What works in delivering intermediate care services?

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> As an independent evaluator of seven NHS Vanguard projects, we have been exploring and sharing key learnings relevant to new models of health and social care.
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> Here we summarise best practice in the delivery of intermediate care services. This is based on our literature review[1] of national guidelines and reports from empirical research. We also highlight the key barriers to effective intermediate care delivery.
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> Please get in touch with our Head of Research, Dr Stephen Boxford, for more detail or to continue the conversation.

1 Context

1.1 What is intermediate care?

1.1.1 Aims

The National Institute for Health and Care Excellence (NICE) describes intermediate care as covering a range of integrated services that aim to (NICE 2017):

- 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.

The focus of intermediate care services is on enabling patients to return to their usual place of residence. Intermediate care is *not* synonymous with transitional care pending longer-term placement (i.e. assessment placements or interim placements), and does not include rehabilitation as part of acute hospital care (Lane 2005).

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[1] If you would like details on the methodology used for the literature review, or a full bibliography, please get in touch with the Cordis Bright research team: info@cordisbright.co.uk

1.1.2 Service model

Intermediate care services are usually delivered for no longer than six weeks and often for as little as one to two weeks (NICE 2017).

The National Audit of Intermediate Care identifies four key service models of intermediate care (NHS Benchmarking Network 2014):

- bed-based intermediate care;

- home-based intermediate care;

- crisis response; and

- reablement.

Intermediate care services can be delivered in a range of settings, including community settings; residential and nursing care homes; dedicated intermediate care and reablement facilities; acute, community and day hospitals; and prisons (NICE 2017).

1.2 Is there a target group?

There is no specific target group. However, most people accessing intermediate care are older: the King's Fund reported that the median age of people using intermediate care or reablement services in 2013 was 83 (Oliver et al. 2014). Accordingly, this best practice review focusses on intermediate care services for older people.

1.3 What is the policy context and what does it look like in practice?

The concept of intermediate care was developed by the Department of Health in 2000 with the intention of reducing pressures on health and social care by supporting people to remain at home or return home (NICE 2017). It has been a policy imperative for the provision and commissioning of care for older people since the Department of Health's National Service Framework for Older People was introduced in 2001 (DoH 2001).

However, the development of community rehabilitation and intermediate care services across England and Wales has not been uniform. Many studies, literature reviews and meta-analyses highlight substantial variation in size, configuration and working practices of intermediate care services (see for example Ariss et al. 2015; Beswick et al. 2008).

2 Best practice in delivering intermediate care

2.1 Overview

There is a wide evidence base regarding the elements of practice that make for more effective intermediate care services. In the following sections we summarise these elements of best practice and the surrounding evidence base.

In the first section we explore official guidelines from NICE, and the relevant evidence base. In the second section we highlight other elements of best practice that emerge from research in the wider body of literature. In the third section we highlight barriers to effective practice that have been identified through research and evaluation.

2.2 Best practice from NICE guidelines

Figure 1 outlines evidence-based best practice elements drawn from the NICE guidelines on Intermediate Care [(NICE 2017)][2]. In this section we provide further detail on each element, and discuss the supporting evidence base identified through our review.

Figure 1: Summary of NICE Best practice guidelines for intermediate care

Service domain	Best practice element
Core principals to apply across the whole intermediate care pathway	Collaborative, person-centred care
	Communication between professionals
	Information and communication with service users
Infrastructure and staffing	A range of different and integrated service models
	Multi-disciplinary and flexible staff teams
	Skilled and well-trained teams
	Clear route of referrals
Delivery	Inclusion
	Promptness
	Clear, relevant and person-centred care plans

Source: NICE Guidelines on Intermediate Care including Reablement ([NICE 2017]))

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[2] These guidelines aim to bring greater coherence and parity in intermediate care delivery across the NHS.

2.2.1 Collaborative, person-centred care

> NICE states that intermediate care practice should be person-centred throughout the care pathway. This means that people should be involved in the planning of their own care and setting of goals. Eligibility should be considered on a case by case basis. Contracting and monitoring processes must be flexible to facilitate this way of delivering care (NICE 2017).

Planning and delivery of care

There is a strong evidence base for the importance of flexible and person-centred care in supporting people to regain or retain their independence through or after ill-health (see for example, Tessier et al. 2016; Coulter et al 2013; Wood and Salter 2012). This is particularly the case for older people with multiple and long-term conditions.

