

West and South Yorkshire and Bassetlaw Commissioning Support Unit



Intermediate Care - a review of evidence and example models of delivery

Doncaster Clinical Commissioning Group

September 2014

Version 2.0



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Version control

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This review has been produced for Doncaster CCG by NHS West and South Yorkshire and Bassetlaw Commissioning Support Unit. Full details of the review are available from state Jill Rutt email: jill.rutt@nhs.net

The contents of the review are believed to be valid at the time of publication 12/09/2014. It is important to note that new research which could influence the content of the review may become available at any time after this date.

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Summary

The West and South Yorkshire and Bassetlaw Commissioning Support Unit have been asked by Doncaster Clinical Commissioning Group (CCG) to prepare a review of Intermediate Care (IC) including published information and example delivery models, with an aim to aid them in determining how to develop their own localised model.

Through the use of IC services Doncaster aim to maximise independence and improve quality, utilising resources effectively to get best value for money whilst improving and simplifying the system for patients and healthcare professionals.

There is no blueprint for the provision of IC services although consensus is that they are usually short-term interventions designed to encourage independent living and prevent people being admitted to hospital or long-term residential care for as long as possible. Both the Department of Health and The Scottish Government have issued guidance but neither sets of guidance are prescriptive as to which model local health and social care organisations should implement.

Although there is no gold standard for IC delivery, a number of important themes emerged through the review from national policy and audit data, evidence, guidelines and national service delivery models. Based on this the following should be considered prior to adoption of a particular intermediate care approach:

- Commissioning decisions should be based on the demographics of the local population tailoring solutions to meet local needs.
- A clear, agreed scope focused on prevention, rehabilitation, re-ablement and recovery.
- Focus should be on individual need, rather than diagnostic group.
- Emphasis should be placed on services that deliver holistic assessment and comprehensive care planning.
- Shared working between services and teams co-ordinated with a multi-disciplinary and multiagency model have shown to be effective.
- Good communication, smooth handover between services, good links and information sharing are essential elements.
- Is it indicated that a single point of access enhances care.



Summary

The review has demonstrated that there are a number of examples nationally of different service delivery models. It is not clear from the evidence how effective these models are. They generally fall under the following categories and these are services which may want to be developed:

- Triage, early diagnosis and assessment
- Acute care at home/Virtual ward/Hospital at home
- Multi-disciplinary rapid response community teams / Community rehabilitation teams/Integrated response teams
- Enhanced support discharge
- Community hospitals and care homes
- NHS pharmaceutical care in the community
- Falls prevention services
- Home care re-ablement
- Services for people with dementia and other mental health conditions

The national IC audit provides an overall picture of current commissioning patterns. Almost three quarters of IC services are jointly commissioned with multiagency boards and 90% undertake joint strategic planning. This presents an emphasis nationally on multiagency development and delivery of IC services which should be considered when reviewing the local model. The use of formal section 75 pooled budgets was lower at 32% which may reflect some of the challenges or implementing a pooled budget approach but does not indicate whether this would be an effective approach to budget management for IC services.

Emerging throughout the review and a key consideration for commissioners is that planning and implementing large scale service changes takes time, this could mean at least a 5 year change process. Nationally it is recommended that services are managed for quality and so it would be recommended that identification of clearly defined, measurable outcomes should be put in place support service evaluation.

In conclusion, a number of national service delivery models are included in this review and the majority include one or more of the national framework principles. Although, it must be noted that the effectiveness of these approaches are not analysed because outcome data is not reported. These may be helpful to consider when looking at service options but caution must be taken in classifying them as 'best practice' models of delivery.



Background

IC services have been nationally defined as follows:

“IC services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between hospitals and where people normally live, and between different areas of the health and social care system – community services, hospitals, GPs and social care” (NHS England, 2013).

“IC should be brought in at times of “crisis” to complement existing care services..., providing a person centred, outcomes focused package of care. It can also form part of a range of planned interventions” (Scottish Government, 2012)

IC is a short-term intervention designed to encourage independent living and prevent people being admitted to hospital or long-term residential care for as long as possible. There is no blueprint for the provision of IC services and across the country they vary enormously in their configuration and size (Smith et al, 2013). Elbourne and Le May (2014) suggest that this ‘lack of direction’ has not hindered development of IC services. Instead it has “enabled providers to develop individual models of IC tailored to clients’ needs in a plethora of venues for example, nurse-led units, stand-alone IC facilities, existing nursing home facilities, and community hospitals”.

IC services can include services such as rapid response teams, community assessment and rehabilitation teams, hospital at home schemes, admission avoidance services, discharge planning, early support discharge and stroke rehabilitation teams.

IC services are important as they aim to ensure that the most cost-effective care is provided in the most appropriate location for the patient. Not only do such services save money, but they can improve the quality of care for patients, ensuring independent living for as long as possible. Doncaster Clinical Commissioning Group (CCG) has identified a range of work programmes relating to care out of hospital, care of the frail and co-ordinated care; one of which is IC. Doncaster CCG’s assessment of frail and elderly intermediate health and social care needs is looking “to maximise independence and improve quality utilising resources effectively to get best value for money whilst improving and simplifying the system for patients and healthcare professionals”.



