NHS
North East and North Cumbria

Adult Social Care and Health Select Committee

Review of Reablement Service

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What is intermediate care?

Intermediate care is short-term care – generally limited to 6 weeks – aimed at maximising a person's independence.

It is either 'step up' to prevent someone being admitted to hospital or moving to a care home; or

'step down' to support someone's recovery after a hospital stay and help prevent readmission.

Common reasons someone may need intermediate care include recovery from a fall, surgery or a stroke.

In addition to reducing pressure on acute services, intermediate care can improve independence and quality of life for patients and those around them.

Evidence suggest that it reduces readmissions and improves independence for people with chronic conditions compared with prolonged stays in acute hospitals.

People who have received intermediate care report improved independence, confidence and mobility.

Most people receiving intermediate care are older adults.

In a 2018 national audit, the average patient age was 79 years and older across all types of intermediate care.

People often have frailty and multiple long-term conditions, such as chronic obstructive pulmonary disease (COPD), heart disease and diabetes.

Over time, the health and care needs of people entering intermediate care have increased.

Demand for intermediate care services is expected to rise due to our ageing population and the increasing prevalence of chronic conditions and frailty.

Types of Intermediate care

Traditionally, there are four main types of intermediate care: reablement, home-based, bed-based and crisis response

Type of care	Definition
Reablement	Support delivered in someone's own home or usual place of residence that aims to help them recover skills, confidence and independence. **Most commonly delivered by social care practitioners**.
Home based	An intervention delivered in someone's own home or usual place of residence that aims to support recovery from illness and maximise independence. It can help people move or stay out of hospital. Most commonly delivered by health care professionals, for example, occupational therapists or physiotherapists.
Bed based	Similar to home-based intermediate care but delivered in a bed-based setting, for example, a community hospital, care home or acute hospital.
Crisis response	Rapid assessment in someone's own home in response to a crisis (for example, a fall, infection or exacerbation of an existing condition). If necessary, a short-term intervention is provided (for example, medication or catheter care), crisis response is mostly delivered as an urgent community response service.

Intermediate Care - context

National Hospital Discharge and Community Support policy has placed significant increased demand/ pressure on ‘step-down’ intermediate care services

Significant national/ regional focus on ‘Discharge to Assess’ rather than assessments in hospital and early discharge once a patient doesn’t meet the Criteria to Reside to support acute hospital pressures

Impact has been seen across both home based intermediate care services (domiciliary care and reablement) and bed based intermediate care services (Rosedale and spot purchased care home beds)

Additional impact on community workforce

Better Care Fund (BCF)

- Since 2015, the BCF has been crucial in supporting people to live healthy, independent and dignified lives, through joining up health, social care and housing services.
- This vision is underpinned by 2 core objectives to:
  - enable people to stay well, safe and independent at home for longer
  - provide people with the right care, at the right place, at the right time.
- Requires Integrated Care Boards (ICBs) and Local Authorities to agree a joint plan, owned by the Health and Wellbeing Board (HWB), governed by an agreement under section 75 of the NHS Act (2006).
- This continues to provide an important framework in bringing local NHS services and Local Authorities together to tackle pressures faced across the health and social care system and drive better outcomes for people.

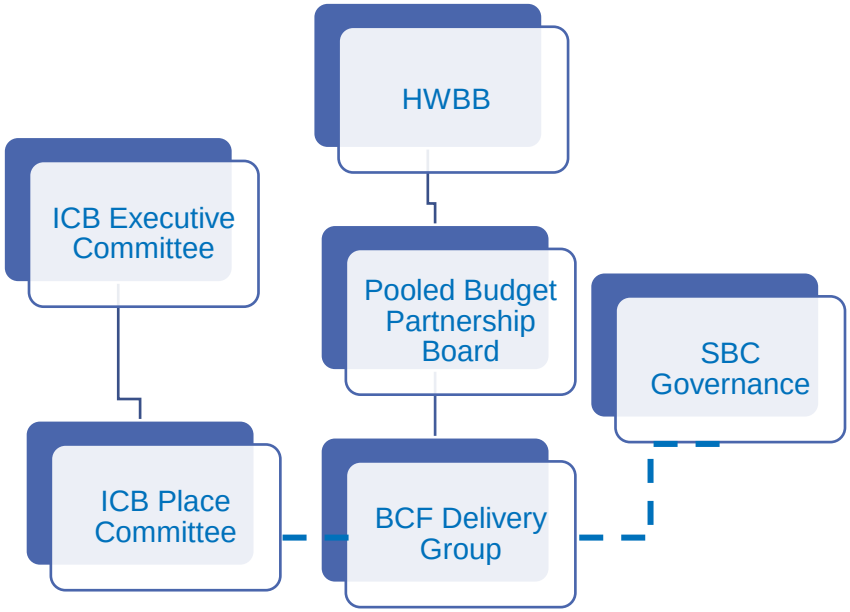
National Condition 2 - Enabling people to stay well, safe and independent at home for longer

Local areas should agree how services they commission will support people to remain independent for longer, and where possible support them to remain in their own home.

