Report to Health in Hackney Scrutiny Commission

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Nina Griffith and Mark Watson

Intermediate Care Beds (ICB)

Purpose of Paper

1. Define Intermediate Care (IC).
2. Describe the current provision and plans for the service.
3. Detail current usage of intermediate care beds
4. Describe arrangements following the closure of Median Road

1. Definition (s)

The Plain English Campaign definition of intermediate care services utilised by the National Audit on Intermediate Care is as follows:

What is intermediate care?

Intermediate care 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.

Crystal Mark 21029 Clarity approved by Plain English Campaign

What are the aims of intermediate care?

There are three main aims of intermediate care and they are to: -

- Help people avoid going into hospital unnecessarily;
- Help people be as independent as possible after a stay in hospital; and
- Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?

Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered?

A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

There are typically four pathways of intermediate care:

i. **Reablement –** provides support in a person's own home to improve their confidence and ability to live as independently as possible. Their goals are likely

to relate to daily living tasks such as getting washed and dressed, preparing a drink or light snack, moving safely around the home or enabling participation in social activities. Specially trained social care support staff visit daily. Their focus is on observing, guiding and encouraging people to do things independently, in order to rebuild the confidence and skills that may have been reduced while unwell.

ii. **Home-based intermediate care –** provides support in someone's own home or a care home if that is where they normally live. The person works with a multidisciplinary team of health professionals and possibly a social worker to agree goals and the type of support they need. It is predominantly delivered by health professionals and might involve nurses; physiotherapists who can provide tailor-made exercises to help them become stronger and move safely from place to place and any aids to help mobility; and an occupational therapist who can help find ways to continue to do daily living tasks more easily and safely.

iii. **Bed-based intermediate care –** involves a temporary stay in a care home, community hospital or standalone intermediate care facility, where a person receives support similar to home-based intermediate care, to help reach their goals. The sooner after referral bed-based intermediate care starts, ideally within two days, the better the chance of success.

iv. **Crisis response –** offers a prompt assessment at home or on arrival at the emergency department. This is to decide if a person's needs can be managed safely by providing short-term care at home (typically less than 48 hours) or, if more appropriate, by arranging a short stay in a care home. If they can, the individual avoids an unnecessary hospital admission and their recovery and a fuller assessment can take place in a calmer, more familiar environment. Staff may decide a person would benefit by moving on to another type of intermediate care.

Interim beds

Interim beds are different from intermediate care beds and are outside the scope of an intermediate care service.

Residents are typically placed in interim beds when they do not require medical care but are unable to stay at or return home. This may be because it is not safe, or an assessment is required to determine a person's long term care and support needs. Following an assessment, an individual may need to move to alternative accommodation or receive a package of community support including adaptations in their home. They may also need to wait for a short period for suitable, alternative housing or a care home to become available. A further distinction is that no active rehabilitation or re-ablement occurs within an interim bed environment.

2. Background and Strategic Context

Intermediate care, whilst a service for all adults, is primarily a service for older people, with the majority of admissions being of people aged over 75 years and more than half

of people aged over 85 years. The National Service Framework (NSF) for older people, which established the concept of intermediate care, recognises intermediate care as a key service for older people. In particular, it reflects the emphasis and urgent need to reduce the demand for excessive and unnecessary use of hospital care and more intensive health and social care interventions. In the most recent data for bed based intermediate care, 93% of people improved or maintained their dependency score (NAIC 2015).

The NSF standard[1] is still relevant to the effective operation of intermediate care;

> *"Older people will have access to a range of new intermediate care services at home or in designated settings, to promote their independence by providing enhanced services from the NHS and Councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care."*

The key strategic aims of intermediate care are:

- Reduction in avoidable emergency ambulance and GP call-outs.
- Reduction in avoidable emergency department attendances and emergency admissions and readmissions.
- Reduction in demand for long-term high intensity care packages including nursing and residential care.
- *Safe and sustainable* discharges from hospital.
- Potential reduction in hospital lengths of stay and excess bed days.

3. Current local Intermediate Care Service:

Locally, City and Hackney's intermediate care is provided by the Homerton University Hospital Foundation Trust's Integrated Independence Team - known as IIT.

The Integrated Independence Team (IIT) was established as a fully integrated health and social care intermediate care service in November 2016. The team provides a crisis response, home treatment and reablement service.

IIT manage arrangements for individuals requiring an intermediate care bed. Where needed, these have been provided predominantly at St Pancras rehabilitation unit. Accessibility to these beds has been variable and especially difficult to gain access to during winter pressure months.

[1] Web address: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/198033/National_Service_Framework_for_Older_People.pdf

Prior to the IIT, intermediate care beds in Hackney were provided at Median Road Intermediate Care Unit (MRICU). This was closed in March 2015.