Methods

This review involved a robust and systematic search of the research evidence of IC. It also outlines some examples of practical approaches that have been taken within IC for frail and elderly people. This information aims to utilise the evidence to aid Doncaster CCG in determining how to develop a localised model.

The following resources were searched:

- AMED
- British Nursing Index
- CINAHL
- EMBASE
- Health Business Elite
- HMIC
- Medline
- NHS Evidence
- Social Care Institute for Excellence
- Google

Main Findings

National guidance

The Department of Health first published guidance relating to IC in 2001. This was followed by 'IC – Halfway Home: updated guidance for the NHS and local authorities' (Department of Health, 2009) which is the latest national guidance document relating to IC. This guidance is designed to support health and social care organisations, in particular commissioners, to review and update their practice in relation to IC services. It stipulates that IC should be available to all adults over the age of 18 and young disabled people; services should be “able to adapt to a variety of needs”; and the core service should normally be provided in the patient’s own home or community settings but a range of services is likely to be required.

“IC 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” (Department of Health, 2009)

An IC service should link and fill gaps in the existing local network of services. Effective links are vital to the success of IC and it is important that all agencies are aware of the service. The guidance requires the IC function to be managed in an integrated way at strategic, operational and performance management levels. This could be done with a single manager or multi-agency teams and facilities.

The guidance intends that IC should be: based on ‘active enablement’; based on ‘individual need rather than diagnostic group’; arranged on the basis of holistic assessment; lead to a care plan for each individual, have shared working protocols and performance management between services; subject to regular reviews of care plans.

Goals should be set by commissioners for the “whole of the health and social care system on which IC should have an influence” and these goals must be measured. Commissioners should review service performance against their indicators at least annually. An appropriate governance framework must be in place.

Investment decisions should be based on the demographics of the local population. IC services should be planned as multi-disciplinary and multi-agency services. It is recommended that the budgets for IC should come from adult care, older people’s service, as well as specialist services such as stroke and neurology.



Main Findings

The core IC team is likely to include: nurses, physiotherapists, occupational therapists (OTs), support workers, community psychiatric nurses and social workers, It may also include a GP or elderly care physician and have quick access to specialist skills including speech and language therapy, dementia care, dietetics and pharmacy. Ideally, the IC service should have a single point of access.

The Scottish Government (2012) issued an IC framework for local health and social care partnerships to assist with the development of IC in Scotland. The detailed framework acknowledges that IC describes a wide-range of services and therefore does not propose a specific model; instead it provides an overview of the issues that should be considered when developing or reviewing IC services. The framework stresses that health, social care, housing, third sector, independent sector, families, carers, neighbours and the wider community all have a role to play in IC. It states that there is 'no 'right' design' but that it needs to reflect and incorporate the local health and social care system.

The framework identifies the key components of an effective IC service as:

- A clear, agreed scope focused on prevention, rehabilitation, re-ablement and recovery
- Time limited
- Accessible, flexible and responsive
- Based on holistic assessment
- Co-ordinated multi-professional and multi-agency skills and
- Managed for improvement

It refers to Anticipatory Care Plans for people with long-term conditions to help them to make 'informed decisions and plan for expected change'.

Good communication, smooth handover between services, good links and information sharing is an essential part of IC. Access to the IC system should be as direct and as quick as possible. As with the Department of Health guidance, the benefits of setting up a single point of access are extolled as this provides a clear route into care.

The framework lists the services that could be part of IC as:

- Triage, early diagnosis and assessment
- Acute care at home/Virtual ward/Hospital at home



Main Findings

- Multi-disciplinary rapid response community teams / Community rehabilitation teams/Integrated response teams
- Enhanced support discharge
- Community hospitals and care homes
- NHS pharmaceutical care in the community
- Falls prevention services
- Home care re-ablement
- Services for people with dementia and other mental health conditions

It also includes scenarios that illustrate key responses required to meet personal outcomes to assess current capability and guide local service changes.

IC is one model of care which has evolved to address the Care Closer to Home (CCH) initiative (Royal College of Physicians, 2012). As with IC, there is no nationally agreed best practice guidance for CCH. Again, some success has been demonstrated but much of the evidence is anecdotal. This narrative document from Royal College of Physicians aimed to identify good practice in four CCH delivery models, one of which was IC. It concludes that at present, CCH initiatives are driven more by policy than evidence and concludes “there is insufficient research to identify evidence of good practice in the delivery of CCH and to provide guidance for its effective implementation”.

Although not necessarily directly related to IC, NICE has recently issued a draft public health guideline around delaying and/or preventing dementia, disability and frailty in later life (NICE, 2014). The draft guideline makes recommendations on approaches in mid –life to prevent or delay dementia, disability and frailty. The aim is to increase the number of older people who can lead independent, healthy and active lives (successful ageing) by:

- reducing the prevalence of behaviours that increase the risk of dementia, disability and frailty
- reducing the incidence of dementia, disability and frailty and delaying their development in people who experience them
- reducing the incidence of a range of other chronic non-communicable conditions in later life that can contribute to disability and frailty (such as cardiovascular diseases, diabetes, chronic obstructive pulmonary disease, and some cancers)”



Main Findings

This guideline ties in with the principles of IC as it concerns the prevention or delay of illness and frailty; i.e. keeping people fit and healthy and independent for as long as possible.