Interventions and care planning that focus on a single long-term condition can lead to chaotic care for patients with multiple conditions (Roland 2013; Haggerty 2012; Beales and Tulloch 2013; Barnett et al. 2012). Research suggests holistic approaches, where care reflects the person's own circumstances and preferences, to be more effective (see Coulter et al. 2013; Wood and Salter 2012).

Person-centred approaches have also been found to support interdisciplinary collaboration: a qualitative study in Norway (Birkeland et al. 2017) found that reablement was more effective when goals were defined by the patient, and that the plan could become a unifying objective between professionals with different disciplinary approaches and priorities.

The "House of Care" model of care for people with long-term conditions, developed by the King's Fund (Coulter et al. 2013) in collaboration with health and care practitioners, also provides a model for the provision of person-centred care. The model takes a collaborative approach to planning care, with people with long-term conditions co-producing a single holistic care plan with their care co-ordinator.

Contracting and funding

The King's Fund emphasise that rehabilitation and reablement services should be flexible to accommodate changing needs (Oliver et al. 2014). People should be able to move when they are ready, and also receive services for longer than six weeks if necessary. To achieve the flexibility needed, The King's Fund recommend that contracting and commissioning are based on the outcomes desired for an individual, rather than on set time periods or tasks. A report from Social Care Institute for Excellence (SCIE) on maximising the potential of reablement also suggests that lump sum payments for providers could facilitate the increased flexibility required in order to adjust support according to changing needs (SCIE 2017).

2.2.2 Communication between professionals

> NICE highlights the need for good communication between practitioners and other agencies in order to coordinate care and to ensure practitioners referring into the service understand it. Communication mechanisms may include multidisciplinary team working practices, joint meetings and training (NICE 2017).

The importance of good inter-agency and inter-professional communication throughout the intermediate care pathway is highlighted across best practice, research and evaluation literature. For example, a 2006 national evaluation of the costs and outcomes of intermediate care for older people outlines the importance of shared information, communication and joined-up working in referral processes across statutory services: it highlighted that teams who refer into intermediate care should have a clear understanding of services to be able to refer effectively (Barton et al. 2006).

A 2014 review of the literature on health care systems fit for older people by The King's Fund emphasized the importance of good inter-agency communication to deliver truly person-centred care plans (Oliver et al. 2014). The review noted that individuals will have personalised and multi-disciplinary aims (for example, around mobility, continence and daily activities) and that an effective plan to meet these aims therefore requires joint-working and effective communication between local health, social care and even housing services.

Research on reablement, in particular, also supports these findings. A systematic review (Tessier et al. 2016) highlights the use of thorough and consistent recording systems as important for multidisciplinary teamwork. Likewise, a study of Norwegian healthcare professionals working in reablement (Birkeland et al. 2017) finds that good communication and shared planning play a key role, especially given the multi-disciplinary approach needed in reablement services.

2.2.3 Information and communication with service users

> NICE states that mechanisms should be in place to ensure good communication between practitioners, service users and their families and carers. Service users should always be given the information and support they need to make decisions about their care. This should be provided in an appropriate format and language (NICE 2017).

Our rapid evidence review found few studies that focussed on the importance of information and communication between practitioners and service users or their families as a key component to effective intermediate care. That said, transparency and access to information is implicit in the principal of person-centred care, which is consistently identified as core to best practice in both research and guidelines.

2.2.4   A range of different and integrated service models

> NICE states that a variety of intermediate service models are required to meet diverse support needs. These services should all be available locally and integrated, allowing easy movement between services as and when support needs change. NICE suggests this would require: a single point of access; a single accountable person; single assessment process; shared understanding of the aims of intermediate care; and agreed approach to outcome measurement across all the intermediate care services (NICE 2017).

A 2015 literature review and secondary analysis of community rehabilitation and intermediate care found no intermediate care service model would consistently achieve a specific impact on admission or readmission to inpatient hospital care (Ariss et al. 2015). Instead they suggested other factors are more important in determining the risk of hospital (re)admission. These other factors include the degree of integration across the acute and secondary care interface, or the capacity for a patient's (sometimes complex) needs to be met within the community.

2.2.5   Multi-disciplinary and flexible staff teams

> NICE states that team composition should reflect the range of needs and circumstances of the people using the service, including a range of disciplines such as nursing, social work, occupational therapy and physiotherapy. Staff members should be able to work flexibly, and follow a person throughout their care pathway (NICE 2017).

The importance of the interdisciplinary team is identified extensively in many literature reviews, secondary analyses and meta-analyses (for example, Beswick et al. 2008; Ariss et al. 2015). For example, a literature review and secondary analysis of datasets from two intermediate care projects finds that interdisciplinary teamwork is associated with better outcomes for patients in intermediate care services (Ariss et al. 2015). It also finds teams that included clinical support and domiciliary support staff were associated with a small improvement in patient outcomes compared to other teams.

