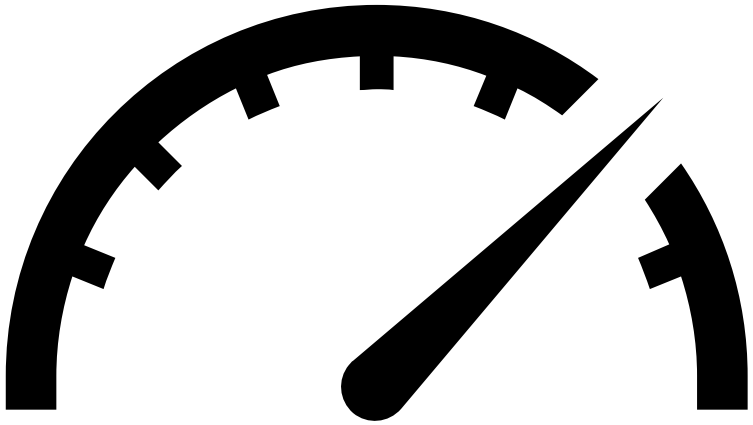
The NHS Intermediate Care Framework

How are Allied Heath Professionals putting it into practice?

Who’s here, and how are you feeling about the Intermediate Care Framework?



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Welcome and introductions

- Lauren Walker, Professional Advisor, RCOT

Overview from NHS England

- Priya Oomahdat, Deputy Director – Rehabilitation, NHSE

Professional body perspectives

- Lauren Walker, Professional Advisor, RCOT
- Judith Broll, Director of Professional Development, RCSLT
- Jackie Lidgard, Professional Advisor, CSP

Learning from the Leeds experience

- Laura Falter, Active Recovery – Clinical Lead, Leeds Community Healthcare NHS Trust
- Jen Throp, Programme Manager – Rehab and Recovery Beds, Leeds Health & Care Partnership
- Brenda Thompson, Speech and Language Therapist – Leeds Community Healthcare NHS Trust

Q&A

Materials from the webinar and other relevant information will be shared on:

- **FutureNHS Collaboration Platform**
  (email england.intermediatecare@nhs.net for access)
- **RCOT website**
- **CSP website**
- **RCSLT website**

Access the Framework and the rehabilitation model here:

Intermediate Care Framework

Community rehabilitation and reablement model

Intermediate Care and Rehabilitation as part of the UEC Recovery Plan

Presented by:
Priya Oomahdat
Deputy Director of Rehabilitation,
Urgent and Emergency Care
NHS England (National)
@PriyaO_NHS

Delivery plan for recovering urgent and emergency care services

Key Ambitions

- Patients to be seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.

- Ambulances attending to patients quicker: with improved ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.

To succeed and enable the improvement of waiting times and patient experience, the NHS is committed to sustaining focus across the heath and social care sectors on five key areas:

1. Increasing urgent and emergency care capacity

2. Increase workforce size and flexibility

3. Improving discharge

4. Expanding care outside hospital

5. Making it easier to access the right care

https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/

What are we trying to solve and where does intermediate care fit?

- Tonight, across England, **thousands of people** will spend the night in an acute hospital bed, and in a short-term community bed instead of a more appropriate place like their home.
- The majority of these people are in hospital due to delays in accessing post-discharge services in the community. There is a lack of capacity in both health and social care 'step down' or 'intermediate care' services.
- The transformation of out-of-hospital services is a key element of the NHS' recovery, in which intermediate care will play a key role.
- **Intermediate care** is a set of short term, multidisciplinary services and interventions organised through health and social care to support people in their own homes, or in community bed-based facilities, after discharge from hospital (or those at risk of hospital admission). Intermediate care is underpinned by the principle that most people recover best at home.

Scaling up intermediate care ambition

Over a year ago NHS England began a programme of work to develop and pilot new approaches to intermediate care, working with local authorities and voluntary and community partners.

- Six 'national discharge frontrunners' have been testing solutions to intermediate care and discharge/flow, including reablement and wrap-around care
- In Autumn 2023, NHS England published a new planning framework to support systems to manage and increase capacity against demand for intermediate care and a new model for rehabilitation and reablement, building on the learning from the frontrunner sites and from across the country

Guiding principles and components

Every person ** requiring rehabilitation has access to the appropriate level of expertise, based on their individual needs

Rehabilitation assessments and interventions are therapy-led but delivered by a core multi-disciplinary team able to draw down or pull in specialist expertise across place as required

An integrated workforce working flexibly in line with a 'one workforce' culture across services, settings and sectors, building relationships and increasing skills