Evidence findings

Two recent systematic reviews have looked at the effectiveness of IC. Smith et al (2013) explored differences between IC configurations and the relationship between different team characteristics and patient outcomes. The results indicated that IC provided by multidisciplinary teams was effective and may well be cost effective. Key results found a positive impact of the delivery of care by inter-professional or interdisciplinary teams. They identified increased shared working, the use of integrated care facilitators, comprehensive assessment and disciplines working effectively in teams as factors associated with a reduction in length of stay, costs of care and emergency admissions. They also summarised that staff perceptions were that an interdisciplinary approach producing better outcomes for patients. The review also summarised that a number of team factors contributed to improve outcomes including; team composition, team tenure, regular team meetings, task allocation, cohesiveness, open communication, collaborative team working, multidisciplinary rounds, supervision, education and training, leadership, a holistic approach to care, and strong interpersonal relationships. Rotation, separate location of team members, constant change to services and risk aversion of staff were identified as potential confounding factors.

A systematic review by Health Quality Ontario (2012) describes IC as 'complex and marked by heterogeneity in study design, quality of interventions, and components'. It concluded that it is difficult to draw conclusions regarding the effectiveness of IC based purely on the literature. However, when looking at a synthesis of evidence on specialised community-based care (also known as IC, it found IC effectively improves outcomes inpatient with heart failure, COPD and diabetes. However the effectiveness of IC in family practice was less clear.

Evidence for the effectiveness of IC is not yet robust. Some evidence is starting to emerge but conclusions are mixed (DH, 2009). Woodford and George (2010) found there was no evidence that IC services are cost effective or reduce acute hospital use. This is also mentioned by Elbourne & Le May (2014) in relation to services provided in nursing home facilities.

Main Findings

There is only a limited amount of literature which looks specifically at models of IC. There is more literature relating to the wider topics of early discharge support (particularly for stroke services), admissions avoidance, and promoting independence of older people. For example Wilson et al (2014) found that IC clinics contributed to improving achievement of targets in patients with diabetes.

National audit results

The National Audit of IC has been running for two years. The second report (NHS Benchmarking Network, 2013a) provides an indication of common services that are commissioned for IC. Of commissioners participating in the audit in 2013 the majority (> 80%) commission crisis response, home based IC, bed based IC and re-ablement services and beds to be used flexibly between 'step up' and 'step down' services.

The audit results indicate that the capacity of IC remains low compared to secondary care provision and that there is nothing to suggest that there has been any change in resources allocated to IC during the last year. The report suggests that more local evaluation may be required to provide evidence to support the case for further investment.

Other key findings from the report (NHS Benchmarking Network, 2013b) include:

- There is evidence of increased integration at the commissioner level. For example in 2013, IC services were jointly commissioned in 74% of health economies (58% in 2012); the use of formal section 75 pooled budgets has increased from 21% to 32%; multi-agency boards are in place in 70% of areas (63% in 2012) and strategic planning for IC is undertaken jointly by 90% of participants (86% in 2012).
- IC services were typically delivered by small local teams – the average number being 2.6 but the range was up to 22 different services. This raises questions about quality assuring these services, fragmentation of services, potentially unclear routes in and out of services, and, lack of economies of scale.
- 20% of bed based IC services reported an average waiting time from referral to commencement of service of 4 days or more, with $\frac{2}{3}$ of service users waiting in wards in acute hospitals. These delays represent a lost opportunity to reduce hospital lengths of stay, as well as creating a poor care experience for service users which may impact upon the effectiveness of their rehabilitation.



Main Findings

- The Nursing skill mix is in line with RCN recommendations for basic, safe care but below those levels recommended for ideal, good quality care. Mental Health workers rarely appear in IC team establishments, and services appear to have limited access to specialist mental health advice. The proportion of home based IC service users relying on their own GP for medical cover appears high at 71% when reviewed against the levels of care being provided by these services. To assure that patient care is most effective in IC requires multidisciplinary teams that include active involvement of doctors with expertise in the care and rehabilitation of frail older people. The finding that 71% of services relied solely upon the patient's usual GP implies a considerable additional demand upon GPs which may be hard to meet adequately.
- The analysis showed that 72% of bed based service users maintained their level of independence (measured as their type of care setting) and 24% moved to a more dependent setting.

Strategy examples

A number of organisations have begun to produce strategies for IC. NHS Central London CCG (2012) published 'Better care, closer to home' which sets out plans to transform out of hospital care for their area. Included within the plans is the intention to build on their inter-practice referral system, encourage providers to proactively raise lifestyle issue with patients, redesign pathways of care, and establish rapid response teams to deliver care in patients' homes, and implement a 'Wellwatch' telephone based case management service for patients with long-term condition. There is currently no available evaluation of the impact of this strategy.

