources needed to meet the goals set by commissioners. In doing so, they should ensure that they have taken account of projected changes in the population, such as increases in the number of people aged over 75 and over 85. It would be useful for providers to carry out point prevalence studies at intervals, at key locations in the system to check whether their estimates of numbers were accurate and adjust the resources as necessary. As well as numbers, length of stay should also be checked.

Commissioners and providers should consult with service users and carers about plans for service design.

An illustration of a service model for a system with a single point of entry, identifying the key points at which critical decisions have to be made, is provided in **Annex 4**.

Providers, including health trusts and local authorities, should design the service spectrum in response to the plans, including:

- plans for the future local workforce and the availability of essential skills, including recruitment and in-service training for unqualified support workers
- plans for IT development and shared electronic records
- estimates for essential support services and infrastructure.

Transport arrangements are important, especially in rural areas. Some community teams have arrangements with ambulance, local authority and/or private transport agencies. Ideally, the ambulance service should be able to refer into the service. Ready and quick access to essential equipment, such as mobility aids, is also essential.

Information sharing between agencies is also essential to ensure a seamless service, so arrangements need to be made for appropriate IT systems and facilities. The use of mobile, shared electronic records will be particularly important where staff teams work in community and home-based settings. For example, information should be shared about individuals at risk who may be frequent users of services, to provide the most appropriate response to their needs. This may involve innovative solutions. Intermediate care teams will need sufficient administrative support to enable them to make full use of shared information.

Some illustrative examples of local intermediate care services are described in **Annex 2**.

Intermediate care pathways

The entire intermediate care service should have a single point of access. Referrers to the service should already have assessed the individual's needs to recognise that they need short-term support but not acute hospital care. The intermediate care service should determine the most appropriate care, completing the referrer's assessment to ensure that it is holistic, using the domains of the single assessment

process[4] or the common assessment framework for adults, being piloted from February 2009. A care pathway should be planned for each individual to take them through their entire episode of health and social care, of which intermediate care services form a part. The transition out of intermediate care to long-term support, if needed, is also crucial. Facilities provided by the independent sector, such as dementia care resource centres, may be useful for longer term support and should be included as an integral part of the overall provision.

Evaluation and monitoring for quality

Monitoring needs to take place at different levels for different purposes. In addition to the delivery of strategic objectives by commissioners, outlined above, providers and commissioners need to develop suitable indicators to monitor the delivery of service performance and service managers need to ensure the quality of practice.

Commissioners, including PCTs and local authorities, need to review the entire service jointly on a regular basis. Some of the nationally determined indicators provide information relevant to these reviews. Local partners, including PCTs and local authorities, determine up to 35 local priorities selected from the set of national priorities from across central government.

At present one national indicator refers explicitly to intermediate care, NI 125. 'Achieving independence for older people through rehabilitation/ intermediate care' relates to the percentage of older people who received rehabilitation/ intermediate care on being discharged from hospital who are still living at home, in extra care housing or in an adult placement scheme setting three months later. The collection for this indicator is still being developed. Its use for comparison purposes is limited, as it does not include those who receive intermediate care as an alternative to admission. Also it compares only a percentages of service users, so could favour services that are highly selective of their users. For these reasons, it should be used in conjunction with other indicators to provide a fuller picture.

The following national indicators are also relevant to intermediate care.

- NI 134, the number of emergency bed days per head of weighted population. This measures the effectiveness of alternatives to admission, especially for those with chronic conditions.
- NI 131, delayed transfers of care. This indicator is not fully developed but the information is available through weekly situation reports from trusts on

4 *National service framework for older people* Department of Health 2001

delayed discharges. It measures the impact of hospital and community services in facilitating timely discharge for all adults.

- Indicator 1 of PSA 19, the self-reported experience of patients/users. This is based on a national survey of users of health and social care in various settings, first conducted in 2007/2008.

Some of the key measures that should be monitored locally include:

- sources of referral
- reasons for referrals not accepted
- case mix of referrals
- timeliness of responses
- time from referral to admission/transfer
- number of delayed transfers of care
- length of stay in acute and subsequent placement
- discharge destinations at various intervals
- readmission rates
- documented achievement of individual goals
- change in functional capacity before and after intervention.

In addition, some process indicators can help to assess whether the service is reaching all members of the community who may need it. Examples include:

- the percentage of intermediate care users who have a primary or secondary diagnosis of dementia
- The percentage of intermediate care users with a BME background (compared with the % in the population over 75).

Commissioners should review performance of the service against their chosen indicators at least annually. However, elements of the service providing a preventative role for people not in immediate crisis may take longer to have a measurable impact. They might reduce admissions to hospital or residential care two or three years later or reduce the need for intensive home care 18 months later. For this reason, commissioners and provider managers monitoring the service should ensure that they take a long-term perspective in interpreting the findings.

Data should be examined through a collaborative process, with managers of intermediate care and other relevant services such as acute care, so that the efficient functioning of the service is accepted as a shared responsibility. The data may also highlight any difficulties arising from poor communication between intermediate care and other services, for example. It is to be expected that as other services develop, then the specific roles of intermediate care will need to be modified.

Funding options

Inter-agency agreements should be made over any sharing of staff resources, including those from third sector agencies, or pooling of budgets. The budgets for intermediate care should not only come from adult care and older people's services, but also from contributions from specialist services such as stroke and neurology, so commissioners of these services need to become involved. The overall service manager should be able to direct resources as needed, to address fluctuations in the numbers of people requiring early discharge or avoidance of admission to hospital or residential care.

Existing budgets should be carefully scrutinised to identify any opportunities to use resources more effectively. If any services do not appear to be performing well or to be duplicating the work of others, decommissioning should be considered. Ways may need to be found to protect specialist provision that is needed fairly infrequently, perhaps by using shared resources between authorities.

Annex 1
Summary of the research evidence

Some evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. It has been shown to reduce the use of acute hospital admissions in some areas and to enable people to regain skills and abilities in daily living, thus enhancing their quality of life.

This summary provides brief details on:

- Evidence from experimental studies of **specific types of intervention** that could contribute to the intermediate care function, such as hospital at home and supported early discharge;
- Evaluation of **national programmes** that included some intermediate care amongst other developments; and
- Studies that provided **evidence to inform the most effective ways to deliver** intermediate care.