Person-led and holistic support, through making every contact count, reducing handoffs and ensuring continuity of care, enabled by a rehabilitation ethos

New ways of working are embraced, making best use of the full range of skills across the workforce, including the use of assistive technologies and digital when appropriate

Distributed system leadership across organisational boundaries; with an agreed champion at neighbourhood level; driving changes in behaviours and culture across the pathway; promoting integration and trust

4 components of the model

A. In hospital stay as part of acute care

Describes activities that should take place while the person is in hospital to support their recovery following discharge, including embedding a rehabilitation ethos

B. Assessment in the community for rehabilitation needs

Describes a flexible approach to timely and safe rehabilitation assessment through maximising use of the registered and unregistered therapy workforce

C. Delivery of rehabilitation interventions

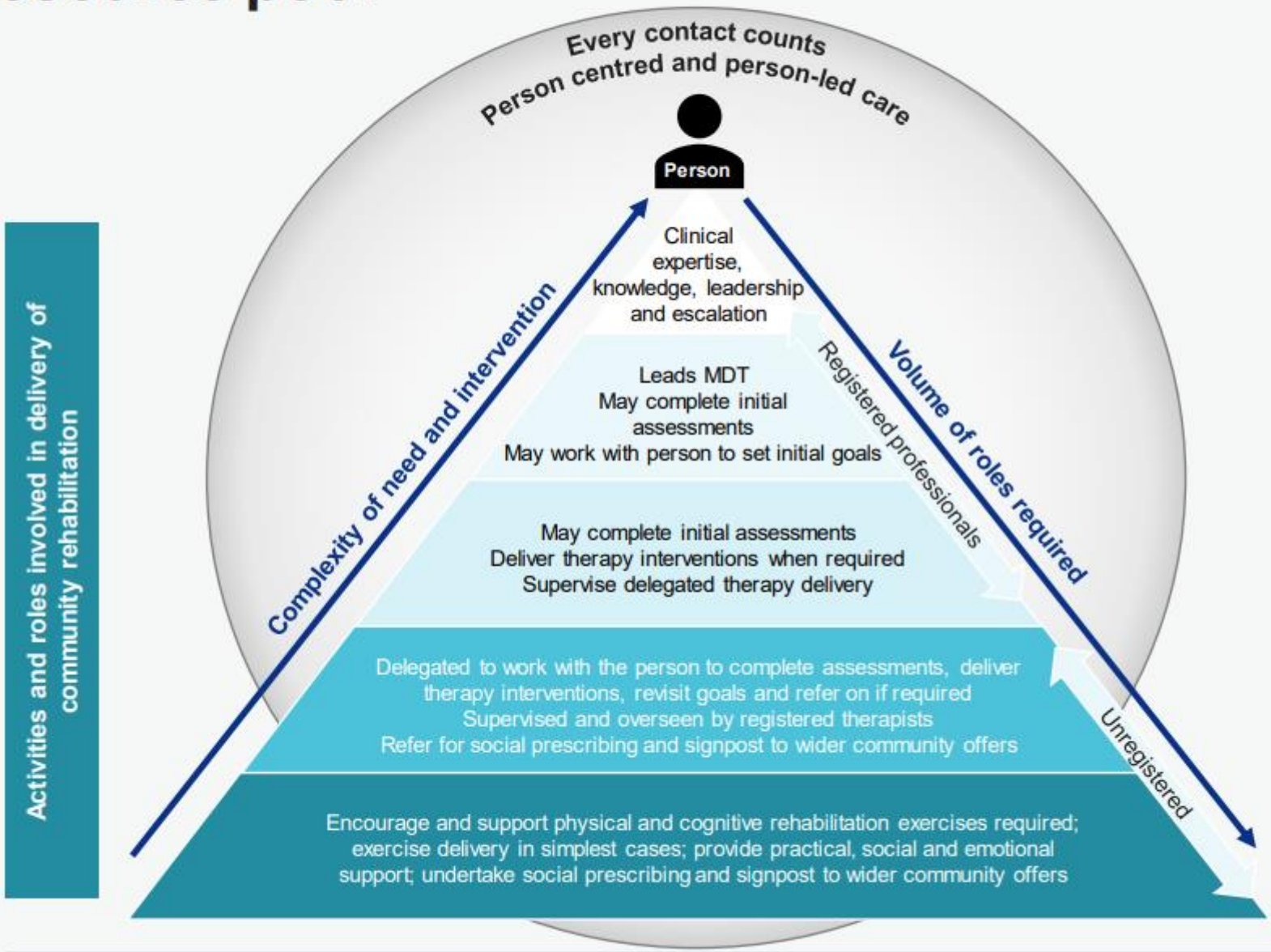
Describes timely delivery of rehabilitation interventions in the community, utilising a skilled unregistered therapy workforce where appropriate, and drawing on a wider resource pool and community assets to meet demand