Two reviews of the need for a local intermediate care bed facility were completed after the closure of MRICU: the City and Hackney joint intermediate care commissioning strategy in March 2016; and the independently commissioned review by Cordis Bright. The recommended number of beds from these reviews ranged from 10 to 20. The National Audit of Intermediate Care (NAIC) reflects the need and benefits of intermediate care beds, although the national trend is that the number of beds provided has decreased year on year since 2015.

4. Audit of need of bed based intermediate care

Since the landscape has changed with IIT in place for three years, and no local bedded provision available, an audit was undertaken to identify the current demand for intermediate care beds.

4.1. Audit methodology

An audit took place between November 2017 and March 2018 where data was collected from the following sources:

- Geriatrician at the front door (GFD): dedicated geriatrician time for three months between November 2017 and February 2018 was allocated to enable Monday-Friday am cover of the hospital "front door" (Emergency Department, Observational Medical Unit, and Acute Care Unit) at Homerton Hospital. There were six days in total over this period when no GFD was available due to other clinical priorities. The primary aim of the geriatrician is to provide an assessment and clinical planning to patients aged 65+ with one of the audit fields being to identify if any patient would benefit from an intermediate care bed. In total, 281 patients were seen of which 32 patients were identified as candidates for an intermediate care bed admission (step up).

- IIT 30 day re-admission data: data was extracted from RIO (a hospital IT system) for all patients referred and accepted by IIT who had a Homerton Hospital admission between October and December 2017 (13 weeks) and were re-admitted within 30 days of their previous admission. The clinical notes in both EPR (another hospital IT system) and RIO were reviewed for each re-admission episode where the question was asked if intermediate care bed availability might have prevented the re-admission. A total of 81 patient records were reviewed of which 27 were identified as potential admission avoidances if an intermediate care bed had been available.

- IIT Home Treatment and Re-ablement (HTR) patients: a prospective audit over 8 weeks was undertaken to identify any patients who could either be admitted

to an intermediate care bed for step up (72 hours acute assessment) or stepped down (benefit from intensive rehabilitation). A total of 10 patients were identified for step down. The step up patients were excluded as these would be the same cohort of patients identified via the GFD and re-admissions audit data.

- Elderly Care Unit (ECU) audit: a rota for IIT clinical staff to attend the Multidisciplinary Meeting and whiteboard meetings on ECU was drawn up for a period of two weeks with an aim to identify any patients who could be stepped down into an intermediate care bed. In total 9 MDM/whiteboard meetings were attended, a total of 2 patients were identified for step down.

- St Pancras and Bridges Units spot purchased activity: the total intermediate care bed days for the past 12 months data was reviewed. Some level of modelling was required in terms of "length of stay" and actual demand given St Pancras and Bridges are outsourced and out of borough rehabilitation units and not exclusively intermediate care bed units. Nonetheless, these data provide an indicative level of demand, especially for patients admitted from neighbouring acute hospitals who are above the threshold for IIT intervention. These data also included those patients (n=8) referred and accepted for St Pancras but who were not admitted.

The GFD and 30-day re-admission data were cross matched as this cohort of patients would potentially be double counted, i.e. those seen at the hospital front door. The admissions to St Pancras and Bridges are estimated to have a longer length of stay than a fully integrated intermediate care bed unit would, consequently the overall number of bed day demand would be expected to be 2-3 weeks instead of the 5.4 weeks achieved at these units.

4.2. Findings and discussion

The audit data demonstrates that there remains a need for intermediate care beds but on a much smaller scale than previously identified.

Data Source	Period	Step Up Beds	Step Down Beds
Geriatrician at the front door (Emergency Department,	Nov 2017 - Feb 2018	1-2	0
IIT 30 Day re-admission data	Oct 2017–Dec. 2017	1*	0
IIT HTR community data collection	Feb 2018–March 2018	0	1-2
St Pancras/Bridges Rehab units	April 2017- March 2018		2
HUH Elderly Care Unit ward audit	February 2018	0	0
Total		1-2**	1-2**

* Data for this removed from the total as it would be the same or similar patients seen with the geriatrician at the front door group.

** Demand for the beds will fluctuate.

Triangulation of this data with other data sources and discussion with clinicians in the hospital and IIT confirmed that these numbers were felt to be a true reflection of demand. Homerton Elderly Care Unit has a very low length of stay and paired with a well-functioning Integrated Independence Team and Integrated Discharge Service, with associated local pilots such as Rapid Discharge and Discharge to Assess (D2A), means the demand on intermediate care bed is far less than previously modelled. This is unsurprising given the modelling for intermediate care bed demand preceded these services being established and embedded.

Despite the need for beds being potentially quite small, clinicians in IIT did confirm that local beds would be beneficial to patients.

The delivery of these beds is challenging as the cost to set-up and manage a dedicated unit of this size would not be economically viable.

