Integrated Intermediate Care (IIC)

HEALTH AND ADULTS SOCIAL CARE SELECT COMMITTEE

MAY2019

Intermediate care in Hampshire

- Hampshire CCGs and HCC have agreed to commission an integrated Intermediate Care service together, under a single service specification
- This service was a recommendation following the Care Quality Commission Local System Review in Hampshire: (many areas already have the equivalent); service a key component of HASC action plan, and HWB previously updated
- The specification sets out the requirements for a combined Rehabilitation, Reablement and Recovery service (3 R's) to prevent unnecessary hospital admission and promote individual's fullest possible recovery following an episode of ill health
- HCC Adults Social Care and Southern Health Foundation Trust (SHFT) are the current providers of the rehabilitation and reablement services which are included in IIC
- A joint proposal for a new operating model to jointly deliver the service has been developed and met with system leader support

Vision for Integrated Intermediate Care (IIC)

An improved client experience that is person-centred, seamless and integrated

A clear and effective pathway for individuals to promote recovery and independence

Enables people to retain their independence and remain in their homes for as long as possible, minimising the need for complex packages of care

Reduces demand on health and care services by reducing avoidable hospital admissions, length of stay and discharge delays

Prevents premature admission for long term care

Improves service efficiency by reducing service duplication and increasing productivity

Key Objectives for Integrated Intermediate Care (IIC)

There will be a unified IIC Service, with a combined workforce which is not bound traditional organisational boundaries or ways of working

IIC will be a County-wide offer but will be sufficiently flexible to blend with local structures, processes and requirements

The Strengths Based Approach will be at the core of IIC

Acute admissions will be avoided whenever possible, and admitted patients 'case-managed out' at the earliest opportunity where appropriate to need

Most IIC will take place in peoples' home or in other community settings

Care co-ordination will be managed through a central function to ensure the objectives of individuals are articulated and met

The Scope of the Service

01

Bed-based rehabilitation / Reablement services

02

Community based rehabilitation/ reablement that is provided to people in their own homes, by both or either health and social care services

03

Urgent community response – these services will form part of the intermediate care response to avoid admission to a hospital or permanent care home setting

04

Acute Hospital Emergency Department admission avoidance and timely discharge support

Key service design principles

To be jointly service led and managed, even if staff remain employees of current organisations

To work alongside and as an integral part of the services provided by acute, primary care and social care colleagues

To be shaped to meet Integrated Care System needs

To take a deselective approach, ensuring that individuals' recovery is optimized before assessing any onward needs

To have a multidisciplinary team structure

To have 'hub and spoke' staff structure to maximise responsiveness and productivity

To have structures, processes and decision making centred around individuals rather than how services currently work and are organised

To work seamlessly across organisational and functional boundaries

The Three Discharge Pathways

When a patient's care needs can be met outside an acute hospital, use one of the three discharge pathways.

1 SIMPLE

What does the patient need?
No change in need
Patient can go back to their usual place of residence

What happens?
Restart & Return package/placement

Restart Return

2 SUPPORTED

What does the patient need?
Additional support needed
Rehab/reablement

What happens?
Refer to Integrated Intermediate Care

IIC

3 ENHANCED

What does the patient need?
Complex needs
For example; continuing care, safeguarding concerns, lacks mental capacity