Specific interventions that may contribute to intermediate care

Hospital at home schemes

A systematic review of admission avoidance through hospital at home (Sheppard et al, 2008; 2009) has indicated that this service can provide a satisfactory alternative to treatment in an acute hospital. The study reviewed 10 randomised controlled trials (RCTs), 5 of which contributed to the meta-analysis, involving 850 patients.

There were no significant differences in the outcomes of functional ability, quality of life or cognitive ability and patients reported increased satisfaction when they were treated at home. There was a non-significant reduction in the death rate at 3 months for the hospital at home group. In addition, two studies indicated that hospital at home was less expensive than admission to an acute, on the basis of a full economic analysis but excluding the costs of informal care.

The hospital at home service requires active treatment by health care professionals, in a person's home for a limited period. It may provide a more intensive level of medical care than in normally provided in most IC services, but is likely to include therapies, as these do.

An earlier Cochrane review of hospital at home that included earlier discharge, as well as alternative to admission (Sheppard et al, 2005) had shown less clear cut conclusions. It included patients with stroke, early discharge after surgery and COPD. It found that hospital at home resulted in a small reduction in length of stay but an increase in the overall length of care. The patients expressed greater satisfaction with the home-based service, but the views of carers were mixed. This study had included 22 trials. A subsequent review of 26 trials of early discharge (Sheppard et al, 2009) found that patients recovering from a stroke and elderly patients with a mix of conditions were less likely to be admitted subsequently to residential care than those who continued to be treated in hospital. They were also more satisfied with early discharge hospital at home. There were no differences in mortality between the groups, but the rate of readmission to hospital was higher for the hospital at home group for some conditions.

A specific study of patients with chronic obstructive pulmonary disease (COPD) treated at home by visiting respiratory nurses showed that home treatment was as successful as hospital treatment (Ram et al, 2003). The study reviewed 7 RCTs, including 754 patients. There were no significant differences in readmission or death rates and the patients and their carers preferred the treatment at home. However, only one in four of the presenting patients were considered to be suitable for the hospital at home schemes.

A comparison of rehabilitation in hospitals, care homes and people's own homes (Ward et al, 2008) was unable to draw any firm conclusions due to inadequate descriptions of the environment and the rehabilitation systems, despite examining 56 studies and 5 review articles. The studies that did specify the environments sufficiently clearly did not have intervention and control sites that were adequately comparable. This area remains a gap in which rigorous evidence is still limited.

Community hospitals

A randomised controlled trial of almost five hundred patients needing rehabilitation after an acute illness (Young et al, 2007) assigned them to either to one of seven community hospitals or to five acute hospitals. The community hospital group showed a higher level of independence, as measured on the Nottingham extended activities of daily living scale (NEADL) than the acute hospital group. A cost-effectiveness analysis found a small, non-significant difference in the quality-adjusted life years, favouring the community hospital group. It also found the resource use to be similar in both groups (O'Reilly et al, 2008).

Other models of care

Evidence cited in the first review of intermediate care (DH, 2002) indicates some limited but generally positive evidence for the benefits of community rehabilitation teams, including specialist services for people recovering from stroke. The authors suggest that such teams should be considered as one component of a comprehensive intermediate care service, of which hospital at home forms another component.

Two studies of nurse-led units indicated that these could provide appropriate care for certain patients, but often led to an increased length of stay. In one study, a high percentage of patients refused the option of care in the unit and the death rate was found to be higher. However, the evidence to date appears to be limited.

The evidence for the effectiveness of nursing home based IC is also limited. A nursing home with input from a multi-disciplinary team, including medical assessment might be considered to be a special case community hospital. Those without such input often have limited access to physiotherapy or OT. Since such therapies are a fundamental component of IC, these settings cannot be considered to provide a full IC service without them.

Day hospital care that provides comprehensive intervention and care appears to be as effective as other forms of care for older people. A comprehensive service should include flexible attendance for assessment and a range of specialist services such as continence services, falls assessment, mental health assessment and therapy outreach to people's homes.

Evaluation of intermediate care services

A small number of studies have attempted to evaluate entire intermediate care services. The services themselves were highly varied and some may not have been fully developed. In some cases the services were too small and too poorly organised to be expected to make a significant impact (Young and Stevenson, 2006). One evaluation of a well resourced city- wide service (Young et al, 2005) found an increase in the use of hospital for patients who had received intermediate care.

Evaluation of national programmes

The Older People's Use of Services (OPUS) programme

A programme of 16 research projects was established to support and inform the service and system changes introduced by the National service Framework (NSF)

for older people in 2002. Some of these specifically included evaluation of service developments such as intermediate care and reimbursement for delayed discharge, whereas others were evaluating innovations or investigating particular areas of need.

The overall report (Askham, 2008) commented that intermediate care was not universally available when the studies ended. It identified a number of difficulties in relation to intermediate care, including defining exactly what constituted it, so it was hard to assess its overall implementation. The services needed to be clearly targeted if they were to reduce admissions.

But some of the individual studies were more encouraging. A controlled comparison of rehabilitation in a general hospital and a community hospital indicated a slightly greater improvement in people's activities of daily living in the community hospital group. This was encouraging to the promotion of rehabilitation and intermediate care in non-acute settings.

Overall, the impact of intermediate care services appeared to be positive for the users. Most people showed improvements in their quality of life and ability in daily living activities. Most of the users returned home or remained at home and most of those followed up at 6 months were still there after this time. Comments from service users indicated that intermediate care appeared to have been successful in supporting them at key points from illness to recovery. These included 'it set me up', 'got me on my feet literally' and 'gave me a boost over the worst part'.

Another study of early intermediate care services (around 2003/04) indicated that such services were most likely to be developed where there was a pressing need to discharge people earlier (especially following the reimbursement legislation), where there were similar services already in existence, where good partnerships existed between health and social services and where there were champions for the service.

A study of the impact of intermediate care in 3 sites, a few years after its implementation, concluded that it had helped to reduce delays in hospital discharge. In one site, intermediate care was seen to make a more significant contribution than the reimbursement policy for delayed discharge but, in the other two, reimbursement was considered to be more powerful. However, the reimbursement policy could run counter to best practice and the intermediate care service could fill up with people whose reimbursement situation gave them priority over others who might benefit more. In contrast, the evaluation of the reimbursement policy noted some instances where the policy caused an obstacle to the provision of intermediate care for some people. Some of those who might

have benefited did not receive it, as priority was given to others who were at risk of reimbursable delay. The authors actually suggested that the policy should not continue.