Central Manchester University Hospitals (2012) has set out a five year development plan for scaling up IC pilots. The pilots were around continuing health care and improving patient experience, the integrated community care pathway for COPD, and end of life care in residential homes. Their IC task force envisages that third sector involvement will be invaluable to achieving their plan.



Main Findings

Service delivery models

Appendix 1. sets out details of examples of IC case studies delivered at different NHS organisations nationally. The following models emerge as themes from these case studies and a brief outline of each is explained below:

Single point of referral models

A single point of referral for IC reduces the opportunity for confusion as to where to refer patients. Three single point of referral models have been located. South Kent Coast has developed an integrated pathway for future IC model which incorporates a Local Management Referral Service i.e. a single point of contact for integrated care. Calderdale has implemented a 'Gateway to Care' and in 2012 Sunderland CCG had plans to develop an IC Hub where multi-agency assessment would take place.

Combined services

Stockport have a number of different IC services: out of hours rapid response service, step up and step down home based services, and step up and step down bed based services. Access to this service is via a joint assessment by a social worker and either a therapist or nurse but there is no mention as to whether this is a single point of referral.

Bed based care

Most examples of IC relate to bed based care. Examples are based on providing short-term beds within the community to which patients can go either from hospital, if they are not able to go home, or from home, to avoid going into hospital. Beds may be provided in a number of locations including IC units and nursing homes. Wherever the location of the beds, the support team generally consists of physiotherapists, OTs, social workers, support workers, geriatricians and GPs. The intention of the care is to avoid the individual being admitted to hospital.

A number of IC units have been established in Norway in recent years; some are within hospitals, some governed by municipalities and others collaborations between specialist and primary care. Staffing usually involves nurse, doctors, physiotherapists and occupational therapists. The average length of stay at these units is between 2 and 3 weeks. Units vary in size between 5 and 30 beds. (Johannessen, 2013). This study describes that for an intermediate unit to become an integrated part of an appropriate clinical pathway in a complex healthcare system, considerable effort in establishing procedures and routines for transferring patient is required.



Main Findings

Home-based care

Services which aim to keep people in their own homes (or existing residential care) have not been well documented. From those that have, Barking and Dagenham, Havering and Redbridge CCGs have successfully trialled two services – the Community Treatment Team and the Intensive Rehabilitation at Home Service. The CCGs are now looking to reduce the number of rehabilitation beds from 104 to between 40 and 60 beds.

Also, Wyre Forest has introduced a virtual ward service where an Enhanced Care Team delivers advanced care in the home rather than hospital; this has reportedly reduced emergency admissions by 10%.

Rapid response services

Rapid response services are designed to keep people out of hospital. Bristol has introduced a rapid response service which has resulted in the prevention of more than 4000 admissions per year. Berkshire's rapid assessment community clinic has also been successful; 599 out of 733 referrals to the clinic led to people maintaining their home environment. 82.1% of these patients preferred their treatment to be carried out by the clinic.

Re-ablement services

Re-ablement is “an ‘approach’ or ‘philosophy’ which aims to help people to do things for themselves rather than having things done for them” (Sunderland CCG et al, 2012). As with IC there is no clear definition of what encompasses re-ablement. Bridges and James (2012) state there is no standard Welsh Government definition of re-ablement and that there is confusion between organisations as to what exactly is included in re-ablement. It is important to note that re-ablement is not just limited to IC.

An Australian study (Lewin et al, 2013) found that “receiving a re-ablement service in comparison to a conventional home service reduced the likelihood of using any home care service for the next 3 years and the need for a personal care service for nearly 5 years”. It concluded that re-ablement services could make a ‘significant contribution’ to containing costs of caring for an aging population.



Conclusion

The Department of Health and The Scottish Government have set out their visions for IC but they are by no means prescriptive. Health and Social Care organisations have the freedom to set up their IC system in the manner most appropriate to their local needs. As a result of this, services are provided in many different ways throughout the country. Due to the disparate nature of these services there is a lack of robust evidence to show the effectiveness of IC.

This review has identified a number of different models for the provision of IC services. However, despite the fact that IC has been around for more than 10 years, there is very little evidence showing the quality of these models and whether or not they are cost-effective. There are pockets of information but there has not been a full evidence review, possibly due to the wide area covered by IC.

However, it is clear from the literature and evidence from practice is that the essential elements to consider when commissioning a successful IC system are:

- Mapping all existing services which contribute to IC
- Multi-disciplinary working – all teams involved must work together and have a shared vision
- Good planning and communication
- Ensuring all teams involved are aware of the system and where to refer
- Use of a single point of contact to reduce confusion
- Tailoring the system to meet local needs
- Involving patients and the public
- Setting relevant and measurable performance targets and monitoring them regularly

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See also Appendix 1 for references for specific service examples.