What happens?
Social Care Assessment by HDT
CHC Checklist and D2A
Fast Track

New Placement or Package

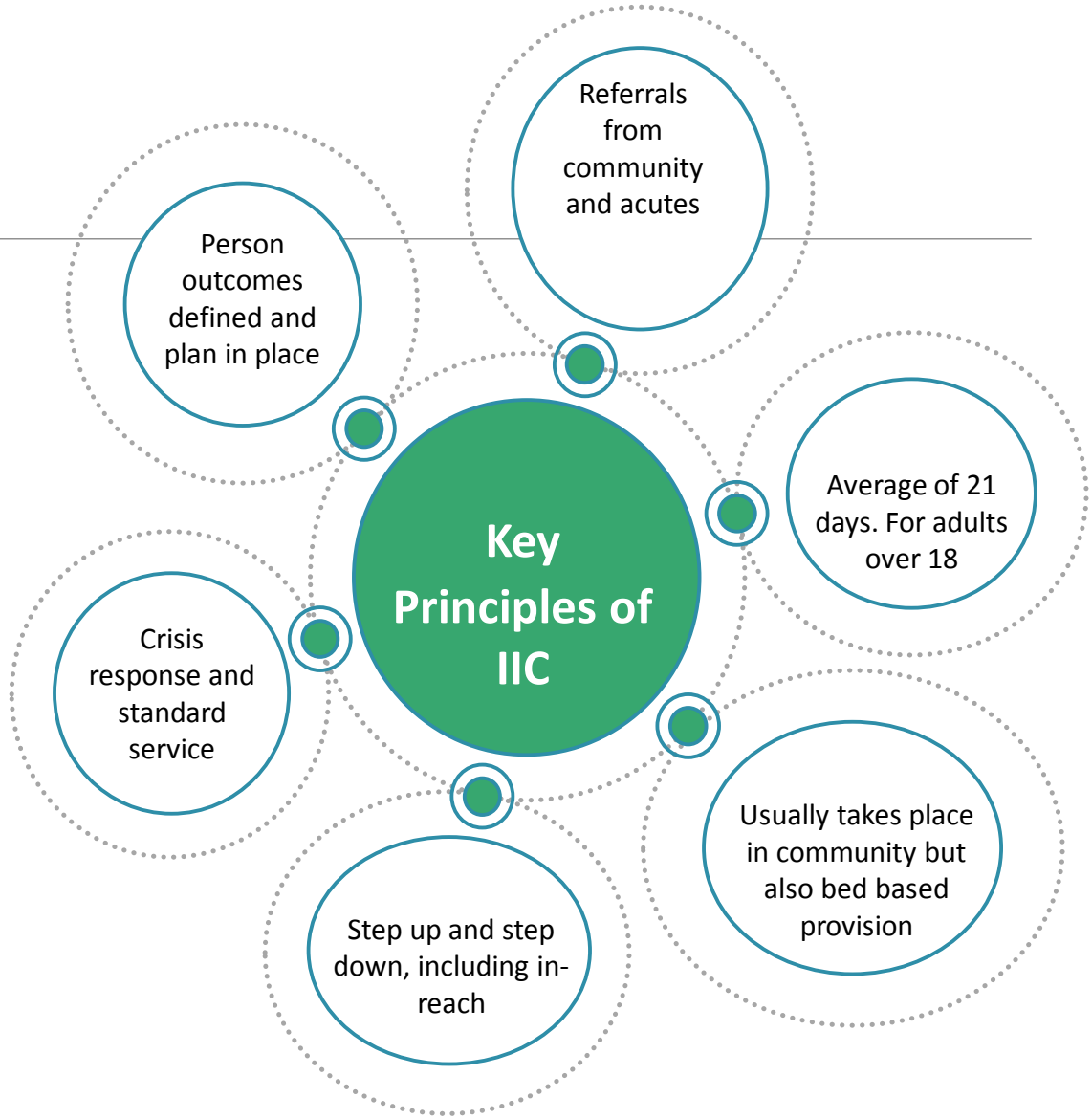
2

SUPPORTED

What does the patient need?
Additional support needed
Rehab/reablement

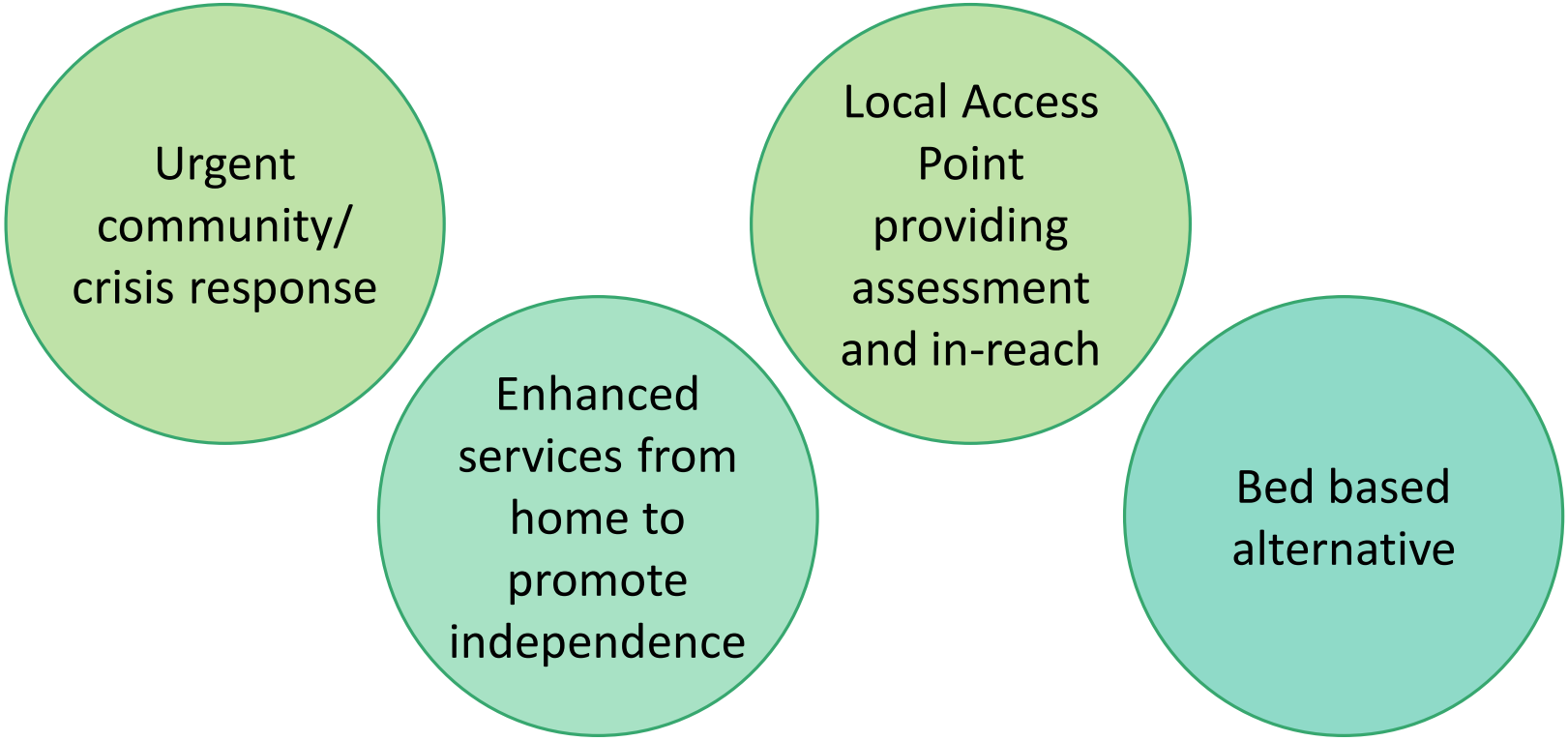
What happens?
Refer to Integrated Intermediate Care