D. Post intermediate care - Long term assessment, Audit and evaluation

Transition for a person's ongoing and longer term needs, and an audit of the service to drive improvement and reduce variation in practice

* Every person - includes people with dementia, delirium or cognitive impairment and people with a serious mental illness who can benefit from community rehabilitation
** National Quality Board definition of quality covering the elements: Personalised/Responsive, Caring, Safe, Effective, Well-Led, Sustainable, Equitable

Rehabilitation pyramid of expertise and wider resource pool



Wider care and support, specialist expertise and community assets who may also be involved include:

- Community nurses; GPs; community pharmacists
- community mental health and dementia teams
- palliative and end of life care teams
- learning disability and autism teams
- social prescribing link workers
- care-coordinators and health and wellbeing coaches; care workers
- social workers
- unpaid carers, families and friends
- voluntary and community sector workers and volunteers
- local authority housing and homelessness teams
- leisure industry workers

NHS England

Thank You

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How is the Intermediate Care Framework relevant to me?

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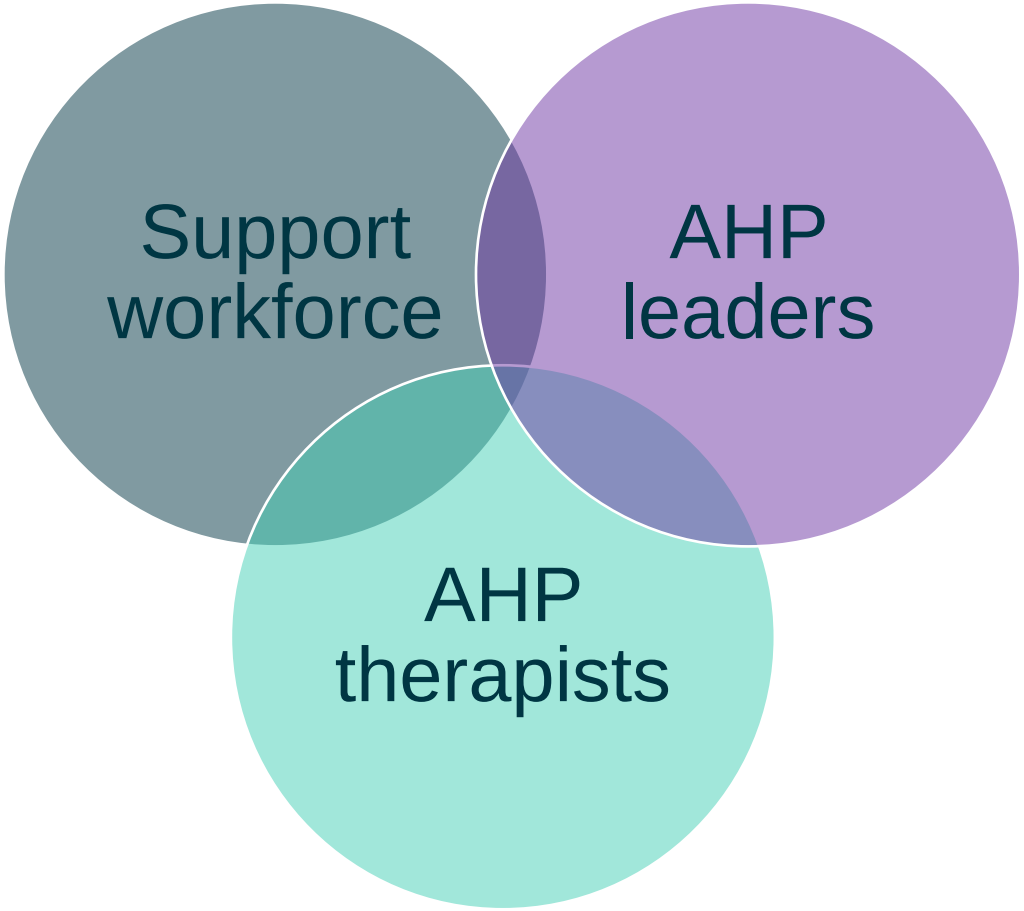
How is the Intermediate Care Framework relevant to me?



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How is the Intermediate Care Framework relevant to me?