UK case studies of intermediate care showed service users felt positive about being able to access expertise from diverse professionals; and that practitioners working in this way welcomed the increased opportunity to work more flexibly and undertake tasks which would "normally" be performed by others (Regen et al. 2008).

2.2.6   Skilled and well-trained teams

> NICE highlights that all staff should understand the ethos of intermediate care, i.e. care that is person-centred and supports people to build independence. Staff should know how to respond to common conditions and needs, and have the skills to support people regain as much independence as possible, including positive risk taking (i.e. enabling people to make informed decisions to take risks as they choose) (NICE 2017).

This best practice recommendation is identified in a range of additional evidence-based best practice literature including research by the King's Fund (Oliver et al. 2014) and SCIE (2017).

Research highlights that staff teams need to have a shared understanding of the aim of intermediate care (i.e. independence) and be able to "stand back" and support positive risk taking (Glendinning et al. 2010; Tessier et al. 2016). Qualitative research suggests training and regular supervision for staff teams is important and helps achieve this shared vision and approach. This is particularly important when staff are recruited from conventional home care services, because reablement's focus on independence and positive risk taking requires a different way of working and a different skillset (Glendinning et al. 2010).

In addition to training in the principles of reablement/intermediate care and ensuring intermediate care practitioners are suitably skilled in their specialist skillset, Glendinning et al.'s research identified that generalist training on dementia or mental health problems was needed to ensure and enhance the effectiveness of reablement (Glendinning et al. 2010).

2.2.7 Clear route of referrals

> NICE states that there should be clear referral routes into commonly used services that are external to the intermediate care team, for example GPs, mental health and dementia services, housing services, diagnostics (NICE 2017).

This is an important factor in assuring promptness of care. See section 2.2.9 for more detail.

2.2.8 Inclusion

> NICE states that people should not be excluded from intermediate care based on a particular condition such as dementia, or particular circumstances, such as being in prison, residential care or temporary accommodation (NICE 2017).

This is in keeping with person-centred approaches to care in that all potential service users must be assessed for eligibility on a case-by-case basis. The key factor in determining a person's eligibility for intermediate care is that the care delivery model must be able to meet the individual's specific needs and provide them with an opportunity to regain or retain independence (Ariss et al. 2015).

That said, systematic reviews of reablement and intermediate care suggest that some groups are more likely to benefit from intermediate care. A systematic review of reablement (Tuntland et al. 2017) found the following factors were significant predictors of successful outcomes: being female; having a fracture as the major health condition; and high motivation for rehabilitation. Significant predictors of poorer outcomes were: having a neurological disease other than stroke; dizziness or balance problems being the major health condition; or having pain, discomfort, anxiety or depression. These findings are supported by another systematic review of reablement, which found it to most benefit

people recovering from falls or fractures, and that people needing ongoing support with dementia or mental health problems benefitted less (Tessier et al. 2016).

Other research has concluded, based on an evidence review and secondary analysis of data from 7,620 intermediate care patients, that intermediate care is more likely to benefit older people with selected long-term conditions where there is potential for rehabilitation (Ariss et al. 2015). This study also identified factors associated with low rates of transfer to inpatient hospital care among intermediate care patients: low need ratings on Levels of Care data, and being resident in nursing home care. For the latter, the authors suggest that even when care needs are high or complex, the surrounding environment, care plans and policies may still be conducive to receiving intermediate care in situ.

2.2.9 Promptness

> NICE emphasizes the importance of promptness. A crisis response should be started within 2 hours following receipt of a referral. A move to bed-based intermediate care should happen within 2 days of referral (NICE 2017).

The NICE guidelines state that delays to starting bed-based intermediate care increases the likelihood of deterioration in health and anxiety reducing the likelihood of successful intervention.

Our literature review did not identify evidence on the importance of prompt responses regarding crisis response and transfers to bed-based intermediate care. However, research has shown timely access to equipment is an important factor in the success of home care reablement services (Glendinning et al. 2010; Tessier et al. 2016). Likewise, rapid assessment for services and quick access to specialist services such as occupational therapy and physiotherapy have also been shown to be important in order for intermediate care to be effective (Glendinning et al. 2010; Tessier et al. 2016; Wood and Salter 2012). Speed of access has been shown to be more important than whether the specialists are actually employed within the range of integrated intermediate care or are simply an external referral partner (Glendinning et al. 2010).