IIC

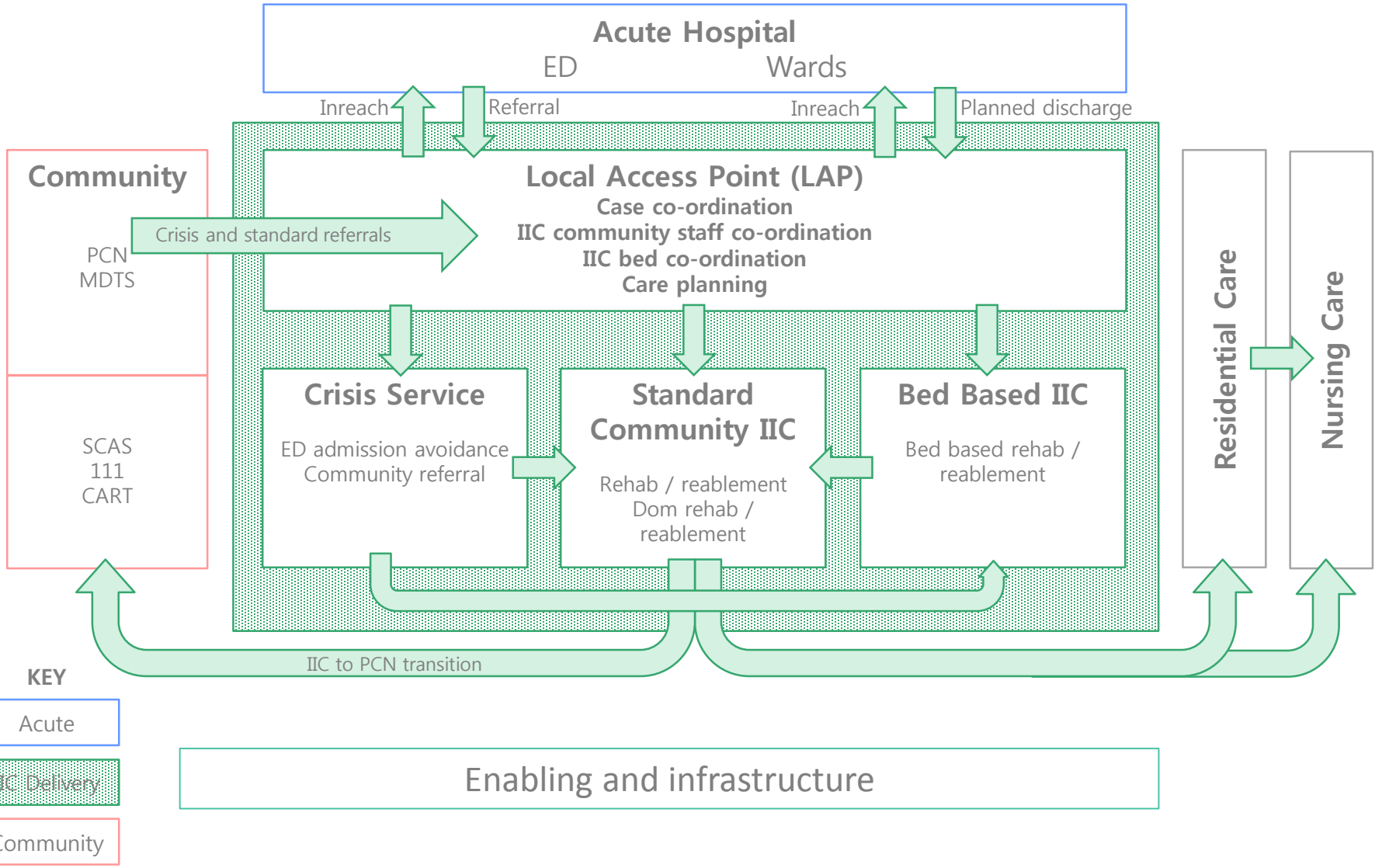


IIC operating model

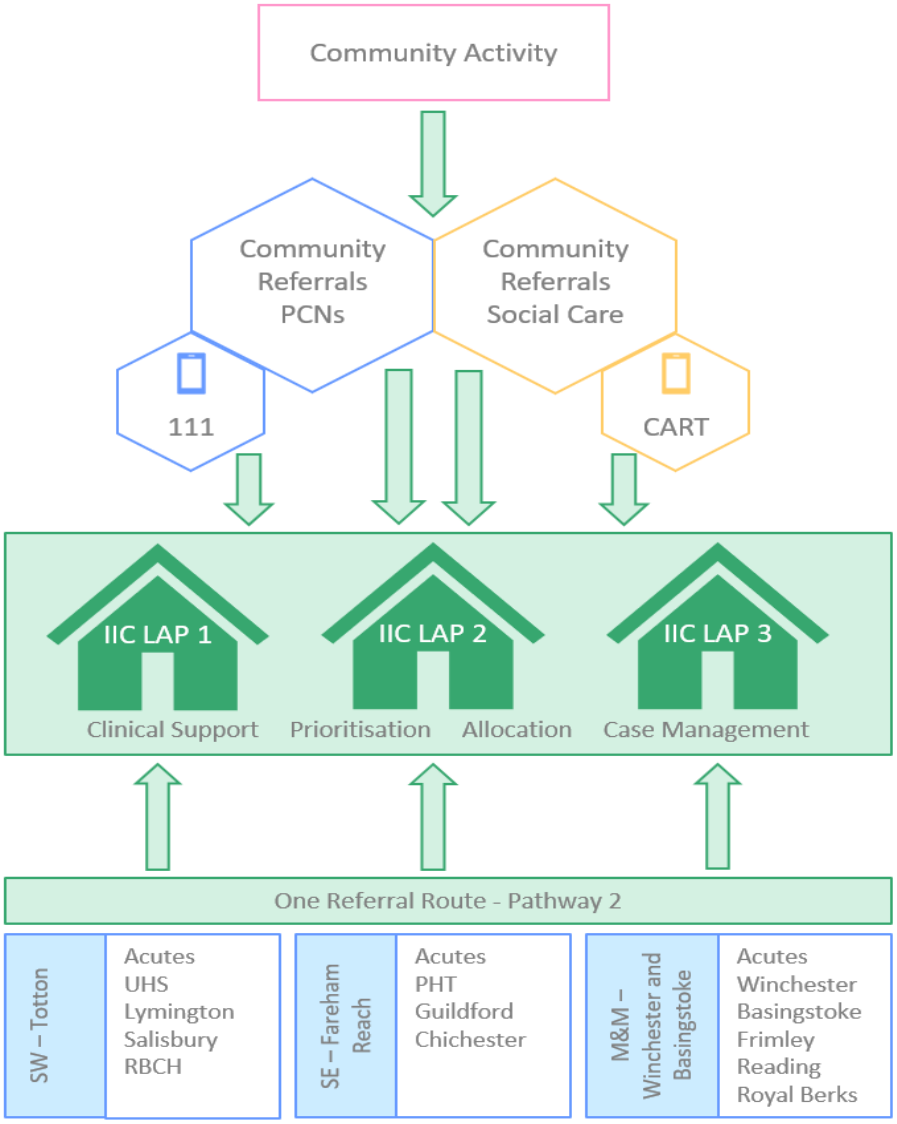
Four core elements:



IIC Operating Model



Local Access Points



Local Area Access Points (LAPs)

Receive referrals from:
Primary Care Network MDTs
Community frailty services
Acute Hospitals
Hants Direct/CART/SCAS/111
AHC Community teams

Prioritise referrals, according to:

- Speed of response requirements
- Bed / home IIC
- Initial IIC input and assessment requirements
- External requirements (e.g. change in protocols during times of peak demand across the system)

Urgent referrals separate process, initial contact by phone (clinician to clinician)

Hospital In-Reach/Assessment

Avoid hospital admission through IIC
Enable people to be discharged from acute wards at an optimal time to continue recovery

- In all acute hospitals in Hampshire
- Combined HCC/SHFT in-reach/assessment team, on rotation from LAPs
- Integral part of the acute 'front door' teams
- Join daily MDTs to enable case finding on wards
- Work with and support ward staff to identify and refer people as soon as they become ready to leave hospital
- Work with acute hospital clinicians, building confidence in the IIC model
- Consultant Geriatricians to work in IIC and support work in the community

Urgent Community Response

IIC First Contact Responder arrives within 2 hours
Rapidly assess needs and assure safety
Stabilise & commence therapy within 3 days

- Avoid non-elective admissions into acute hospitals from community or acute 'front door'
- Referrals made by clinicians and professionals in community and acutes