Older people with mental health problems appeared to suffer from poorer services than others in some instances. The study of delays to hospital discharge indicated that some people were waiting on acute wards because psychiatrists were unavailable to carry out assessments and others had no suitable community services or care home placements to go to. The study of nursing care in care homes also identified that assessment of those with mental health problems in care homes was sometimes inadequate and that clear guidance on the responsibility for this was needed.

One study of intermediate care found that the needs of people eligible for intermediate care and those contemplating a move to residential care could not be clearly distinguished and were part of a continuum. The need for proper integration of health and social care services and their assessment procedures is underlined by these findings.

The Partnerships for Older People Projects (POPP)

A programme of partnership projects for older people ran from 2006 for 3 years. The projects took place in 29 local authority-led sites in England, although each site had several projects, making 470 projects in all. The partners included health, community and independent organisations. They were intended to provide personalised, integrated care, promote independence and prevent or delay the need for institutional care. One of the evaluation criteria was to assess their impact on the PSA target of reducing emergency bed days.

Most (71%) of the projects provided 'general support' to older people to help them to maintain independent lives, including gardening, handyman shopping and leisure schemes. Intermediate care was rarely a major part of these general schemes, except in assessing people's needs for longer term support after a period of assistance towards enablement. The remaining projects involved 'additional support' to those at risk of admission to hospital (14%) or 'specialist support' to those at serious risk of imminent admission (8%). A further 6% were working to facilitate early discharge from hospital or nursing homes. Most of these involved health services and many explicitly included intermediate care services.

A second interim report from the national evaluation team (Windle et al, 2008) reported on the findings so far and their implications. The users' views were encouraging. Findings from the first round projects that were able to provide data

(11 sites) indicated that all users of the 'additional' and 'specialist' support projects (eg. falls services and assistive technology) who completed questionnaires said their quality of life had improved. In addition, the health-related quality of life in five key areas of daily life (and pain/anxiety) had improved, in comparison with a group who had not received the POPP projects.

Taken as a whole, the projects appeared to lead to a significant reduction in emergency hospital bed days. The evaluation calculated that, for every £1 spent on POPP, £0.73 was saved on the cost per month on emergency bed days, at the same time as the quality of life had improved. An analysis of the costs in comparison with the health related quality of life (QALY) system adopted in the National Institute for Clinical Excellence concluded that the projects were definitely cost effective. The savings effects were most pronounced when the interventions were specifically focused on hospital avoidance, although some effects have been shown through lower level interventions to improve people's quality of life, such as practical assistance at home and befriending (Robertson et al, 2008).

In addition, the use of overnight hospital stays and overall health service use (such as A&E attendances and outpatient appointments) was reduced in comparison with the three months before the POPP intervention, leading to a mean cost reduction of around £500 per person. There was a small reduction in the use of home care but an increase in the use of meals on wheels, GP, social work and community nurse contact, bringing the net cost reduction to around £400 per person. The reductions were all in secondary health care and the increases in primary and social care, implying the need for a reallocation of resources from secondary to primary care services if similar services were to be developed widely in the longer term.

Recommendations for local authorities from the evidence available included a number that were important for intermediate care services (Robertson et al, 2008):

- Invest in the full range of interventions to promote older people's independence and well-being, including practical help, advice, activities, housing choices and transport;
- Develop systems for identifying people who are likely to need information or services (case finding) and facilitate a package of services, based on assessed need (case coordination);
- Develop rapid responses to deal with crises in people's own homes to avoid emergency admission to hospital or residential care, linked to intermediate care services;

- Facilitate timely discharge from hospital, including step-down beds in settings other than acute hospitals;
- Develop joint health and social care rapid and flexible response services, targeted at older people with mental health problems;
- Promote intermediate care rapid response services in-reaching into care homes; and
- Scrutinise and review the core spend and make investment decisions for the longer term (up to 5-10 years), based on evidence of what is effective in producing savings and improving quality of life.

Examples of POPP sites providing good practice in reducing the use of hospital and institutional care included:

Bradford. An intensive community support team provided specialist support over 6-12 weeks to older people with mental health problems who were considered to be at risk of admission to hospital or institutional care. The evaluation indicated that 26% of the service users were prevented from being admitted to a care home, 13% had a hospital admission prevented or delayed and the home care hours needed were reduced by 26%. The net savings were estimated at more than £0.5m per year.

East Sussex. A mix of 12 different projects provided a range of services, mainly in conjunction with health services. They included a rapid response team, a rapid social care assessment team, an intensive community support team for older people with mental health problems, a memory assessment team, a falls prevention team, home care out of hours, signposting help and medicines management. The evaluation indicated that an overall saving of 15-35% was achieved, mainly through reduced heath service activity. The use of hospital for emergency or overnight admissions had reduced and people's quality of life had improved.

Brent. A wide ranging set of services was provided to people at risk of avoidable hospital admission, premature admission to residential care or otherwise causing concern, based on holistic assessment. The services included help at home, assistance with moving accommodation and referrals to other health and social care providers. The evaluation showed that A&E attendance and admissions to hospital were reduced, leading to net savings equivalent to around 20 bed days per year. There was also a reduction in falls from 21% to 4% of the client group in the first month of service.

Further details of the Leeds POPP site is included in Annex 3, illustrative examples of practice in mental health and dementia care.

Evidence to inform the most effective ways to deliver intermediate care

Study of workforce variations

A large study of community and intermediate care services for older people (Nancarrow et al, 2008) investigated the impact of different staffing configurations on outcomes for patients, service use and costs and staff satisfaction. Almost 200 services were included in a survey and 20 services studied in depth, including almost 2,000 patients and 4 in-depth case studies of teams with innovative roles.

The services were highly varied in terms of the location of the care provided, services offered, availability of (and links with) other hospital and community services, target criteria and staffing. A particular area of interest was the potential for substitution from highly qualified workers to less qualified workers and the delegation of certain tasks. Most of the intermediate care services involved nurses, physiotherapists, OTs, therapy assistants, support workers, social care staff and voluntary sector workers. The professional groups mentioned most often that would be valuable but were not present in teams were social workers, mental health nurses, psychologists, dieticians, SALTs, pharmacists and GPs with a special interest in intermediate care.