Recommended actions:

- Find out how AHPs are involved in planning, developing and delivering intermediate care pathways in your system

- Consider how your existing services align with the framework and the rehabilitation and reablement model

- Use the FutureNHS Collaboration workspace to learn from frontrunners and network with other AHPs who are implementing the framework.

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Making best use of the multidisciplinary team

Delivery will be by a "multi-disciplinary workforce"

- **“Maximising therapy input, supported by new and blended roles" (Integrated Care Framework, 2023)**
- **AHPs are central to the Framework.**
  - The breadth of the AHP workforce
  - Capacity and skill mix
    - ➢ Deliver better care to meet someone's mental, physical, social and communication needs
- **The Framework invites us as AHPs to think differently.**
  - Retain your unique identity as a clinician but be embedded in the MDT
    - ➢ Meet population need

The Importance of data

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

<u>Recommended actions:</u>

- **Find out who your data people are**
- **Think about outcomes across the pathway – how will you evidence value**
- **Talk to staff and patients**

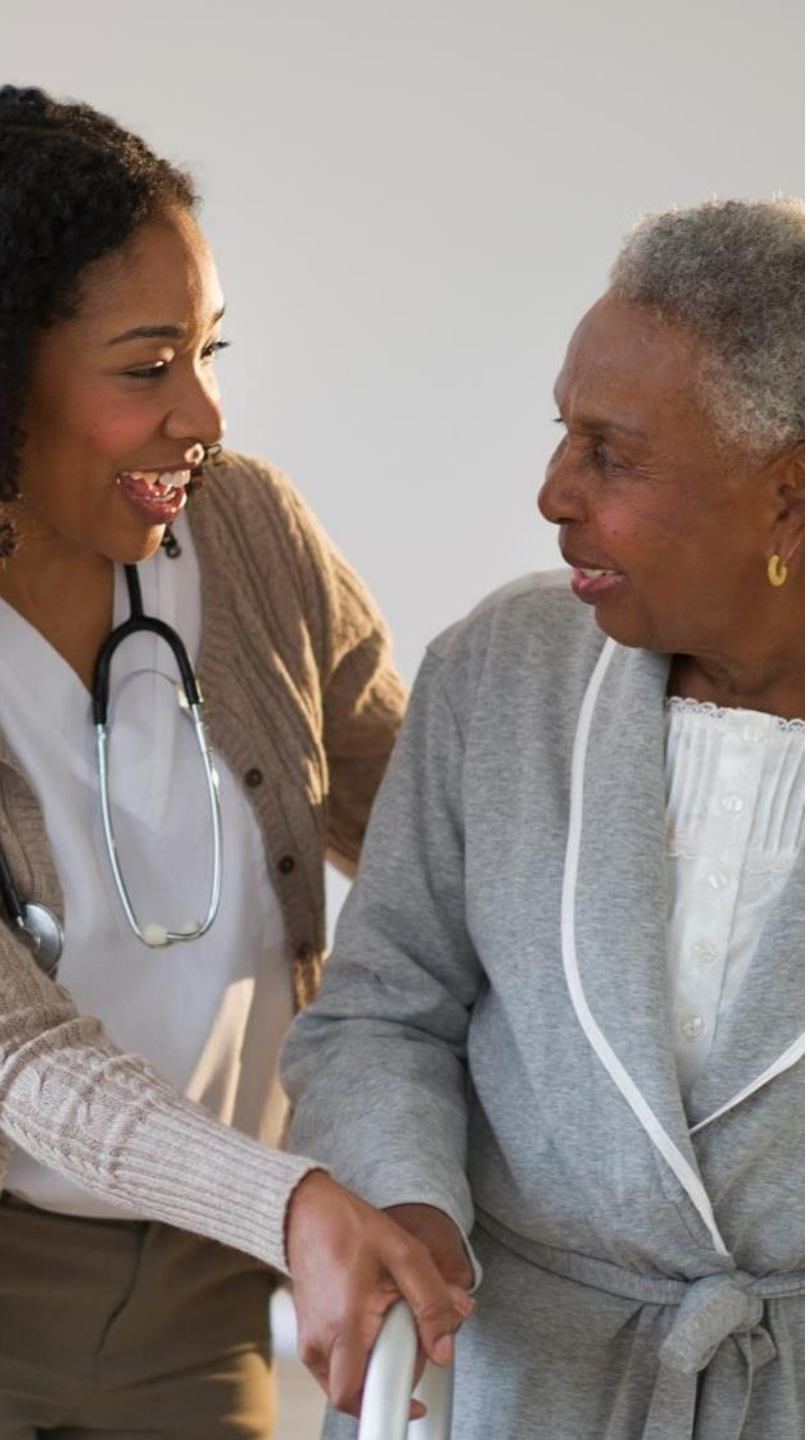
Home First Programme

Jen Throp – Programme Manager Home First Short Term Beds

Laura Falter – Clinical Lead Active Recovery

Brenda Thompson – Senior Speech and Language Therapist

HomeFirst Programme | Leeds Health & Care Partnership



Why redesign intermediate care in Leeds?