Stockton-on-Tees BCF Schemes include:

- Reablement services
- Assistive technology
- Carers' support services
- Rosedale Intermediate Care Centre (step-up and step-down)
- Additional Roles within iSPA

Stockton-on-Tees BCF Governance



Role of BCF Delivery Group/ PBPB:

- ensure oversight of delivery and monitoring of the plan
- review current schemes
- agree future proposals/ business cases

- Number of operational working groups / forums to supporting the transformation

BCF Metrics

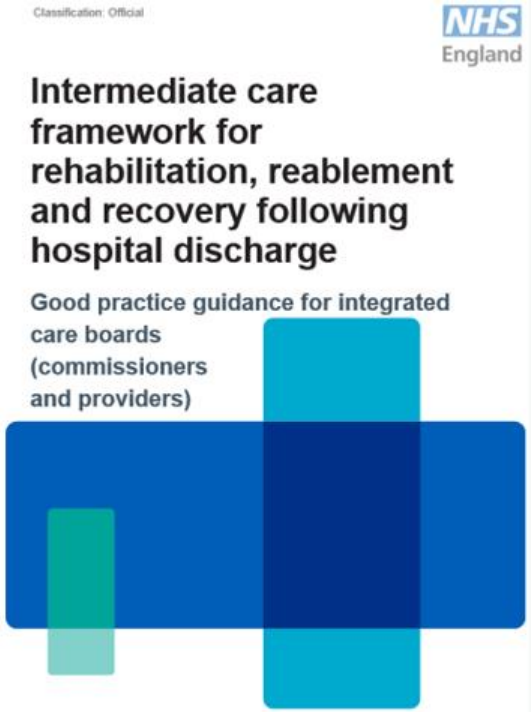
Provide people with the right care, at the right place, at the right time

- discharge to usual place of residence
- new: discharge metric ahead of winter 2023 (Discharge Ready Date)

Enabling people to stay well, safe and independent for longer

- permanent admissions to residential and care homes
- unplanned admissions for ambulatory sensitive chronic conditions
- **the proportion of older people who were still at home 91 days after discharge from hospital into reablement or rehabilitation services**
- new: emergency hospital admissions due to falls in people over 65.

Intermediate Care Framework



Priority area 1: Improve demand and capacity planning

- Gathering data to plan and commission services
- Increasing productivity
- Agreeing actions and determining system impact

Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model

- Implementing the new model through workforce approaches
- Changing behaviours and culture

Priority area 3: Implement effective care transfer hubs

- What is a care transfer hub's role in intermediate
- care?
- Developing care transfer hub capability
- Priority actions for systems
- Medium-term actions for systems

Priority area 4: Improve data quality and prepare for a national standard

- Preparing for a national standard
- Embedding real-time data into day-to-day operational working
- Evaluation and ongoing monitoring of the impact of interventions
- Developing the data

Community rehabilitation and reablement model

1. Acute inpatient / virtual ward care

From admission

- Planning ahead with the person to prepare for discharge
- Actions taken to reduce the risk of deconditioning
- Movement and physical and social activity supported and encouraged by ward team

No longer meeting criteria to reside

- Information collated for care transfer team
- Physical, psychological, social, cognitive and communication needs included

Care transfer

- Single referral system
- Triage and direction to appropriate local team with the right skills to undertake the assessment
- Most people will be assessed and receive their rehabilitation intervention at home. A small proportion may require a short-term bedded unit.

Assessment to take place as soon as possible after no longer meeting the criteria to reside

Discharge

2. Rehabilitation assessment in the community

- Holistic assessment with integrated MDT to agree personal goals and outcomes
- Involves the person and their family, friends, carers and others involved in supporting them if appropriate and agreed with them
- Delegation to skilled support workers where appropriate
- Oversight and supervision by registered therapist, and escalation protocols in place
- Following assessment, where appropriate a person can be directed to supported self-management
- Outcome of assessment recorded in Individual Rehabilitation Plan

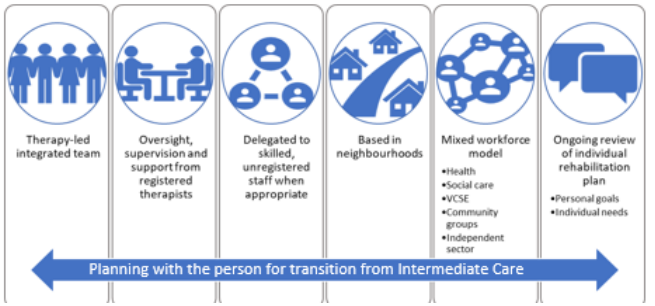
Flexible therapy workforce

Therapy assessment delegated to skilled support worker or practitioner where appropriate, for example	Therapy assessment undertaken by registered therapist, for example
• Less complex / lower level needs	• More complex / higher level needs
• Standard interventions	• Bespoke interventions

Supported self-management

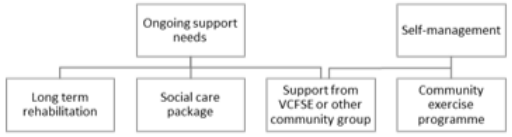
- Could include Apps, videos, online/paper based guidance and information
- Draws on support from VCFSE sector when required
- With agreed process for self-referral and/or advice and guidance if further support is required

3. Delivery of rehabilitation interventions



4. Transition from intermediate care

Transition for long-term/ongoing needs



One or more elements may be required
Additional assessments may be required, e.g. a new or updated Care Act assessment or NHS Continuing Healthcare assessment

- Transition for long-term/ongoing needs
- Planned with the person and their family, friends or carers as appropriate
- Audit, peer reviews and evaluation to inform improvement in delivery, training and upskilling, and reduction in variation

Discharge