4.3. Options

In the longer term, broader changes to the health and care landscape through the neighbourhood model are likely to shift this picture further. However, the following options for provision of beds over this period have been considered:

Step Up and Step Down Options

Step up Option	Advantages	Disadvantages
Combined step up and step down four bed unit in the community (Hackney) managed via IIT.	● Bespoke infrastructure ● Integrated model ● Local and locally provided	● Cost will be high as capital investment required and then ongoing operating costs will be high per bed day due to small scale ● Physical location limitations in Hackney ● No direct on-site access to diagnostics ● Long-term lease, what if demand decreases?
Two assessment beds located within HUHFT	● Cost efficient ● Diagnostic access ● On the same site as IIT	● Identification of space at HUHFT

	● If acute admission required, no patient journey required	● Cultural challenge of delivering a real intermediate care service within an acute ward - service models and approach are very different. ● Management of gender specific beds will be challenging
Do nothing/continue with current arrangement of admissions to HUHFT. i.e. patients that can be safely supported at home will be, those that need a bed will be admitted	● No additional investment required ● Place of safety for patients (medically and if social admission)	● Opportunities for admission avoidance limited
Step Down Options	**Advantages**	**Disadvantages**
Do nothing/continue with existing arrangement which is spot purchase beds at units in other boroughs- e.g. St Pancras	● No set-up costs ● No recruitment and staff management ● No requirement to identify physical location	● External provider and consequently not integrated with City and Hackney ● Rehab unit vs. intermediate care ● Not in Hackney ● Cost per bed day high ● Access to beds limited and variable
Identify two beds within an existing Hackney provided facility	● Reduced cost ● Night observation possibly covered ● Local ● Enable IIT in-reach and continuity of care	● Compatibility with existing patient cohort could be an issue ● Travel distance from IIT may be inefficient ● Resources, e.g. gym, dining area, Activities of Daily Living facilities unavailable at some sites
Identify two beds within Hackney e.g. within a Housing Association	● Local ● Enable IIT in-reach and continuity of care	● Travel distance from IIT may be inefficient

		● Visibility of patients overnight for safety ● Cost
Operate two beds on an acute ward at HUH	● Cost efficient ● Proximity to IIT ● Access to wider hospital resources e.g. diagnostics, dietetics, etc ● Access to gym, Activities of Daily Living kitchen	● Identification of space at HUHFT ● Cultural challenge of delivering a real intermediate care service within an acute ward - service models and approach are very different. ● Management of gender specific beds will be challenging

There has been a significant effort to identify locations for beds within the borough. This showed that there are limited options available, though those that were visited and feasibility was explored. However, in each case utilisation of the space for such a small number of beds was prohibitively expensive.

5. Budget, Spend and recent activity

Figures show that while a slightly higher use of the current beds we have at St Pancras is projected, their use is well below that budgeted, highlighting the low level of demand for a bed based service.

Intermediate Care Beds BCF Budget			
Financial Year	**Budget**	**Spend**	**Variance**
2018/19	**£437,000**	**£73,264**	**£363,736**
2019/20 (projected)	**£437,000**	**£110,000**	**£327,000**

These figures represent actual numbers of individuals as follows:

- 2018/19 the spend was £73,264.20, and this was for five patients. A significant proportion of this cost was on one patient who spent 101 days in St Pancras costing £33,330.

- For 2019/20 the spend was projected at around £110,000 which was based on about eight patients needing the service.

6. Next steps and Future plans

We will continue to explore options for bed based provision of intermediate care within the borough in the short to medium term.

This should be considered within the context of a broad programme of work to develop and improve our intermediate care and wider discharge services. For example, the Better Care Fund partnership recently commissioned an independent evaluation of the pilot Discharge to Assess[2] model, being run by IIT. The evaluation has provided helpful insight into how IIT and other services can function more effectively to support more timely and effective discharges.

The IIT service contract ends in November 2020, we will use this as an opportunity to review the service specification in detail and consider the longer term options for bed based services as part of the whole service offering.

8. Summary

Hackney has a strong integrated, intermediate care service, run by the Homerton Hospital and commissioned since 2016 by both the CCG and LBH.

Since the success of the new service the current need for intermediate care beds is far less than previously modelled and this needs to be recognised as a significant validation of the overall efficacy of the health, social care and voluntary sector system within City and Hackney.

Other boroughs in North East London, including Barking and Dagenham and Redbridge, have closed substantial amounts of intermediate beds, and this is a national trend. The evidence continues to show that getting people out of beds and into their own home is critical.

We will build into the review of IIT and the Integrated Discharge Service options for intermediate care beds review, based on the recent audit numbers.

It is also important to remember that:

- Hackney and City has a significant intermediate care service and the lack of intermediate care beds in borough does not significantly impact services the IIT provides.

[2] Web address for more information: https://www.england.nhs.uk/urgent-emergency-care/hospital-to-home/improving-hospital-discharge/discharge-to-assess

- Local benchmarking against other CCG/Council partnerships shows a picture of a reduction of the number of intermediate care beds with increased capacity in community services.
- Evidence suggests that people recover quicker and reduce the exposure to hospital-acquired infections when they are able to go home as quickly as possible.

2nd September 2019