2.2.10 Clear, relevant and person-centred care plans

> NICE states that care plans should be person-centred, outcomes-focussed, clearly documented and reviewed regularly. They should be co-produced with the person and/or their family/carer, in keeping with principles of person-centred care. This also applies to transfers between or out of intermediate care services, which should also include a contingency plan (NICE 2017).

In addition to the evidence identified around person-centred care (see Section 2.2.1), findings by other primary research and systematic reviews support this recommendation. For example, the following factors have all been shown to be important in assuring an effective home care reablement service: high quality initial assessments by senior reablement staff; clear and achievable goals negotiated with users; regular reassessment; and flexibility in content and duration of reablement (Glendinning et al. 2010; Tessier et al. 2016).

Reviews from Demos (Wood and Salter 2012) and The King's Fund (Oliver et al. 2014) also highlight the importance of planning for necessary on-going care once the period of reablement is completed, particularly for vulnerable older people. The transition and on-going care plan (and responsibility for provision of services) should be specified in the provider's contract. Where an older person is not eligible for ongoing health or social care, but is in need of additional support, the intermediate care team should support and signpost the person and their carers to voluntary sector support such as befriending services.

2.3   Best practice from other sources

Our review of the literature also identified some additional success factors that support the effective delivery of intermediate care services.

2.3.1   Clarity about aims, potential and limitations

A comparative mixed-methods study identified the importance of clarity among staff about the aims, potential and limitations of home care reablement (and, by default, other intermediate care services). This includes both the intermediate care team and external health and social care practitioners who deal with referrals into or transitions out of intermediate care services, such as hospital discharge planning staff and adult social care managers (Glendinning et al. 2010).

2.3.2   Long-term care capacity

Individuals who need continuing help at the end of a reablement package may need to be transferred to long-term care services. The Glendinning et al. study also highlighted that adequate capacity in long-term home care was needed to avoid reablement services becoming *"blocked"* by clients awaiting transfer to long-term care (Glendinning et al. 2010).

2.4   Barriers to effective delivery of intermediate care

Our review also identified five key barriers to effective intermediate care. These are summarised below:

2.4.1   Perceived shortage and short-term nature of funding

Evidence from a 2008 national evaluation of intermediate care services by the Leicester Nuffield Research Unit found perceived shortages of funding to be a key barrier to effective practice (Regen et al. 2008). Interviewees across five sites highlighted short-term, non-recurrent funding for intermediate care and the widespread use of short-term appoints acted as an impediment to service development in the medium to long-term. The evaluation also highlighted wider sectoral financial pressures that meant the health and social care services underpinning intermediate care were frequently under-funded themselves.

2.4.2   Staff recruitment and retention

The same 2008 national evaluation (Regen et al. 2008) found that stakeholders across all five intermediate care case study sites identified the recruitment and retention of (qualified

and non-qualified) staff as the most significant challenge to the implementation of intermediate care services. The two main factors in this were insufficient funding and the difficulty of attracting staff to posts. Professionals were deterred from posts for reasons including the potential for professional isolation (i.e. working in small, multi-disciplinary community-based teams) and poor awareness of intermediate care. For support staff, deterrents included low wages and unsociable hours.

2.4.3   Low buy-in from medical professionals

Lack of support for intermediate care from the medical profession was also identified as a barrier to the development and use of intermediate care services across the five case studies sites (Regen et al. 2008). Doubts from the medical profession were linked to concerns about insufficient evidence for effectiveness and fear that the aim of keeping older people out of hospital could be discriminatory. However, it should be noted that this research was conducted ten years ago, and attitudes may now have changed.

2.4.4   The acute care agenda

The Regen et al. evaluation (2008) also reported that people interviewed at case study sites were concerned intermediate care was becoming dominated by an acute care agenda that was aiming to free up beds rather than aiming to support personalised approaches to maximising recovery and supporting individuals' independence.

2.4.5   Social and environmental factors

Intermediate care is not the only factor that supports an individual's independence. Social, psychological and environmental factors are also key factors that can impede or facilitate positive outcomes. For example, Demos highlight how a reablement programme that focuses too narrowly on home tasks can be ineffective at reducing the risk of hospital admission, and that individuals need to also be supported to re-engage with their community networks (Wood and Salter 2012). Likewise, Tessier et al.'s systematic review on effective reablement concludes that addressing psychological and social needs is a vital part of the recovery process (Tessier et al. 2016), while Greyson et al.'s qualitative study provides further detail on how social, functional and environmental aspects necessary for the recovery process can be overlooked by services, and that these factors may hinder recovery once older adults return home (Greyson et al. 2015).