- Too many people spend more time in hospital than they need to
- Our short-term care in the community is provided across many different services
- Outcomes for people can vary depending on where, when and how they are supported
- We have a high use of bed-based care
- Many older people could reduce or avoid the deconditioning that has an impact on their independence and long term care needs

What did the evidence say to drive our ambition?

- **400+ more people** every year could be supported to recover at home
- People spend up to **twice as long** as they need to in a community bed
- **1,700 more people** could avoid admission to hospital
- **100 long-term residential placements** could be avoided each year with effective, consistent intermediate care

HomeFirst Programme Vision

Why is this a Priority?

For People

- Patients, service users and carers can have better, more independent, health and care outcomes
- Reduce harm that our system can cause
- Simple services, with Communication, Coordination, Compassion

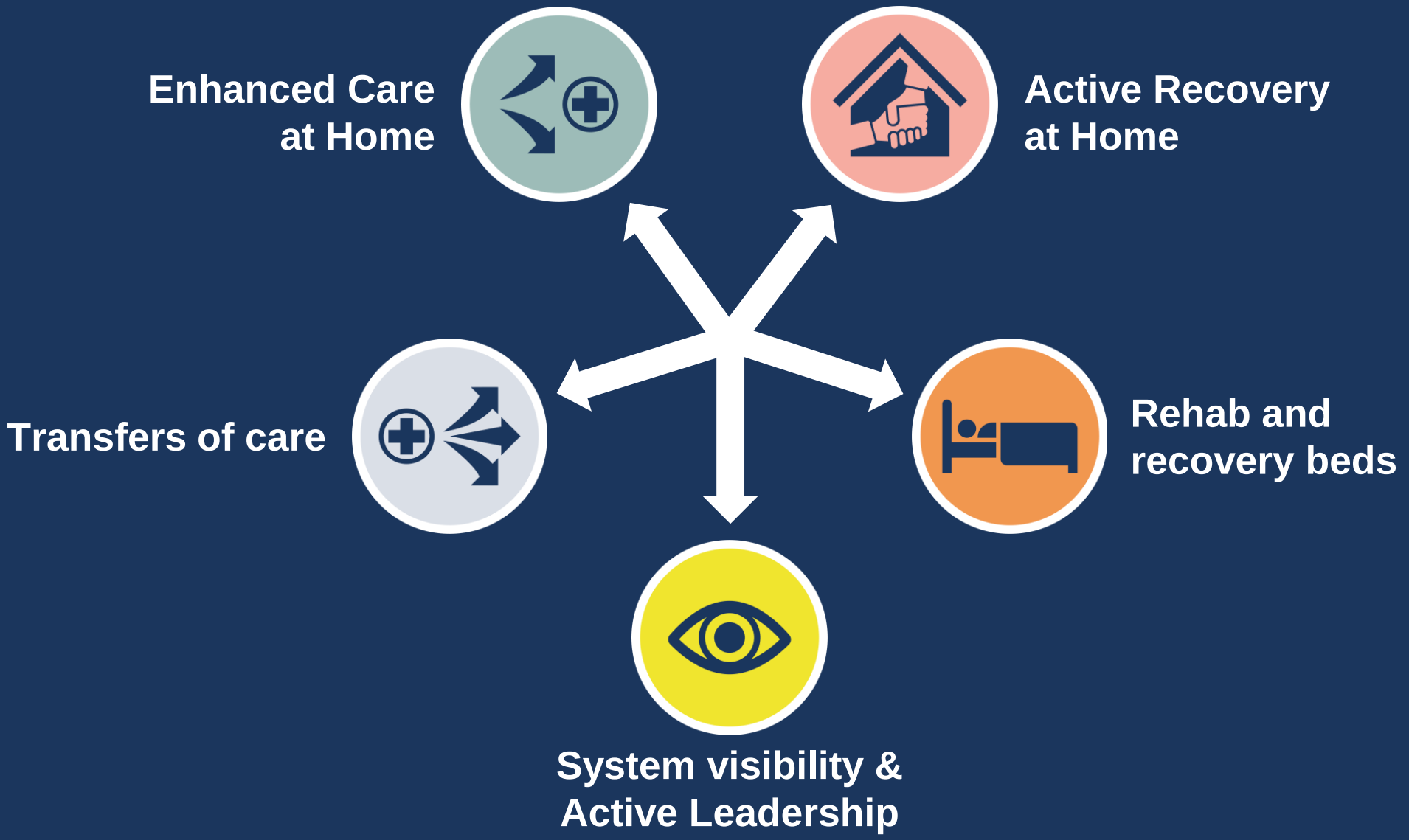
For Staff

- Reduce frustration of delays and lack of capacity
- Simpler, patient-focused processes and pathways
- Improved tools and systems