- Purpose and processes for urgent community response referral understood
- 07:00 to 20:00, 7 days a week
- Refer by phone call, through a designated number
- Direct referral discussion clinician/professional to clinician/professional
- IIC First Contact Responder initial visit to assess safety and IIC need
- Work with the individual may commence immediately and may be for a relatively short period
- May be home or bed-based IIC

Independence at home: Community-based IIC

- Work allocated to local teams by the LAP
- Takes place in peoples' home, or wherever they call home
- 'Step up' and 'step down' (pre and post hospital admission)
- Blended approach of reablement and rehabilitation
- Individuals' goals are established with at the outset
- Outcomes measured throughout IIC, and people are transitioned out of IIC once these are met
- Reablement input for average of 21 days
- Works alongside and supports community frailty models
- Works alongside PCN MDTs
- Locality based multidisciplinary teams

Bed-based IIC

- IIC in peoples' homes, but may be occasions where bed based service necessary
- Temporary, intensive stay in a residential or nursing care environment
- 3 R's and strengths based approach
- Emphasis on transitioning from medical dependence to medical independence to rehabilitation and reablement to home
- IIC beds multifunctional/flexible use, with some 'specialist' beds
- Integration of SHFT and HCC IIC bed based provision
- LAPs to co-ordinate the provision of beds

IIC Forerunners/test projects

Commenced Autumn 2018, to test, learn and implement for different functional parts of the operating model across different parts of the County.