Appendix 1. IC service delivery models – national examples

Single point of referral

Location	Service	Description	Outcome	Reference
South Kent Coast CCG	Model for IC provision	Undertook a service review and needs assessment of IC which has resulted in a model of care based on an integrated IC pathway. Recommendations cover integrated care and pathways, integrated service reviews and audit, flexible levels of provision, appropriate use of services, location of service provision, timely response to patient needs, patient engagement, integrated communication and training and joint implementation plan.	Integrated pathway for future IC model incorporates a Local Management Referral Service – a single point of contact for integrated care.	South Kent Coast CCG. 2013. <i>IC Project: report to South Kent Coast Health and Wellbeing Board</i> . [Accessed 12 September 2014]. Available from http://moderngov.dover.gov.uk/document/s/s6364/Intermediate%20Care%20Project.pdf
Sunderland	Model for IC provision	Undertook a service review to clarify which intermediate services were being provided and identify gaps in provision. Resulted in a 'map' of core services with surrounding 'support services(p15) and vision for future	Agreement of a future model for IC in Sunderland in which patients flow through the IC service via the IC Hub, where multi-agency assessment take place to ensure the patient receives the right	Sunderland CCG, South of Tyne and Wear and Sunderland City Council. 2012. <i>Strategic direction for IC in Sunderland 2012-2015</i> . Sunderland: Sunderland City Council. [Accessed 12 September 2014]. Available from http://www.sunderland.gov.uk/CHttpHandler.ashx?id=13412&p=0

Appendices

			intervention	
Calderdale CCG and Calderdale Council Contact: Rhona Radley, Senior Service Improvement Manager	Integrating IC	Devised new model of integrated care using a 'Gateway to Care' which either refers to an integrated team providing rapid response, falls prevention, community rehabilitation and re-ablement or other social care. Single point of access to the service implemented November 2011	<p>"Our message to you:</p> <ul style="list-style-type: none"> • Single/integrated commissioning is not easy but it makes sense • Approach any problem from the point of view of what you want for the patient/person using services • Learn from people who have done it before • Be brave – just because something is radical doesn't mean you shouldn't do it • Communicate, communicate, communicate • Don't give up – it is worth it!" 	Calderdale CCG: 2013. <i>Integrating Intermediate Tier Services</i> . [Accessed 12 September 2014]. Available from http://www.nhsbenchmarking.nhs.uk/CubeCore/uploads/icsurvey/NAIC%202013/NAIC2013Calderdale.pdf

Combined services

Location	Service	Description	Outcome	Reference
Stockport IC Service	Rapid assessment service Bed based facility Home based service	Services consist of Out of hours rapid response service Step up home based service Step down home based service Step up bed based service	Pharmacy role proven to provide direct patient benefits. Recommend it is an essential component of IC service support.	National Audit of IC. 2013. Stockport intermediate car service – the role of the pharmacist within the IC team . [Accessed 12 September 2014]. National Audit of IC. 2013. Stockport IC Service – The role of the Community

Appendices

		<p>Step down bed based service</p> <p>Access to service is via joint assessment by social worker and therapist or nurse.</p> <p>Pilot project examining pharmacist in IC.</p> <p>Pilot project for community psychiatric nurse role</p>	<p>CPN role has evolved the IC service, supporting the service.</p>	<p>Psychiatric Nurse in IC [Accessed 12 September 2014].</p>
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Bed-based care

Location	Service	Description	Outcome	Reference
Hilltop Manor, Stoke on Trent	80 bed home containing 34 beds for IC (30 permanently commissioned, 4 for 'spot purchase')	<p>Patients admitted from hospital (sometimes from A&E) or referred from community by healthcare staff. Assessed to ensure they can benefit from care. Do not admit patients with advanced dementia. Nursing care, physiotherapists, OT, psychiatric input, GP visits the home every day. Within 24 hours of admission, personalised care plan drawn up. Weekly multidisciplinary meetings. Staff visit proposed accommodation for suitability and recommend equipment and modifications as appropriate. Home visit with patient takes place to see how they cope. Can be assessed for nursing and</p>	<p>Intention to get people home.</p> <p>Occasionally they go into nursing or residential care.</p> <p>Average length of stay (LOS): 26.5 days.</p>	<p>Anonymous. 2013. <i>Independent Providers: case studies: back on their feet</i> Health Service Journal Jun 7 p.S24-25 Full text: Available ProQuest at Health Service Journal [Accessed 12 September 2014].</p>