Most teams provided services in several locations, predominantly in people's own homes, and to a lesser extent in specialist intermediate care hospital beds, community hospitals, residential/nursing homes, A&E and sheltered housing. The most common host organisation for the team was a PCT, although acute trusts and joint PCT/ social services management was not uncommon.

Better patient outcomes (on standardised measures of dependency and daily living abilities) were found to be associated with teams that included a higher proportion of support workers and where the patients saw fewer different types of practitioners. There was also a small effect on better outcomes of teams with fewer senior staff, fewer different types of practitioners and overall larger teams. Having greater access to technology and equipment was associated with a reduced length of stay in the service. Some of these findings need to be interpreted with caution, as it is possible that the individuals who were cared for by support workers may have been less dependent than others and more likely to re-gain skills quickly.

However, the study also found that teams with a higher proportion of support workers also had higher costs. One possible reason suggested for this is that support workers have more contacts and spend more time with patients than qualified staff. Having a larger number of different types of practitioner working with the patient and having a larger number of staff in the team overall was also associated with higher costs.

The individual patients who gained the most tended to be younger, female and to have a higher level of dependency on admission to the service. Higher staff satisfaction was associated with smaller team size, weekly (as opposed to less frequent) team meetings, having a single team manager and a high level of team working and integration.

Findings from other studies

Key findings in other published literature on rehabilitation services provide some support for these findings. One study in the USA also found that using competent, non-qualified nursing staff, as well as providing more nursing hours per day, was associated with greater gains in functional ability (Nelson et al, 1999). However, this study also found that having a higher proportion of qualified nurses was associated with a shorter average length of stay.

A study in 4 European centres found that those providing more contact hours of physiotherapy and OT had better functional outcomes, even though the overall staffing ratios were similar (De Wit el al, 2007). A study in Israel and Italy (Gindin et al, 2007) also showed that greater gains in daily living were associated with a larger number of physiotherapists, OTs and aides, even though the number of nurses was similar.

Another found better patient outcomes to be associated with better team organisation (Strasser et al, 2005). Perhaps not surprisingly, patient satisfaction was shown to be associated with well trained workers and respectful staff, and was reduced with delayed or absent workers and poor retention of staff (Nancarrow et al, 2008).

Another study found that employing an advanced practice nurse to provide care and train other staff, led to improved outcomes and fewer individual problems in nursing homes (Krichbaum et al, 2005).

The Accelerated Development Programme (ADP)

This pilot programme was developed in 50 intermediate care teams across England for 12 months, beginning in 2003. It was intended to enable support workers in

intermediate care teams to reduce the number of different staff seen by patients and lead to better use of care managers' and professionals' time. All participating teams had support from senior managers in the key participating agencies and provided monthly reports, as well as completing questionnaires at the start and end of the pilot. The impacts have been described by Ottley et al (2005).

Almost all the teams provided care 7 days a week, with one third of them providing it for 24 hours. The results indicated that almost 400 workers in the 50 teams were working differently after a year in the programme. Many teams had used it to expand the role of traditional home carers.

The percentage of support staff with training to NVQ levels 2 and 3 had more than doubled during the 12 months. Team members of all types reported increased knowledge of health and social care, higher motivation and job satisfaction, belief that a career pathway is possible for support staff and feeling that the quality of care had improved. Some pilots (Doncaster) introduced a training pack for support staff, with input from nursing, physiotherapy, OT, SALT, dietetics and home care practitioners. Others devised a competency-based training framework (Middlesbrough).

The new roles had to take account of the pay, terms and conditions of health and social care staff to make these acceptable to both agencies and fair for staff. Keeping up to date job descriptions and person specifications were essential. The training arrangements usually attempted to make use of existing training courses as far as possible, use joint training for health and social care staff, included accreditation such as NVQ or Open College Nursing (OCN) and encourage links to other professions. Some teams found that links to their local Workforce Development Confederation (WDC) were helpful. An example was given of a former mining town with many unemployed miners (in the North East). Two former miners were recruited as home care support workers; both completed NVQ level 2 and 3 and later became team leaders of other support workers. Later, both followed professional careers, one in podiatry and the other in social work.

Most of the teams intended to spread the role further after the pilot period. Some developed their own local evaluation of the programme, including staff satisfaction and patient readmissions to hospital. One team (Salford) found that over half of the users of this expanded intermediate care home care service did not need continuing services afterwards and most of those who did needed only one visit per day.

The national evaluation concluded that individuals from any background can step onto the career framework in health and social care if they are given the right support, guidance and education.

Commissioning community hospitals

Little clinical evaluation has taken place of community hospitals. Guidance on their use and the commissioning of their services has been provided by CSIP (CSIP, 2008). They have a wide range of functions, including ward-based and community-based rehabilitation, as well as therapies, diagnostic support services, and a base for community teams.

The guidance on commissioning recommends taking a medium to long term perspective (at least 3-5 years or longer) and ensuring that reviews are integrated with overall reviews of care pathways and the wider service context. The reviews should focus on the main agendas and goals of the service, such as reducing the length of in-patient stays or making greater use of community settings. The models proposed will depend on the existing configuration of local services.

Forecasts need to be made of local need, depending on the demographic characteristics of the population and possibly ward-base forecasts. The activity data for beds, day hospital activity, minor injuries, x-ray etc. should be monitored on a standard basis. The bed types should be classified by type, such as medical, rehabilitation and palliative care, and the average stay length, occupancy and case mix calculated.

Costs can be compared with available national figures (and possibly those for comparable services) for services such as outpatient attendances, occupied bed days, outpatients etc. Performance Indicators such as delayed discharges should be monitored. Options for efficiency savings should take account of plans for the full range of services and the possibilities of service substitution.

Some examples of commissioning for a change in service include:

Gloucester, in which an assumption was made of reduced use of the acute hospital, partly by reducing the length of stay and partly through direct admissions to the community hospital. Such arrangements could be part of an overall spectrum of care, integrated with intermediate care services. Estimates were made by reviewing the number of patients with a list of conditions that could be treated in a different way (eg stroke, recovery from hip fracture or surgery). The costs of the change also had to be included in the calculation.