Current forerunners are:

- Care staff integration – SE
- Occupational Therapy integration
- Hub development – Winchester

Phase 2 forerunners to include:

- Admission avoidance ‘iFit’ (Integrated Frailty Intervention Team) – Basingstoke
- In-reach model into acute settings – UHS and PHT
- Local Access Point development
- IIC/Primary Care Network multidisciplinary team working

Key Outcomes

Design aligned to SCIE model

Four critical questions:

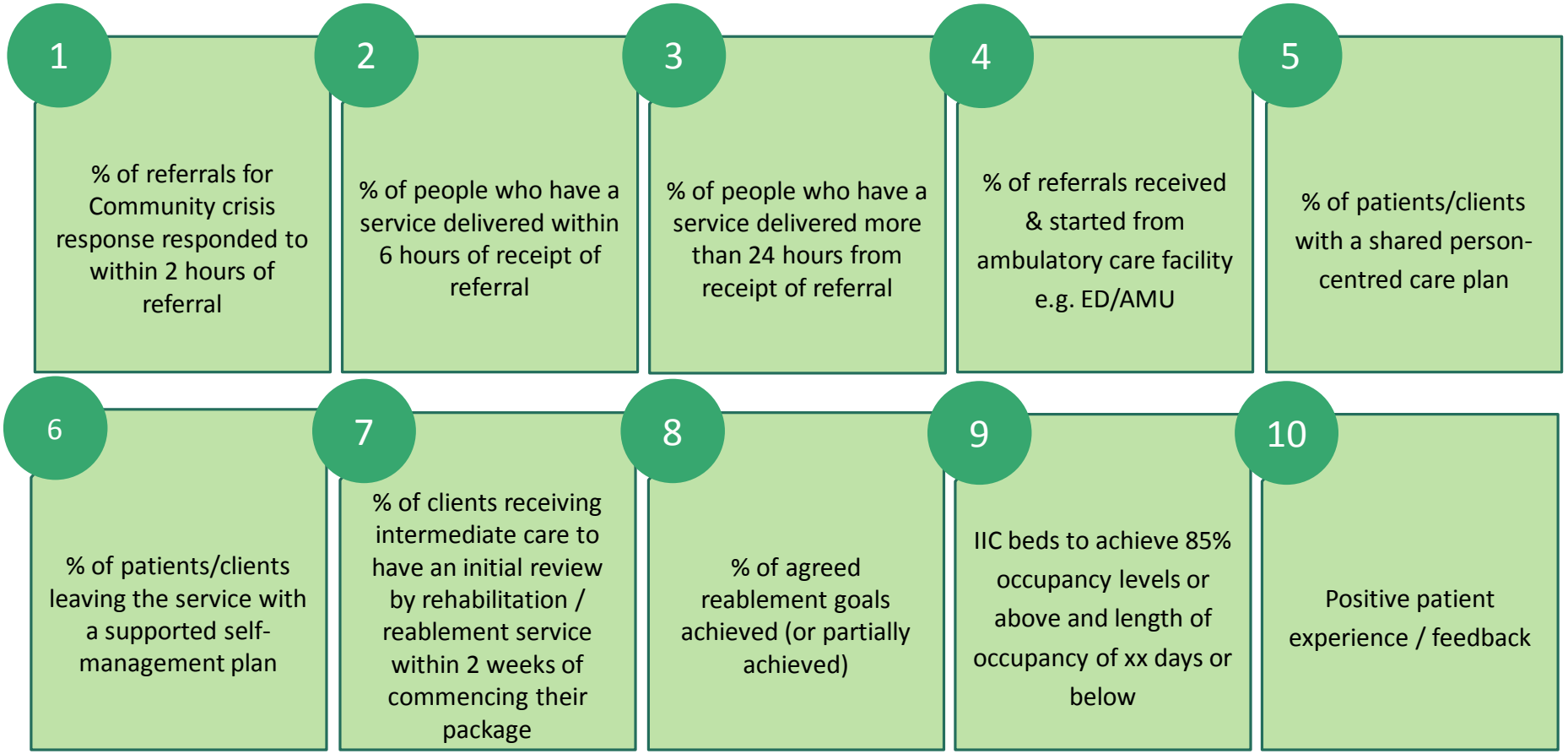
Is the service improving the experience of care?

Is the service proactive and preventative in the way it operates?

How well are professionals and organisations that make up the service working together?