For the System

- Simplify our current fragmented offer
- Support system flow and reduce pressure
- More financially sustainable

5 Interdependent Projects



Active Recovery - Integrated Community Rehabilitation Offer

Better experience for the person, who has to tell their story once and, from their perspective, is supported by one team

Referral triaged by Active Recovery jointly with OT/PT and reablement. Assessment scheduled.

LCC Case Officers and LCH Therapists do a joint assessment (where needed and/or possible) and align Care Plans

Care is delivered by LCC staff working towards the SkILs Reablement Care Plan

Aligned care delivery by:
1) Joint weekly MDTs
2) Joint Daily Huddles
3) Joint Teams space
4) Co-location

Care is delivered by LCH staff working towards the Neighbourhood Team Care Plan

More independent outcomes by better coordination and working towards one set of goals

LCC = Leeds City Council
LCH = Leeds Community Healthcare NHS Trust

Active Recovery
A partnership between Leeds City Council (LCC) and Leeds Community Healthcare NHS Trust (LCH)

Active Recovery joint rehabilitation care delivery plan with Julia

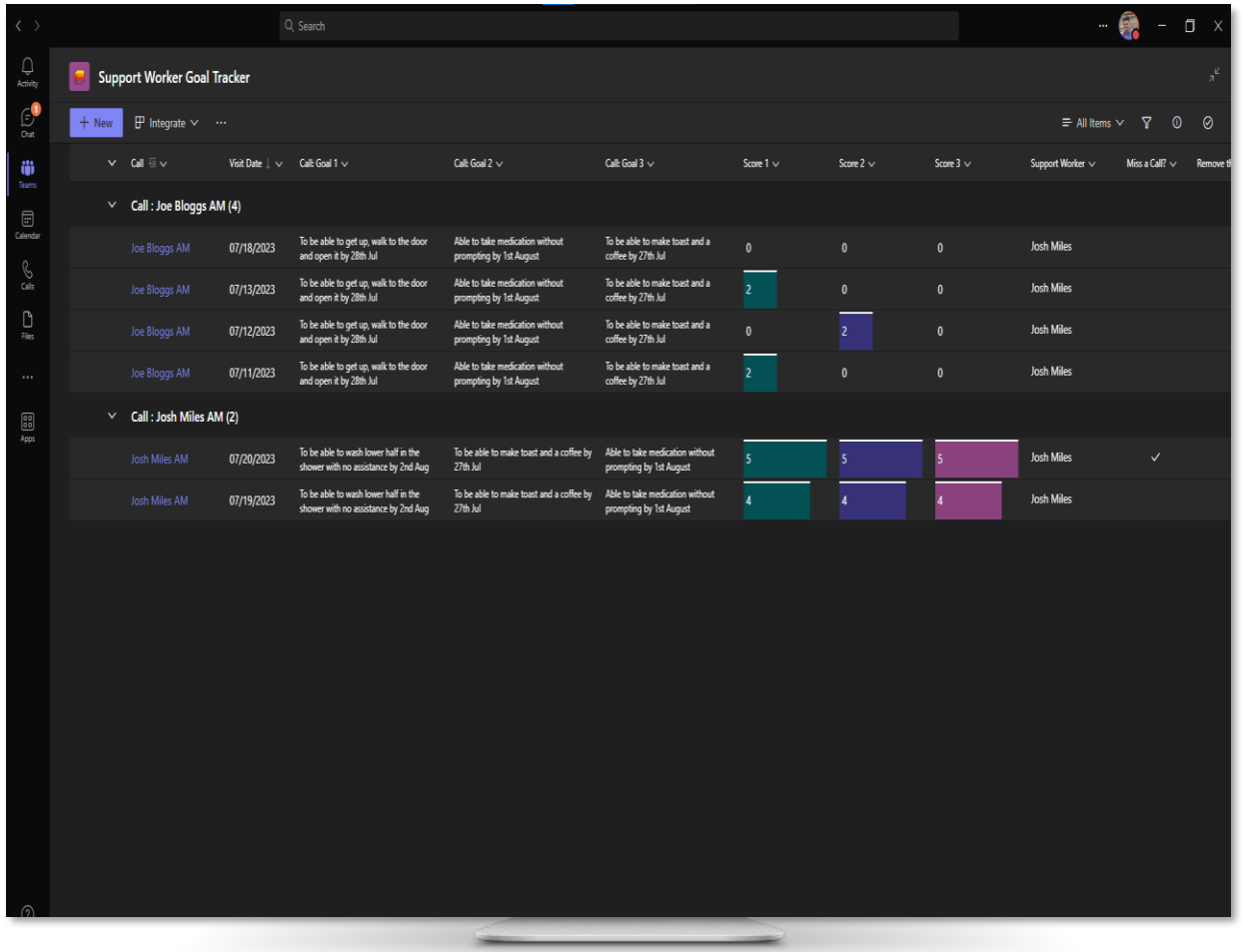
HomeFirst Programme | Leeds Health & Care Partnership