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		continuing care needs. On return home, patients passed to local community teams.		
Westview Lodge, Hartlepool	20 transitional and rehabilitation beds commissioned by Hartlepool Borough Council	Patients often admitted after falls. 8 rehabilitation beds with OT, physiotherapy and support workers input. Community rehabilitation team based within the home. 12 transitional beds overseen by physiotherapists. Includes nurse with prescribing rights. Gym and kitchen area to build up confidence. Environmental visit carried out before patient goes home/residential care. Co-ordinate with social workers.	Intention to get people home. Max LOS should be 6 weeks. Average LOS is 3 weeks. Transitional beds: 36% returned home, 32% to short stay setting, 12% into residential rehabilitation, 15% readmitted to hospital Rehabilitation beds: 29% into transitional care, 14% readmitted to hospital, 7% to short stay setting.	Anonymous. 2013. <i>Independent Providers: case studies: back on their feet</i> Health Service Journal Jun 7 p.S24-25 Full text: Available ProQuest at Health Service Journal [Accessed 12 September 2014].
Four Seasons Health care	Placing frail patients in care homes	CCGs now commissioning beds and services in private care homes – buying the bed but also therapeutic input for patients – the full package of care. NHS Hertfordshire IC strategy looked at providing beds through local nursing homes to allow patients to remain closer to home and have input from nurses and therapists. Homes have KPIs agreed with commissioners. Use internal care teams	More conducive for rehabilitation, assessment and enabling for patients than if they were in hospital. Patients able to return to their own homes with an appropriate package of care. Private care homes need assurance of longer term contracts in order to invest in	Moore, A. 2013. Independent providers: more than just a bed. Health Service Journal, 7 Jun, p.S22-23 Full text: Available ProQuest at Health Service Journal [Accessed 12 September 2014].

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		and therefore community teams not put under extra pressure.	this method of care.	
Greenview IC Unit, NW London Contact: Claire.hilton@nhs.net	12 bed IC unit located in one wing of a nursing home. Provide rehabilitation for people recovering from physical illness in the general hospital who had co-existing psychiatric disorders but were not assessed as being able to go home.	GICU is nurse-led. Rehabilitation staff include physiotherapists, OTs, staff grade psychiatrists, and psychologist. Visiting senior medical support including GP, psychiatric and geriatrician. Initial pre-admission assessment takes place.	57% of patients improved sufficiently over a number of weeks to return home. Difficult to identify people likely to benefit from IC targeted at people with physical plus mental disorders. NB It is not clear whether this unit is still operating. It was proposed that this would close as part of the review of community IC beds in Harrow	Hilton, C et al. 2013. <i>An IC unit for older people with both physical and psychiatric disorders: naturalistic outcome study</i> . International Psychogeriatrics, 25:6, p895-900. Full text: Available ProQuest at International Psychogeriatrics [Accessed 12 September 2014].
Spiral Health CIC, Blackpool Contact: chris.walbank@spiralhealth.co.uk	40 bed rehabilitation unit run by a social enterprise at Bispham Hospital.	Part of IC pathway on Fylde Coast. Most patients are older and visit hospital for nursing, physiotherapy or occupational therapy or to recover from major surgery. Patient-centred journey developed by Spiral Health CIC comprises a number of initiatives under one umbrella all focusing on what the patient wants. Staff trained in person-centred approaches. Use	100% of patients recommend service to family and friends. 100% say there were treated as individual. Little financial investment required. 'Dramatic culture change' achieved within 6 months.	National Audit of IC. 2013. Spiral Health CIC - IC Patient Centred Journey [Accessed 12 September 2014].

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		'Working together for Change' business planning process which collates and assesses information and feedback and change made to the service as required.		
East Cheshire NHS Trust IC Service Contact: edwinaslade@nhs.net	Integrated bed and home pathway plus integrated health and social care services in the IC team. Bed based service is at a community hospital site and 2 local care homes. Home based IC services provided in patients' own homes.	Adults from 18 years but most are over 65 years. All types of medical conditions as long as stable ie don't require onsite doctor. Cross-professional working through a single assessment framework, a single professional record and shared protocols. Team includes social workers, nurse, OT and physiotherapists, support workers, IC doctors and pharmacists.	To support transition to functional independence so patient may return home/usual place of residence.	National Audit of IC. 2013. East Cheshire NHS Trust – IC service: patient case study . [Accessed 12 September 2014].
Northumberland CCG	Frail elderly pathway	Healthcare professionals identify patients at risk of unnecessary hospital admission. Each patient has structured assessment covering mobility, nutrition, depression, memory impairment etc. Care packages built around need. Pathway introduced one year ago.	Aim to join up care and avoid hospital admissions. Unnecessary admissions rate is now down to below average.	Carlisle, D. 2014. <i>Bridging the divide</i> . Nursing Standard, vol. 28 (20), p22-24 Full text: Available EBSCOhost at Nursing Standard [Accessed 12 September 2014].
Hallingdal sjukestugu,	Community hospital in a rural district	This is a decentralised, specialist health care service under the administration of a	Average LOS 6.3 days. 455 acute admissions to the	Lappegard, O. and Hjortdahl, P. 2012. <i>Acute admissions to a community</i>

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Norway		<p>general hospital 170km away. GPs, under telephone supervision the hospital specialists, run the inpatient department. containing 14 IC beds</p>	<p>hospital. 40% were younger than 67 and 36% older than 80 years of age. Half admitted for observation and half for treatment. Main diagnostic groups: infections, injuries and palliative care. 17% were later transferred to the general hospital for further treatment.</p>	<p><i>hospital: experiences from Hallingdal sjukestugu. Scandinavian Journal of Public Health, 40 (4), 309-315 .</i></p>
Total Care Living Complex, UK	Person-Centred IC	<p>20 bed IC facility housed within total care living complex. Run by a charity providing health and social care for older people. Multi-disciplinary team originates from the charity, local acute hospital and primary care comprised of nurses, care workers, physios, OTs, social workers and doctors.</p>	<p>On discharge 74.1% returned to own home, 5.3% to residential home where they previously resided. About 88% of service users with a completed BI showed a statistically significant increase in their functional improvement. Number of challenges re the implementation around team pressures and organisational misunderstandings. Highlights that “those wishing to establish a new ‘team’ must be mindful of both the</p>	<p>Elbourne, H and Le May, A. 2014. <i>A multi-disciplinary approach to person-centred practice. Nursing & Residential Care,14(4), 199-202.</i></p>