Does the service have the capacity and resources to deliver?

Key metrics


1
% of referrals for Community crisis response responded to within 2 hours of referral
2
% of people who have a service delivered within 6 hours of receipt of referral
3
% of people who have a service delivered more than 24 hours from receipt of referral
4
% of referrals received & started from ambulatory care facility e.g. ED/AMU
5
% of patients/clients with a shared person-centred care plan
6
% of patients/clients leaving the service with a supported self-management plan
7
% of clients receiving intermediate care to have an initial review by rehabilitation / reablement service within 2 weeks of commencing their package
8
% of agreed reablement goals achieved (or partially achieved)
9
IIC beds to achieve 85% occupancy levels or above and length of occupancy of xx days or below
10
Positive patient experience / feedback

Finance

The redesigned and integrated service is intended to provide the following benefits:

- Yield economies of scale
- Stabilise the workforce through improved recruitment and retention and increased workforce flexibility
- Increase productivity
- Improve service resilience
- Provide positive impact on health and care systems by enabling people to remain in good health in their homes for longer

Intention to not increase financial envelope but if there is a case of demonstrating beneficial impact through an expanded service then an appropriate business case will be brought

Demand and capacity

Demand likely to increase due to:

- Demographic changes/aging population
- Increase in admission avoidance through implementation and increased effectiveness of admission avoidance models
- Consistent identification of people and earlier discharge from acute hospitals (MFFD), accelerated by Patient Flow programme pathway definition and development
- Increased identification of IIC needs within the community (PCN interface)

Detailed demand forecasting work currently under way

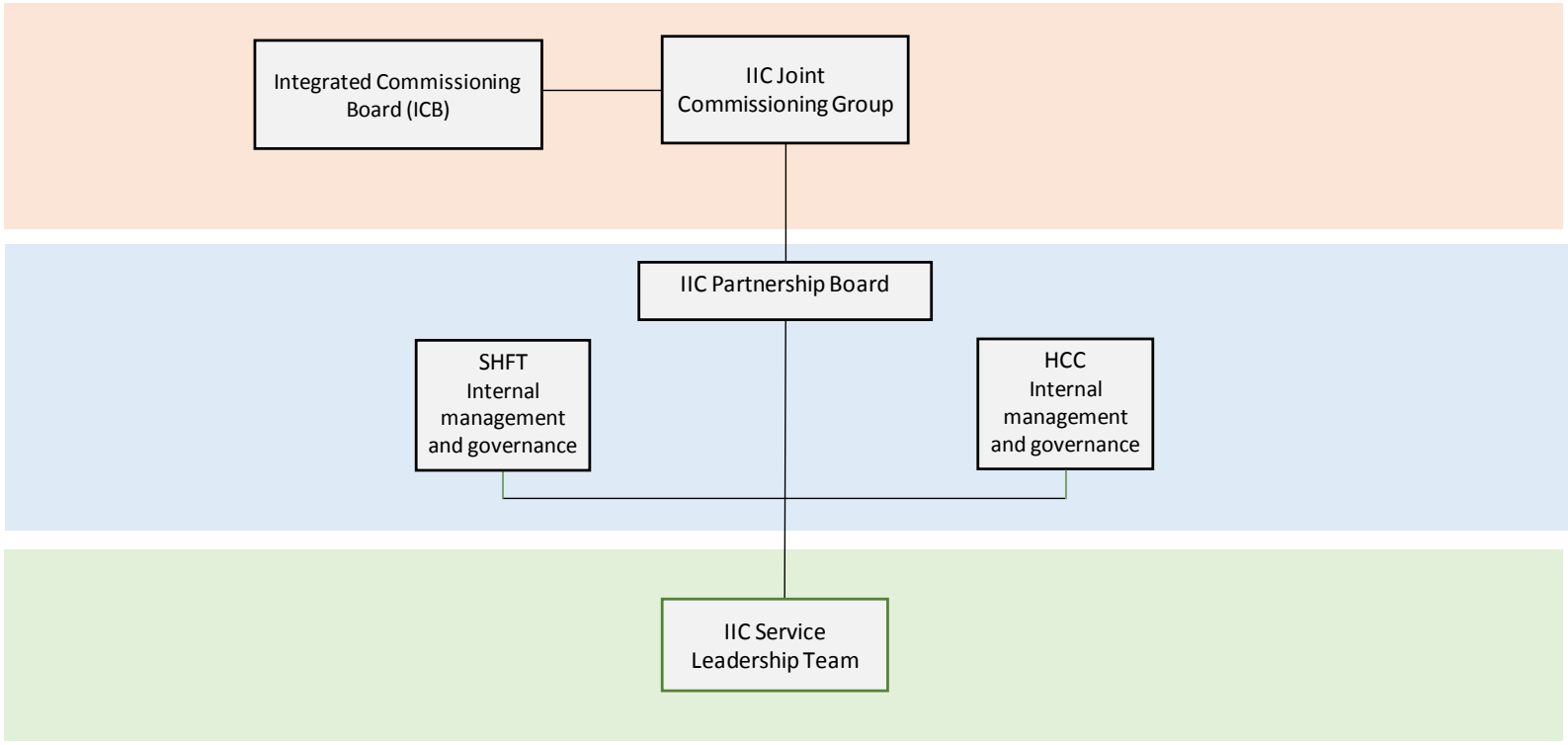
Measures to increase capacity include:

Increase bed occupancy rates	Reduce length of stay	Increase productivity through changes to structural change and work practices (e.g. location of teams within localities, within localities, flexible and mobile working, etc.)	Joined workforce providing elimination of duplication, etc.	Adjust mix of bed based and home based IIC by transitioning people into community as soon as possible

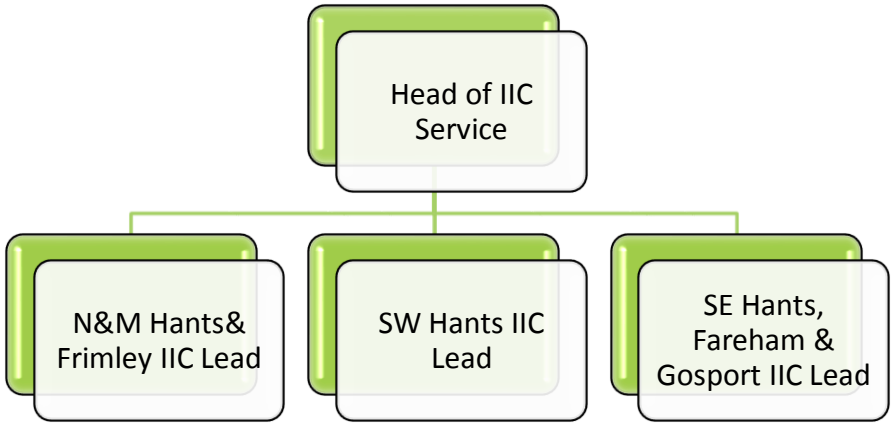
Governance

- To ensure the Service meets local requirements, need to maintain relationship between regional commissioners and IIC regional service delivery
- Proposed that Integrated Commissioning Board addresses major issues and make key decisions on service delivery
- IIC providers will be part of an IIC Partnership Board
- IIC providers will continue to report into their parent organisations through respective management and governance structures
- Proposed that integrated service operates under a Section 75 arrangement
- Opportunity to use the Better Care Fund to account for any joint funding requirements