LCC Reablement

- Julia requested twice daily rehabilitation to regain personal care skills. Goals set with with OT/PT support.
- Rehabilitation approach and not ‘providing’ care.
- Joint visit with therapy assistants.
- Goal based and support worker goal tracker.
- Daily huddles and weekly MDTs.

LCH OT/PT

- Support plans focused on goals and independence.
- Assistive technology adaptation provided to make Julia safe.
- Risk assessments conducted.
- Mobility progression.
- Use of evidenced based outcome measure (TOMs).



Active Recovery
A partnership between Leeds City Council (LCC) and Leeds Community Healthcare NHS Trust (LCH)

Leeds Active Recovery Phase Two

Rehab & Recovery Beds – Key Components

Dedicated Adult Social Care Support	A dedicated social work representative for each bed base that has responsibility for every person admitted to that location to ensure joint decision making and better joint working.
Whole-team Rehabilitation Model	Training sessions with entire teams to ensure that everyone is clear on their role and delivering their part of the rehabilitation model. Introduction of a more formal structure to MDT meetings by formalising Chair and Challenger roles with a focus on goals based care and planning.
Progression and Tracking	Daily handovers focused on progressing individuals in their rehabilitation journey and towards discharge – submitting daily data to the Dashboard. Capturing MDT actions and progress data in the MDT tracker and reporting on it weekly.
Performance Visibility Dashboard	Performance data is analysed and visualised in a simple and clear, meaningful way to inform the operational governance.
Operational Governance Restructure	Setting up key touchpoints required at a service user, bed base, and whole service level. Ensuring we have the right people, information and structure to a continuous data driven improvement cycle.
Discharge Planning from Day 1	Ensuring that we have a clear plan for discharge and estimated discharge date as early as possible to enable accountability on the rehab journey and discharge plan.
Pharmacy assessment from induction	Ensuring that everyone has had the right level of assessment from admission to maximise their independence in terms of medicines management.

Challenges We Faced In Implementing The Changes

Culture Change

- The primary hurdle was changing **staff attitudes toward faster discharge,** what that meant for their job satisfaction and the patients they cared about.
- We tackled this challenge through various channels such as one-on-one discussions, comms from managers, sharing patient stories, and other methods, recognising that everyone would have to go through a **change journey which wouldn't be linear**.

Aligning multiple organisations on the same vision

- Keeping our core design group small, so we could **build relationships and make decisions quickly.**
- We didn't always get the right balance between **articulating a clear vision and keeping up engaging with multiple groups**, meaning there were times where some groups/individuals were not on the same page as us or weren't sure what the next steps were.

Finding the time to invest in people

- We had to find a balance between driving change at pace while also investing in people—enhancing their **skills, confidence, and relationships**.
- To achieve this balance, we held regular meetings with small groups of stakeholders to express concerns & offer insight. Despite the significant time investment, this approach proved highly valuable: fostering staff engagement, facilitating the better adoption of change, and enhancing job satisfaction.