Leicester and Rutland, in which a plan was made to increase step-down care, community provision for stroke and pneumonia, day case surgery, outpatient services, and diagnostic tests in 10 community hospitals. A study examined the current patient flows, stay length, case mix, local needs and the ability of community hospitals to adapt, including equipment. An ideal model for length of stay for given types of case was developed (eg average 5 days for sub-acute medical conditions, 28 days for stroke rehabilitation and 21 days for intensive rehabilitation). A financial forecast was developed, on the basis of estimated income for occupied bed days.

Hereford and Worcester PCT carried out a review of current services, including bank and agency spend and a demographic overview. Indicators included the type of beds provided, assessment of the patient environment, discharge destinations, rehabilitation day services, therapies, infections, complaints and incidents.

West Kent PCT used capacity modelling for functions such as in-patient, day hospital, minor injuries unit (MIU), out patients and radiology. Bed use included finished consultant episodes (FCE), length of stay and occupancy. Day hospital included attendances and activity. The plan was to reduce average length of stay to 18 days and maximise care at home, reduce A&E admissions, identify cost variations and the reasons for these. A new model of care was introduced for all wards, day centres, MIU and respite beds.

Annex 2
Practice illustrations

Tameside and Glossop

The intermediate care service is jointly commissioned and funded by the PCT and the local authority.

Its main resource is a community assessment and rapid access (CARA) team which provides a single point of access to the intermediate care service 7 days a week (8am – 10pm) and is linked with the district nursing service which operates overnight. It has 26 operational staff (4 nurses, 4 physiotherapists, 2 occupational therapists, 7 assistant practitioners and 9 support workers) plus a manager, 2 administrators, an information officer and a part-time clerk. The team carries out a comprehensive assessment of the individual and directs them to the appropriate 'stream', which may include some time in a residential or in-patient unit.

The CARA team has established referral protocols, including with the ambulance service, so that certain patients can be referred directly to the team rather than taking them to A&E. The target maximum response time for rapid response is one hour. The team also has access to specialists based in other community teams, including SALTs, advanced practitioners, diabetic nurses, and mental health support staff and facilities such as ophthalmology, wheelchairs and other aids, telemedicine and voluntary sector resources.

The service is currently developing a team to work more closely with the acute hospital to improve the management of patients pre- and post-discharge. There are two additional 'streams', one providing rehabilitation on discharge from hospital and another linking with specialist teams for particular conditions, such as stroke.

A 36-bed residential intermediate care unit is mainly concerned with facilitating hospital discharge. Patients discharged from the unit often receive initial support at home from the CARA team. There is also an intermediate care outpatient service, which includes a falls prevention programme.

Each team/unit has a number of Intermediate Care monitors, who plan care pathways, including stays in in-patient units if needed, and monitors the person until they have been discharged and fully handed over to satisfactory community services. Their situation is checked again after 3 months.

The service has a dedicated information system and information officer. The system is constantly updated so that current information is available about all aspects of the service, including regular performance analysis.

The service usually receives over 200 referrals per month, which are associated with both avoiding hospital admission and facilitating hospital discharge. The more common conditions include falls, mobility problems, fractured neck of femur and infections. The average time from referral to assessment is one day, and the average time from assessment to admission to the service is one day. The average length of stay in Intermediate Care is around 23 days.

In 2008, 47% of the users of the Intermediate Care service were designed as 'step up' (avoiding hospital admission) and 53% as 'step down' (facilitating hospital discharge)[1]. Approximately 80% of users were discharged from community based services and 20% from residential facilities[2]. 85% were discharged to their own home (60% without further support), 9% to hospital and 6% to residential or nursing home care.

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1 From April to December 2008
2 As at November 2007

Bolton

The intermediate care service has a number of different elements and is provided within an integrated network of health and social care services. The bed based services are jointly commissioned and funded between the local authority and PCT. Those services delivered in people's own homes are commissioned and provided by the PCT.

The service has a single point of access via a referral and assessment team that operates 7 days per week, as part of a crisis response team. The crisis response team includes nursing, therapy and support workers and provides a 24 hour response. It is intended for people in a health/functional or social care crisis who, without intervention, would be at risk of being inappropriately admitted to hospital or who would be unable to maintain independence. It has a target time of 2 hours to respond and one day to provide a service. All the other elements of the service have a target time of 24 hours to process referrals and arrange provision. Transport is arranged through either the ambulance or local authority service or a private agency. A recent pilot achieved a 20 minute response through locality based teams.

At the centre of the intermediate care service is a resource centre based in a former local authority residential home. This provides 24 hour enhanced nursing and medical care for up to 30 acutely ill patients, alongside comprehensive assessment and rehabilitation services. It has a jointly managed staff team including nurses, physiotherapists, occupational therapists, assistant practitioners, doctors (consultant/staff grade and GP), social care navigators, generic support staff, care supervisors, a pharmacist, pharmacy technicians and care staff. There is also access/advice or referral to a falls service, neuro rehabilitation, SALT, podiatry, dietetics and equipment services.

The resource centre also provides an office base for associated teams such as the rapid response team (hospital at home) and a base for out-patient clinics. The intermediate care at home team is for people who do not need 24 hour support but can respond to a period of active therapy or treatment at home. If the individual needs continuing social work support after a period of intermediate care, they are transferred to the local authority assessment and care management team.

3 Managed under a section 31 Health Act flexibilities agreement

Three more local authority residential homes provide a further 50 beds dedicated to therapy and enablement care. People are admitted to one of these residential units if they need 24 hour support that cannot be provided at home. Six of these beds are designated as mental health intermediate care beds and specialist assessment by the mainstream mental health providers is being developed for those with dementia. A partnership agreement underpins all bed based intermediate care.

The Intermediate Care service also has a 9-bedded urgent care unit within the local acute hospital which 'pulls' potential intermediate care/ community service recipients through from the nearby A&E. It has nursing staff, medical cover, social workers and an on-site manager. This provides holistic assessment using SAP, care planning and access to other parts of the service and community provision. Flexible transport arrangements are made by the service.

A shared information system records in real time what is happening in the different services, using consistent data collection, and is used for service evaluation. If a potential blockage appears likely in any part of the network, an 'escalation plan' is put into action.