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			physical and emotional labour that goes into providing care in a dynamic care system” Success is reliant on: good planning and communication, motivation and shared vision, emotional as well as physical labour takes place, and emotional labour should be recognised and people supported organisationally.	
Norway	IC Hospital	In-patient ward with 12 beds co-located with primary health care services. Hospital is 50km away “.Goals are to develop an integrated care pathway for elderly and chronically ill patients, and an arena for professional collaboration with exchange of information and knowledge between the general hospital and primary health care. IC hospital staffed by mainly nurses and OTs, physios and a GP	The IC hospital reduced the co-ordination challenges during discharge of elderly patients from hospital to primary health care. However, the IC was more like an extension of the hospital and did not meet need for communication across care levels.	Dahl, U et al. 2014. <i>Hospital discharge of elderly patients to primary health care, with and without an IC hospital – a qualitative study of health professionals’ experiences</i> . International Journal of Integrated Care, 14, April-June 2014 http://www.ijic.org/index.php/ijic/article/view/1156/2386 [Accessed 12 September 2014].
South London homeless hostel	Homeless IC pilot project	Provide clients who have deteriorating medical conditions with intensive clinical and social support. Advise hostel staff on	Number of emergency department and hospital admissions dropped	Schneller, K. <i>IC for homeless people: results of a pilot project</i> . Emergency Nurse 20 (6), p2024.

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		<p>how to avoid unnecessary ambulance call outs and make use of clinical support service such as NHS Direct, GP OOH. Nurse and health support worker. And GP. Hostel also had substance misuse worker project worker and housing resettlement workers who all worked together.</p>	<p>significantly. Awarded Nursing Standard Community Nursing Award 2011.</p>	
<p>5 Boroughs Partnership, St Helen's and Knowsley</p> <p>Contact: Sarah.haworth@5BP.nhs.uk Or Rachel.bryers@5BP.nhs.uk</p>	<p>IC Unit</p>	<p>20 bed IC unit is part of a collaborative relationship between St Bartholemew's IC Unit (charitable home) and 5 Boroughs Partnership Foundation Trust. Aim is to facilitate early discharge from hospital, prevent hospital admissions and maximise independence to prevent premature admission into long term care. Offers step up and step down facilities but faces increasing pressure for step down beds from acute sector and therefore there is a lack of step up beds. Therefore a review of the discharge process took place which resulted in the redesign of the IC pathway and process.</p>	<p>St Barts became one of three pilot site for Shared Decision Making programme in which patients are encouraged by health professionals to select the care options to suit them. Patient focus groups were set up between carers and patients to discuss what had gone well with their care as a result of which changes were made to care provision. Now being rolled out across other IC units.</p>	<p>National Audit of IC. 2013. http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/icsurvey/NAIC%202013/Casestudies/IntermediateCareCaseStudy5BPV2.pdf. [Accessed 12 September 2014].</p>

Home-based care



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Location	Service	Description	Outcome	Reference
Barking and Dagenham, Havering and Redbridge CCGs and local councils and North East London NHS Foundation Trust Contact details:	Community Treatment Team (CTT) and Intensive Rehabilitation Service (IRS)	Trialling two services across 3 boroughs: Community Treatment Team: doctors, nurses, OTs, Physios, social workers and support workers provide: short term intensive care to people experiencing health/social care crisis to be cared for in their own home; supports people to return home; single point of access to intensive rehabilitation at home or a bed in community rehab unit if necessary. Hours: 8am – 10pm – 7 days a week. Intensive Rehabilitation at home service: physios, OTs, healthcare assistants and others offering intensive physio and other therapy in patients own home; intensive in-home support and involves between one and four home visits each day. Hours: 8am – 8pm – 7 days a week.	Consulting on making CTT and IRS permanent services and merging three existing community rehabilitation units into one unit. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. Since introducing CTT and IRS on a trial basis, a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. Intention to reduce no of rehab beds from 104 to 40-61.	Redbridge CCG internet site includes links to further information: http://www.redbridgeccg.nhs.uk/intermediatecare Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups. 2014. Making IC better in Barking and Dagenham, Havering and Redbridge. [Accessed 12 September 2014].
Wyre Forest Enhanced Care Model	Virtual ward	Enhanced Care team consists of rapid response crisis intervention, earlier supported hospital discharge, care home admission avoidance and virtual ward case management. Virtual ward – the	Overall emergency admissions reduced by 10% (£1.2M). Significant cultural change required which takes time	Jones, A. and Carroll, A. 2014. <i>Hospital admission avoidance through the introduction of a virtual ward</i> . British Journal of Community Nursing, July 2014, vol./is. 19/7 p330-4, [Accessed 12 September 2014]. Available from EBSCOhost at British Journal of Community Nursing