Value and impact of Speech and Language Therapists in the short term intermediate care beds

Community referral model

Method	Outcomes
Referral sent to community teams	Delayed response to patient need
Urgent Response times between 2-6 weeks	Reduced nutrition and ability to participate in rehab
Routine Response times significantly longer	Uni-disciplinary working resulting in inefficiency and duplication
	Limited access to complete information
	Incorrect patient journey

SLT being integrated in MDT

Method	Outcomes
Attend MDT & daily meetings	Pull model of referrals by listening to safety huddles
Staff training	Urgent response to dysphagia and early intervention for communication impairment
Setting SMART goals	Reduced risk of aspiration/choking and maximising safe swallowing
Maximising communication support	Patient at centre of decisions
Timely intervention to manage risk	Improved therapy understanding of patients and their ability to identify symptoms of concern
Educating team around the patient e.g. carers and catering staff	

Value and impact of Speech and Language Therapists in the short term intermediate care beds

HomeFirst Programme | Leeds Health & Care Partnership

Community referral model

- Referral sent to community teams
- Initial presentation did not meet urgent criteria
- Would have been seen >18 weeks later unless swallowing deteriorated further
- Reduced nutrition and ability to participate in rehab
- Eating/Drinking at risk without support in place
- *Post discharge from ICB was referred to community – 7 month wait for input

SLT being integrated in MDT

- Meet James – admitted to ICB following hospital admission due to Covid 19 (Dec 2022)
- No SLT input indicated in hospital, PT input to improve mobility
- Carers noticed coughing when eating/drinking, family highlighted weight loss and concern about his understanding.
- Seen same day for SLT input, OT/PT input to improve mobility and ADLs
- Ax indicated possible aspiration and variable attention to task
- SLT provided recommendations to carers/therapists/nurse/ catering staff on swallowing and communication
- Immediate change in care plan to minimise risk and maximise participation in therapy
- Video fluoroscopy arranged for further swallow ax – revealed unsafe swallow on all consistencies
- SLT worked with DT, catering team, carers and family to maximise intake – EDAR in line with James' wishes
- His participation in PT/OT therapy increased enabling a discharge to his home (Jan 2023).

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CHARTERED SOCIETY OF PHYSIOTHERAPY

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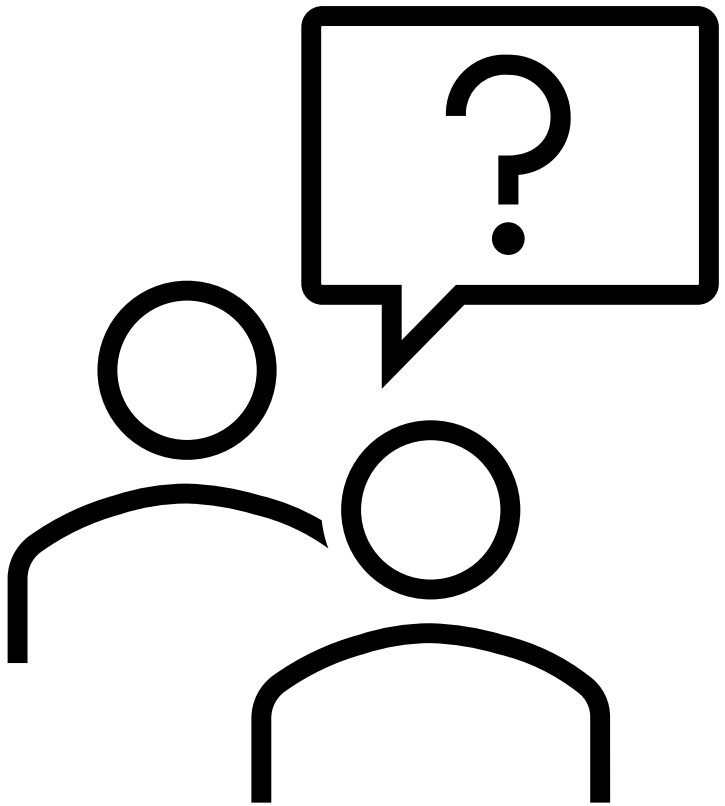
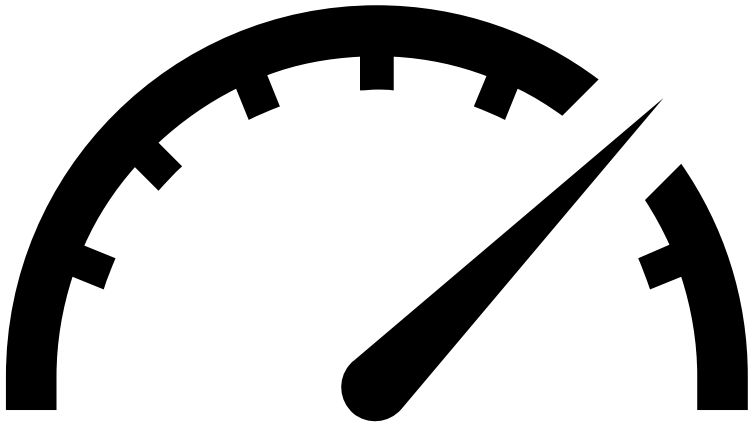


How do you feel now?



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