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East of England

Guiding principles for intermediate care

2024

Eastern Region joint NHSE/ADASS

Foreword

We hope you find this set of guiding principles for intermediate care that have been developed jointly across the Eastern Region by ADASS and NHSE useful. They have been developed as a collaborative process between NHS and Local Authority staff in the Eastern Region with experience in the delivery and commissioning of intermediate care, drawing on best practice and existing guidance and national reviews. Please use this document as a resource to support your work as a system when developing your intermediate care offer – the step up in the community as well as step down from hospital.

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Background

A joint regional NHSE/ ADASS workshop was held in July 2024 to bring together key people from across the region to agree a set of guiding principles that could be used by systems working together seeking to improve their intermediate care arrangements – both step up in the community and step down from hospital.

The workshop was attended by around 40 nominated representatives from the Local Authorities and ICBs in the Eastern Region with both operational and commissioning/ strategic expertise.

Existing guidance and reports about best practice were used as a basis for narrowing down a definition and guiding principles. Further work will be completed to agree a small set of metrics to be used across the region.

This represents a regional resource for local systems to use when working together to improve intermediate care at a place/ system level. It creates an opportunity to come together as a system and have a conversation about intermediate care.

It is hoped that this can provide a basis for future work to understand and compare models, investment and performance across the region. It is an amplification of what is already in national reports and guidance and reflects views from those at the workshop about what is important to the Eastern Region.

Guiding principles

The population this applies to

People living with frailty, mild cognitive impairment, dementia or delirium, palliative and end of life care needs, mental health conditions, learning disabilities, autism, people experiencing or at risk of homelessness.

Definition of Intermediate Care

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

A range of integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admissions and premature admissions to long-term care, support timely discharge from hospital and maximise independent living.

(NICE)

Four categories of Intermediate Care

1. Bed-based services are provided in an acute hospital, community hospital, residential care home, nursing home, standalone intermediate care facility, independent sector facility, local authority facility or other bed based settings.
2. Community-based services provide assessment and interventions to people in their own home or a care home.
3. Crisis response services are based in the community and are provided to people in their own home or a care home with the aim of avoiding hospital admissions.
4. Reablement services are based in the community and provide assessment and interventions to people in their own home or a care home. These services aim to help people recover skills and confidence to live at home and maximise their independence.

Governance

- A single strategic framework jointly owned across an Integrated Care System.
- A shared whole system ambition and understanding of what intermediate care aims to do.
- An integrated approach to planning, funding and delivery of the four categories of intermediate care.
- System leadership overseeing how different service models operate as a single joined up service.
- A collaborative and integrated approach to planning, funding and delivery of a single intermediate care model across a system.
- System leadership overseeing how different service models operate as a single joined up service.
- An agreed approach to outcome measurement for reporting and benchmarking.
- A single agreed approach to tracking delivery and measuring success- a single cross partner performance management/ data set/ dashboard/ outcome based framework.
- Capacity planned across whole patient flow- a balance between step up and step down and step up care is developed and protected not shifted towards step down when under pressure.
- System (including professional/ clinical) leadership with a focus on culture and behaviours*.

Commissioning

- Strategic commissioners need to set the outcomes they want for the population.
- Commission a person centred and outcome / impact based model.
- A single narrative across the system about a 'Home First' approach.
- Intermediate care services needed to be commissioned and contracted in a way that allows services to be flexible and person centred.
- An integrated and shared risk on resource across the system (removing the health / care divide).
- A pooled resource.
- A recovery based model.
- All adults are supported to remain independent in their own home for as long as possible in their own home.
- A joint or integrated commissioning function for intermediate care in which health and social care resources are aligned if not pooled.
- Intermediate care services are contracted for and monitored in a way that allows services to be flexible and person centred.

Delivery – integrated systems and processes

- A single point of access for all aspects of intermediate care- similar to transfer of Care Hub model.
- An integrated management structure across all services that includes a single accountable person, such as a team leader.
- Named accountable person/care coordinator identified on behalf of the system.
- A single assessment process.
- An agreed MDT composition in which staff can work flexibly.
- Access to health and social care records ideally in an integrated/shared electronic record.
- Information is shared across health and social care in a secure and timely way that supports best outcomes*.
- Right response at right time (drawing on system wide services).
- Maximise use of technology and digital interventions.

Delivery – person centred approaches

- All adults and their carers are actively involved.
- Individuals are at the centre of discussions about their goals and the support needed to achieve those goals based on a 'what matters to you' approach*.
- Support is preventative, holistic and person centred with a focus on enabling people to achieve the goals that are important to them.
- The service will ensure that the person's experience takes prominence in shaping design.
- Build a person's knowledge, skills, resilience and confidence and adopt positive risk taking.
- Conversations include the individual and their family or carers where appropriate*.
- Any transition points are managed effectively ensuring an as seamless as possible experience*.
- No wrong front door.
- Doesn't matter who you work for, we should all put the person at the centre of what we do (person centred).

* *taken directly from NHSE intermediate care framework*

Next steps

These jointly developed guiding principles for intermediate care serve to deliver consistency to a truly integrated approach across health and care for patients and citizens in the East of England. How these principles are applied in practice at a local level is what matters next. System leaders are urged to use these principles as the basis for transforming and improving the intermediate care offering for their local populations, using the core outcome measures as a continuous marker of success for their delivery.

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