IIC Governance



Management and Leadership



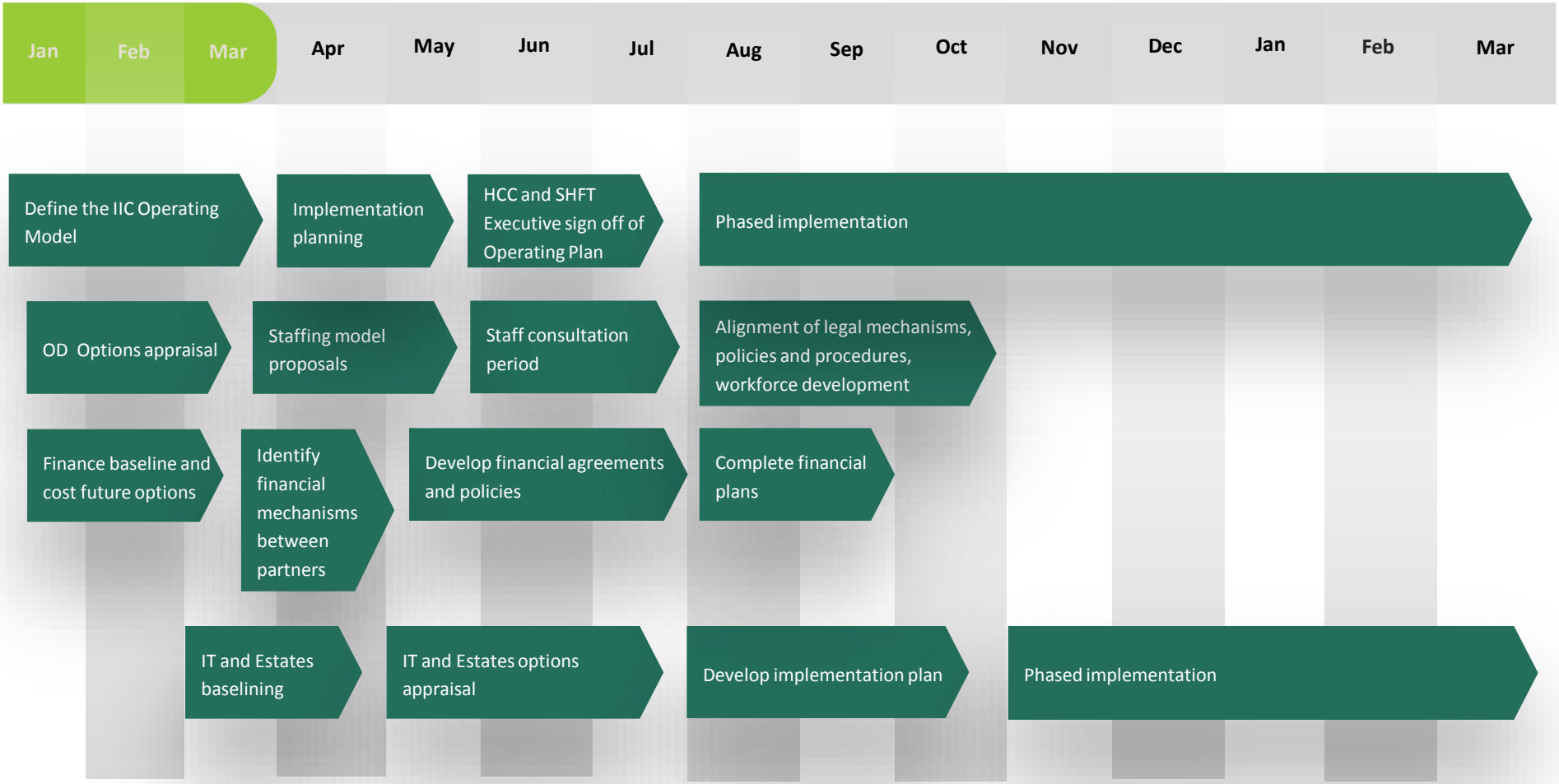
Senior Management Team

- SMT proposed to be jointly appointed and funded
- Reports to Partnership Board
- Links to HCC and SHFT management structures but not line management
- Responsible for delivery of the service
- Interfaces with the wider system and connected with locality by being ICS ‘shaped’
- At this time not proposed that wider staff are jointly appointed

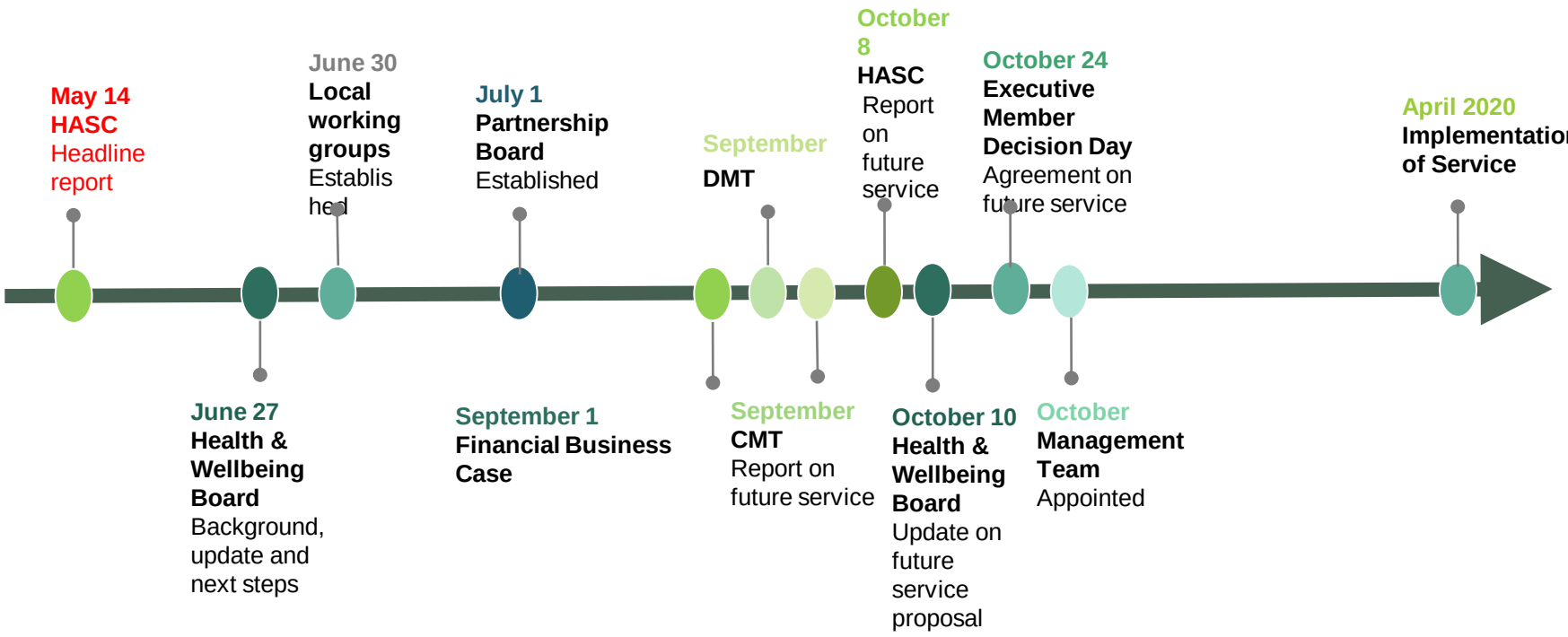
Key next steps in Organisational Development

1. Undertake joint appointments
2. Co-locate staff wherever possible
3. Undertake further scoping work and preparation to deploy a s.75
4. Bring forward final recommendations for preferred structure following joint consultation with HCC and SHFT staff

IIC Service Development Timeline



Integrated Intermediate Care Governance Timeline



HASC Recommendations

- To note and support the approach to create the integrated Intermediate care service
- To endorse the preferred route to organisational alignment and integration
- To receive a further update in October 2019