In 2008, 61% of admissions to the Intermediate Care service were designed as 'step up' (avoiding hospital admission) and 39% as 'step down' (facilitating hospital discharge).[4] 32% of the users were discharged from community based services and 68% from residential facilities. 66% were discharged to their own home (26% without further support), 16% to hospital and 16% to residential or nursing home care.

The service managers have identified a number of gaps that they are working to address. These include care for people under the age of 65, care for people with advanced dementia or behavioural problems and medical visits or input to team meetings.

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4 From April to December 2008

Bristol

The Bristol intermediate care service is managed under one umbrella but contains several teams and units, accessed through a single point in each side (north and south) of the city. The elements include:

- Rapid response teams to prevent admission, with access to 'step-up' beds in different parts of the city when needed;
- Rehabilitation in people's own homes as well as 2 residential centres, each with 20 beds and additional flats to facilitate discharge, prevent admission to long term care and maximise independence
- A 'reconnect service' to facilitate discharge for people who need short term input but not therapy; and
- 'React teams' working at the front of the hospitals to prevent admission; and in-reach nurses to work with ward staff to identify patients who could be discharged to intermediate care.
- The residential rehabilitation centres also provide an office base for the majority of the other staff

Admission to intermediate care is through a single point of access (SPA) and is a developing a case management team working across the city. The service uses a shared database which has the advantage of all professionals recording electronically on the same case notes and contributing to the assessment.

A development group for intermediate and long term care, including representatives from health providers and commissioners, social care and the acute trusts, meets monthly to review the performance and activity of services.

A range of professional groups are involved in the service, including mental health nurses, physiotherapists (including specialists), OTs, social workers, nurses, pharmacists, SALT, dietician, assessment and review coordinators, assistant practitioners, generic health and social care assistants, rehabilitation support workers, administrative staff and resource managers. The health and social care staff each have a good understanding of each other's practice and have competency based roles. The joint approach aims to provide access to multiple skills within the same organisation, challenge stereotypes, promote 'whole system' thinking, improve communication between professions and focus on the whole person.

The service includes all those over the age of 18 and some over the age of 16 living in the city of Bristol. The rapid response team also covers patients registered with a Bristol GP even if they are living outside the city. People with dementia are included, and specialist expertise is provided by the mental health nurses and pharmacists. Assistive technology services are increasingly available to support people with dementia at home.

In 2008 the service accepted 3762 referrals, of which approximately half were facilitation of discharge and half prevention of admission. Almost half (48%) of referrals were for people in the 65-84 age group, 15% were under 65 and 37% were over 85.

Following the intermediate care intervention, 80% of people remained at home. The majority of admissions to hospital were from the rapid response teams where the patient's condition was too acute to be managed at home or in a safe haven bed.

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South Gloucestershire

The intermediate care service in South Gloucestershire is made up of two multi disciplinary teams who work on a locality basis to cover the whole of South Gloucestershire. The service has a shared budget with contributions from the PCT and social services and has a single manager. The teams consist of physiotherapists, OTs, nurses and rehabilitation assistants. There are also mental health nurse specialists, a dietician, SALTs and administrative support. In addition, the local authority funds two care management assistants to support the team and to assess and set up ongoing services if they are required in order that discharge from the service is timely.

The team also has access to four beds in residential homes for people who are not well enough to remain at home.

The service is provided seven days a week between 8.30 and 21.30 and referrals are taken during office hours.

The service includes anyone over the age of 18 with an identified re-ablement/ rehabilitation goal who would need input from both a professional and rehabilitation assistants, with an expectation that they will achieve this goal within a short period of time. It also includes adults with an acute infection needing intravenous antibiotics in conjunction with some therapy input, but who do not require hospital admission.

The manager has identified a number of needs that the service could usefully develop further, including:

- a more comprehensive lower level service to prevent avoidable admission to residential care and assess more accurately people's needs for social care, also better links to leisure and voluntary sector facilities;
- extension of the working day to cover the evenings so referrals can be taken later;
- a more robust assessment/liaison team to be more proactive within the hospital identifying potential discharges earlier and working with nursing staff to increase trust in the team's ability;
- the same liaison team to assess community referrals, thus ensuring a more consistent approach to assessment;
- work with stroke patients at an earlier stage, in the absence of a specialist community stroke service, so reducing length of stay in hospital;

- further work with the acute sector identifying the types of rehabilitation currently undertaken to see if these could be provided at home
- access to beds in two geographical areas in order that relatives do not have to travel far to visit.

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Lewisham

The Lewisham intermediate care service has a single point of referral to which hospitals, the local authority and all community services may refer. It is staffed by a clinical nurse specialist, managers and admin support.

A community response team of nurses, physiotherapists, OTs, social workers and local authority therapy rehabilitation officers provides support to avoid admission or to support people on discharge from hospital. The London Ambulance Service can refer directly and the local GPs have an emergency number they can call between 9am and 10pm, 7 days per week. The care is always provided as part of an integrated pathway, with specialist pathways for falls, stroke and respiratory problems.

A social worker and a nurse are based in A&E to identify patients for whom a hospital admission could be avoided. They can provide a time-limited care package to support people at home, as well as transport home and equipment that might be needed.

Residential beds are available in 2 nursing homes, with 11 beds in each for either admission avoidance or supported discharge. The teams and the residential settings have access to a consultant, a dietician, a GP, OTs, physiotherapists, social workers and a psychologist.

The service has a system for tracking people with frequent hospital admissions, presentations to A&E or calls to the London Ambulance Service. The information about vulnerable individuals with repeat admissions is coordinated with community services such as community matrons, social workers, and a computer link to A&E. These may be taken to a multi-disciplinary 'patient at risk' case conference, where suitable arrangements are put in place to meet the needs appropriately. In some cases, multiple admissions have resulted from social isolation, so arrangements have been put in place to address this.

Commissioners are planning to give GPs incentives to visit residential and nursing homes, so they can also help to identify vulnerable individuals.

The commissioners of the service collect data to identify whether admissions have been avoided through the service and monitor the use of the intermediate care beds, for their occupancy rates, types of condition, length of stay and outcomes, including destinations on discharge.

