

# Hampshire Integrated Intermediate Care (IIC)

HAMPSHIRE HEALTH AND WELLBEING BOARD
JUNE 2019

# Integrated intermediate care (IIC) in Hampshire

- Hampshire CCGs and Hampshire County Council (HCC) have agreed to commission the service together, under a single service specification, planning to operate under a Section 75 agreement
- HCC and Southern Health Foundation Trust (SHFT) are the current providers of the services which are included in IIC. A joint proposal for a new operating model to jointly deliver the service has been developed

#### Intermediate care will:

Maximise independent living

Promote faster recovery from illness

Prevent
premature
admission to longterm residential
care

Support timely discharge from hospital

Prevent
unnecessary acute
hospital admission

# The Scope of the Service

01

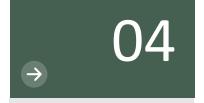
Bed-based rehabilitation / Reablement services



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



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



Acute Hospital
Emergency
Department
admission
avoidance, and
supporting
timely discharge

## Vision

There will be a unified IIC Service, with a combined workforce which is not bound by 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 'pulled out' at the earliest opportunity

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

There will be an IIC Urgent Community Response function to prevent hospital admission

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

## Discharge Pathways

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

### **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

## **SUPPORTED**



#### What does the patient need?

Additional support needed Rehabilitation/reablement

#### What happens?

Refer to Integrated Intermediate
Care

### **ENHANCED**



#### What does the patient need?

Complex needs For example; continuing care, safeguarding concerns, lacks mental capacity

#### What happens?

CHC Checklist (where appropriate)
CHC Assess (5 days for majority)
Social Care Assessment by HDT
D2A

Restart Return

IIC

New Placement or Package

# IIC operating model

### Four core elements:

Urgent community/ crisis response

Enhanced services from home to promote independence

Points
providing
assessment
and hospital
in-reach

Bed based alternative

# 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 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

# Local Working Groups

IIC Local Working Group to be set up in each of our 3/4 local delivery systems/ICPs to develop and optimise the implementation by system



# 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

## Timeline

- Intermediate care providers commenced developing operating model through forerunners November 2018
- Health and Social Care Commissioners developed a joint specification, signed off in January 2019
- Operational Delivery Group commenced work on operating model January 2019. Delivery of Operating Model proposal March 2019
- Development of Implementation and Transition plan May 2019
- Forerunners expanding to introduce and test key service elements by system
- HCC Executive Member decision day to agree the future service
   October 2019
- Full service roll out April 2020

## HWB Recommendations

- To note and support the project approach and direction of travel to create the Integrated Intermediate care service
- To note the managerial, service and legal options available in creating an Integrated Intermediate Care service and endorse the preferred route to organisational alignment and integration