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		<p>team delivers advanced level of care to patients in homes rather than hospital. Team includes community matrons, nurse, OTs, physios, health-care assistants, social care links, GP support. Patients have access to team 7 days a week. Team can access specialist nurses and consultants. Patients normally 'admitted' via predictive risk stratification. Community matrons are responsible for patients. Anticipatory Care Plan devised and shared care ensues. Initial discharge set a 3 months but this proved challenging.</p>	<p>and is ongoing. Anticipatory care plan must be a 'shared, real-time tool but all teams use different It systems with no common interface and therefore there is repetitive documentation. Sets out innovations and new initiatives.</p>	
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Rapid-response

Location	Service	Description	Outcome	Reference
Bristol CCG, Bristol City Council and Bristol Community Health – intermediate tier, multi-	Rapid response service to assess, treat and support individuals in their own home	<p>Integrated management and multi-disciplinary membership. 18 years plus but predominantly older people</p> <p>Registered nurses, physios, OTs, social workers, mental health specialists, pharmacists and re-ablement workers.</p> <p>Offers IV therapy. 7 days – 7.30am-7.30pm. Out of ours team provides cover</p>	<p>Over 60% of referrals are from primary care – “acts as a true step-up/admission avoidance service”.</p> <p>Prevents over 4,000 admissions per year.</p> <p>Advance Nurse Practitioners have been introduced to</p>	<p>National Audit of IC. 2013. Bristol CCG, Bristol City Council and Bristol Community Health – intermediate tier, multi-disciplinary health and social care service.</p>

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<p>disciplinary health and social care service</p> <p>Contact email: jayne.clifford@bristol.gov.uk</p> <p>or</p> <p>lizanne.harland@bristolccg.nhs.uk</p>		<p>outside these times but is not a large input. Referrals made through single point of entry and response times guaranteed within 4 hours. Primary focus on ambulatory care sensitive conditions.</p> <p>3 Rapid Response Nursing teams which include an advanced nurse practitioner. Introduced ALERT course which trains staff to spot patient deterioration and act appropriately. Rapid response teams carry out in-reach work at Bristol Royal Infirmary's emergency department. Clinical advice provided over phone by ANPs to rapid response nurses and other team members.</p>	<p>provide clinical support.</p> <p>Further development of the Community IV Therapy service.</p>	<p>Penfold, J. 2014. <i>Rapid response team enables patients to remain at home.</i> Primary Health Care, Jun 2014, vol. 24, no. 5, p. 8-9.</p>
<p>Berkshire Healthcare NHS Foundation Trust</p> <p>Contact: Claire.barker@berkshire.nhs.uk</p>	<p>Rapid Assessment Community Clinic (RACC)</p>	<p>Services available:</p> <ul style="list-style-type: none"> • Specialist team Including Associate Specialist, ANP, Occupational Therapist, Physiotherapist • 2 Consultant clinics per week • Saturday RACC clinic will be in operation from the 2nd November for a 6 month period • Rapid access to enhanced IC Support Services • Domiciliary appointments • Direct access to community hospital beds • Access to a variety of CHS Including the 	<p>Over a 35 month period, 733 referrals received – 599 maintained their home environment, 91 were admitted to community hospital bed and 83 advised to admit to secondary care.</p> <p>When given the choice, 82.1% patients preferred</p>	<p>National Audit of IC. 2013. Berkshire Healthcare NHS Foundation Trust – The Rapid Assessment Community Clinic (RACC)</p>

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		<p>CHC, Community Matrons and the DN's</p> <ul style="list-style-type: none"> • Same day transport available <p>Access on site to diagnostics</p> <p>Referrals can be made via the Community Access Point (CAP) 24 hours a day, 7 days a week</p> <p>Assesses each patient within 2 – 48 hours</p>	<p>their treatment to be carried out in the RACC, 7.1% in the GP surgery and 0% favoured the acute setting</p> <p>Based on ONLY admissions into secondary care being avoided</p> <ul style="list-style-type: none"> • Based on 2011/12 tariff for admitted patient care and outpatient procedures (primary diagnosis costed) • Total annual savings £387,000 	
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Re-ablement

Location	Service	Description	Outcome	Reference
Greenwich Community Health Services	Re-ablement	Use of people management within integration of services. Integration services won staff engagement category at HSJ awards in 2011.	Significant savings from people not needing care packages after re-ablement. December 2011, 937 hours saved and reinvested.	Wells, J. 2012. <i>The whole is greater than the sum of the parts</i> . Health Service Journal 26 April 2012.

Additional case studies from IC can be found in:



West and South Yorkshire and Bassetlaw Commissioning Support Unit

West & South Yorkshire and Bassetlaw CSU

Douglas Mill

Bowling Old Lane

Bradford

BD5 7JR