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Cumbria joint assessment and resource sharing arrangement

The intermediate care services in Cumbria have established an interdisciplinary procedure in which physiotherapists, OTs, nurses and social workers can all have a care/case management function. Each client has a single file and care plan for their intermediate care episode. The arrangement was prompted by the need to eliminate cross referral (and consequential multiple assessments and delay) within the service and to enable all staff to access both PCT and social services resources. A physiotherapist can assess for and order social care services, whilst a social worker can assess for and order items of OT or physiotherapy equipment.

Legally this can only be done by developing a HAF agreement, which gives the ability to share commissioning, funding, and service provision within a legal framework. The agreement covers not only joint finance but also performance indicators, HR issues, complaints procedures and information sharing protocols. It also provides a vehicle for joint governance accountability. The joint complaints procedures enable the single management of the service to function within the legal framework of both PCTs and Social Services.

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Annex 3
Illustrative practice examples for mental health and dementia care

Leeds

The Leeds intermediate care service for people with mental health problems or dementia was developed as part of a POPP project, with several linked components. An evaluation (University of Leeds, 2008) has begun to provide some initial findings after the first 17 months.

An intermediate care rapid response team operates 7 days per week up to 9.30pm in NW Leeds. It targets people experiencing a crisis with their mental health (all functional mental health problems and dementia) who are at risk of admission to hospital, also those in hospital who could be discharged with an advanced level of care for a short time and those who need intensive short-term rehabilitation to avoid going into residential care. The team is nurse-led and includes nurses, health support workers and an OT. The team offers intensive home treatment and has access to a night sitter through the mainstream intermediate care service of the PCT. During the first 17 months, there were 429 referrals to the team, of which 261 were admitted to the service.

A multi-disciplinary liaison psychiatry team operates in the general hospital, including a psychiatrist, mental health nurses, an OT and health support workers. It provides expertise in diagnosis, treatment and management of older people with mental health problems; and training and support to hospital staff, aiming to bridge between general acute and specialist mental health services. Most referrals to date have come from the main acute hospital wards. Few have come through A&E, possibly because it has been difficult to complete appropriate mental health assessments within the four-hour waiting time target, and there are no suitable facilities for undertaking these in A&E.

Just over one third of those referred to the liaison service had some type of dementia, over a quarter had a functional mental health problem, over a quarter had a combination of mental health problems and 8% had a severe and enduring mental health problem. Over half were unknown to specialist mental health services, indicating considerable under-recognition of such problems in older people. The interventions provided by the team varied widely, with only one third having more than a few contacts. Around 40% returned home, some with community support, 20% went into long term care, 10% went into an acute mental health bed and 5% to an Intermediate Care bed either in general intermediate care or one of the mental health resource centres (see below).

Three resource centres in different areas of the city each provide five intermediate care beds and active rehabilitation for people with mental health problems. They are led by social services and have support from the mainstream intermediate care team (including general and psychiatric nursing, OT and physiotherapy), mental health specialists, joint care managers, care staff and outreach workers to provide enabling assistance in the centre and in the transition to the person's own home. The centres also offer day care for limited periods. The service is targeted to older people with dementia who might otherwise have an unnecessarily prolonged stay in acute hospital or residential/nursing care.

The main sources of referrals to the centres to date have been the acute general hospital, social services, the intermediate care rapid response team, the long term joint care management team and community health services such as GPs and district nurses. Around half were previously known to mental health services. The mean length of stay was 33 days, with considerable variation, and almost two thirds returned home.

A mental health community support service in NW Leeds provides short-term (6-8 week) enhanced assistance from community support workers, aiming to prevent admission to hospital or institutional care. It works alongside other professionals and carers and assists with assessment, to maximise the possibility that any long term service will promote independence.

On discharge from the community support service, just under three-quarters (44 of 67) remained in their own home; one person was admitted to an acute general hospital and two to a mental health ward as a result of a deterioration in their physical or mental health; one person was admitted to long term care; and one was admitted to temporary residential respite care.

A BME community development worker works with community groups and services working with older BME people to help them to deliver better services to those with mental health problems. A workforce development programme and a SAP/CPA facilitation programme are developing a training programme for the hospital trust, the mental health trust, the PCT, the social services department, voluntary sector agencies, service users and carers. This aims to promote best practice in older people's mental health and to share best practice across all partner agencies.

The POPP project's end of second year report showed a significant fall in admissions of people with both primary and secondary diagnoses of dementia to the main acute hospitals, against a rising trend. It estimated that 550 admissions had been avoided, leading to a saving of £1.2m. The acute mental health unit in the area also showed a fall in admissions of people with these diagnoses and estimated that 74 admissions had been avoided.

The length of stay for people with a mental health diagnosis in the main acute hospitals also showed a significant reduction. The average number of 'excess' bed days for this group fell from 120 per month to 32 per month, making a saving of 1056 bed days over a year. In addition, the monthly average number of bed days due to emergency admissions for people with a primary or secondary mental health diagnosis fell significantly, leading to further savings.

There were also falls in the number of placements made in residential and nursing homes for people with a mental health diagnosis and an increase in the number with mental health problems receiving home care.

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Hunter's Lodge, Leicestershire

This is a residential home with multiple registration, based in a rural community. Most of the residents have dementia or some kind of mental health problem. The home has strong relationships with the local GP practice, community nurses, therapists and social workers.

A two year pilot arrangement with the PCT has enabled the local GP to purchase one bed for the purpose of avoiding hospital admission. The GP provides a physiotherapist who works with the care staff to ensure that exercise regimes are followed. The GP and community nurses maintain continuity after people leave. The bed is kept occupied because it is purchased by the GP.

In the first 17 months, 19 people have been cared for by the scheme, all of whom had some degree of confusion or dementia and would otherwise have been admitted to hospital. The kinds of problem have included hip fracture, falls, urinary tract infection and confusion, dizziness and confusion, self neglect and recuperation after flu. Most people subsequently returned home, although 4 were admitted to a care home after a period of assessment and stabilisation. One was admitted to hospital. The average stay in the bed was 20 days, although this varied from 7 to 40 days.

In the first year, the GP practice estimated that they had saved £60,000 by avoiding hospitalisation, through using this single bed. The feedback from service users and their families has been very positive.

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Huntingdonshire

For the past 3-4 years the Transitional Care (TC) team at Huntingdonshire PCT has employed a Registered Mental Nurse (RMN) to facilitate the care of people with mental health problems or dementia within the service. Initially the post was based jointly with the TC team and the hospital, but has since moved to be solely hospital based, as the role has become mainly one of facilitating discharge.

The RMN assesses people's mental state and capacity (often for the Mental Capacity Act) both on the ward and in the community. She advises and supports the TC team, suggests possible medication to the GP if necessary and advises carers during the TC period. If the person needs longer term mental health support and is not known to the CMHT, she can refer them to this team, with which liaison is very important. Support is provided for people who are discharged to their own home, but there is no residential facility at present for people with a mental health problem or dementia who need an interim bed as part of TC, as the current TC beds do not accept them.

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Avon and Wiltshire mental health trust

The trust has 10 contracted beds in an independent nursing home in Bristol, for people who would otherwise be in acute hospital beds, waiting for a mental health care home placement. The needs of the individuals are assessed by a doctor and a senior mental health nurse, and the objective for an intermediate care episode agreed. The scheme enables them to stay in a more appropriate setting than an acute ward, with their own room and input from OT, physiotherapists and other professionals. On the basis of extended visits, the team designs an individual care package for their longer term care. Some of the beds can also be used for respite care, to avoid break down of the family support and admission to hospital.

The scheme has led to a significant reduction in the need for specialist EMI nursing home placements and an improvement in the level of functioning of individuals, with a reduction in challenging behaviour. Some people have been able to return home. The median time spent in the scheme is nine weeks, but this is partly due to the waiting time for continuing care or residential/nursing home placements.

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Central Lancashire PCT

The service has 10 beds in a residential home for intermediate care for people with dementia, transferred from acute hospital wards. A multi-disciplinary team provides support, especially OT and other therapies, aiming to re-skill people to become independent. Cognitive assessment and rehabilitation is an important element.

The team also provides outreach support when people leave, linked with a community resource centre providing enhanced day care, drop-in, open access and the base for the CMHT and voluntary organisations. The model of care in the resource centre is based on dementia day care and re-skilling, including horticultural and other therapies, using a similar approach to that in the residential beds. The team also provides some training and support is provided for intermediate care home care staff, to help them to care for people with dementia.

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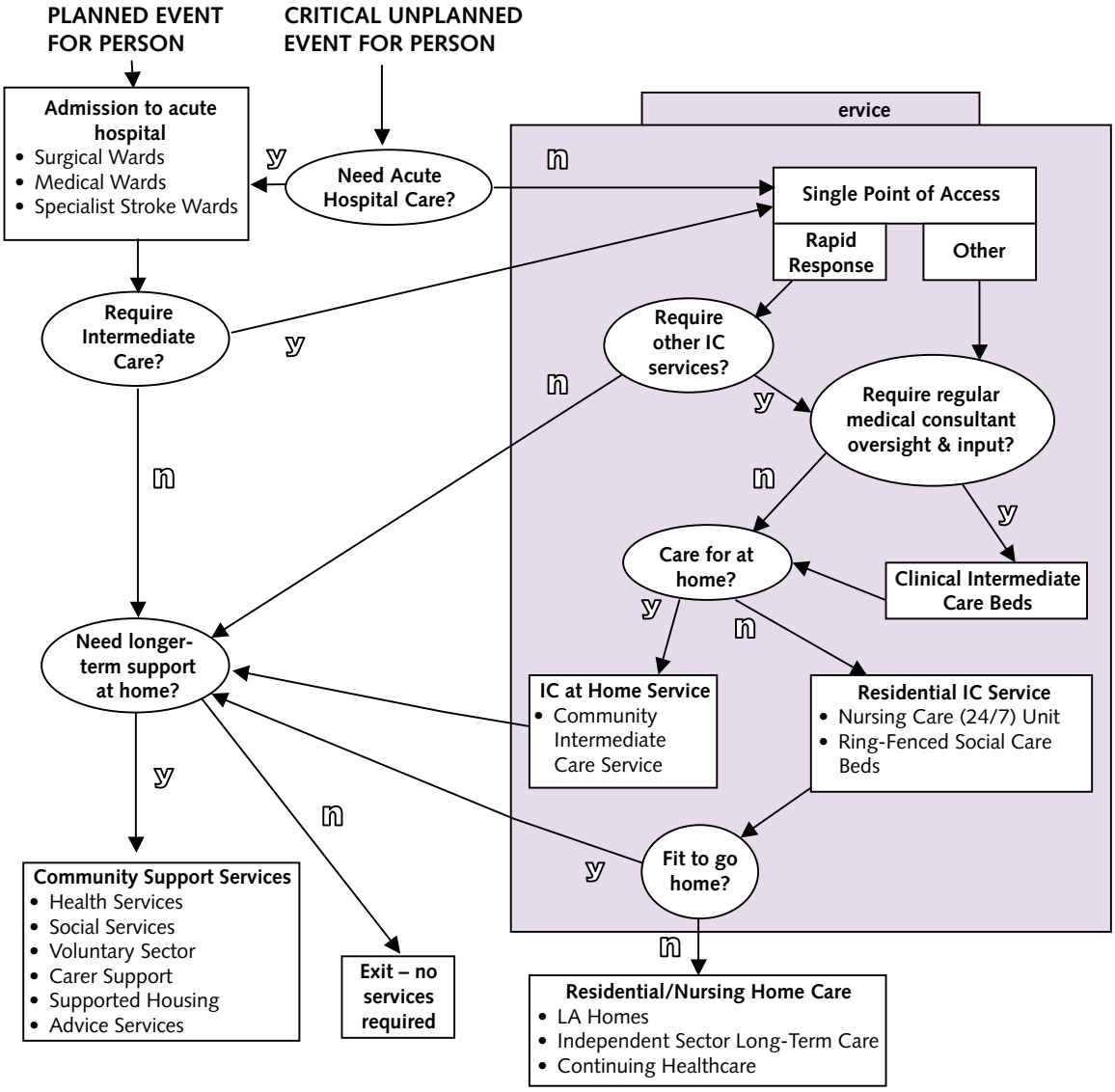
Annex 4
An intermediate care service pathway with single entry point

(shaded area indicates integrated IC service)
Adapted from Brophy (2008)



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