Somerset County Council
Scrutiny for Policies, Adults and Health Committee
– 3rd March 2021

Update on Intermediate Care Model

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1. Summary

1.1. Somerset's model of Intermediate Care was stood up in March 2020, in response to the Covid-19 pandemic. It built upon the Home First model for hospital discharge that has been operating in Somerset since 2016 and incorporated all intermediate care stepdown support from hospital as well as services to prevent admissions. It was expanded over winter 20/21 to provide more capacity to prevent admissions and to support people returning straight home from hospital, as well as additional beds for gradual rehab.

1.2. This paper provides a summary of Intermediate Care and some early indication of the impact of the additional capacity. It also highlights the impact of the pandemic on these services.

1.3. This links to the County Plan Adult Social Care targets of helping vulnerable and elderly people, long-term prevention, and joining-up with health. It also supports Priority Four of the Improving Lives in Somerset Strategy: Improved health and wellbeing and more people living healthy and independent lives for longer. The model is a tangible part of the Somerset health and care integration agenda, developed collaboratively with health organisations across the system.

2. Issues for consideration / Recommendations

2.1. Consider the information in this paper and the attached presentation and be aware of the progress made in expanding services.

2.2. Understand the impact of the pandemic on demand for Intermediate Care.

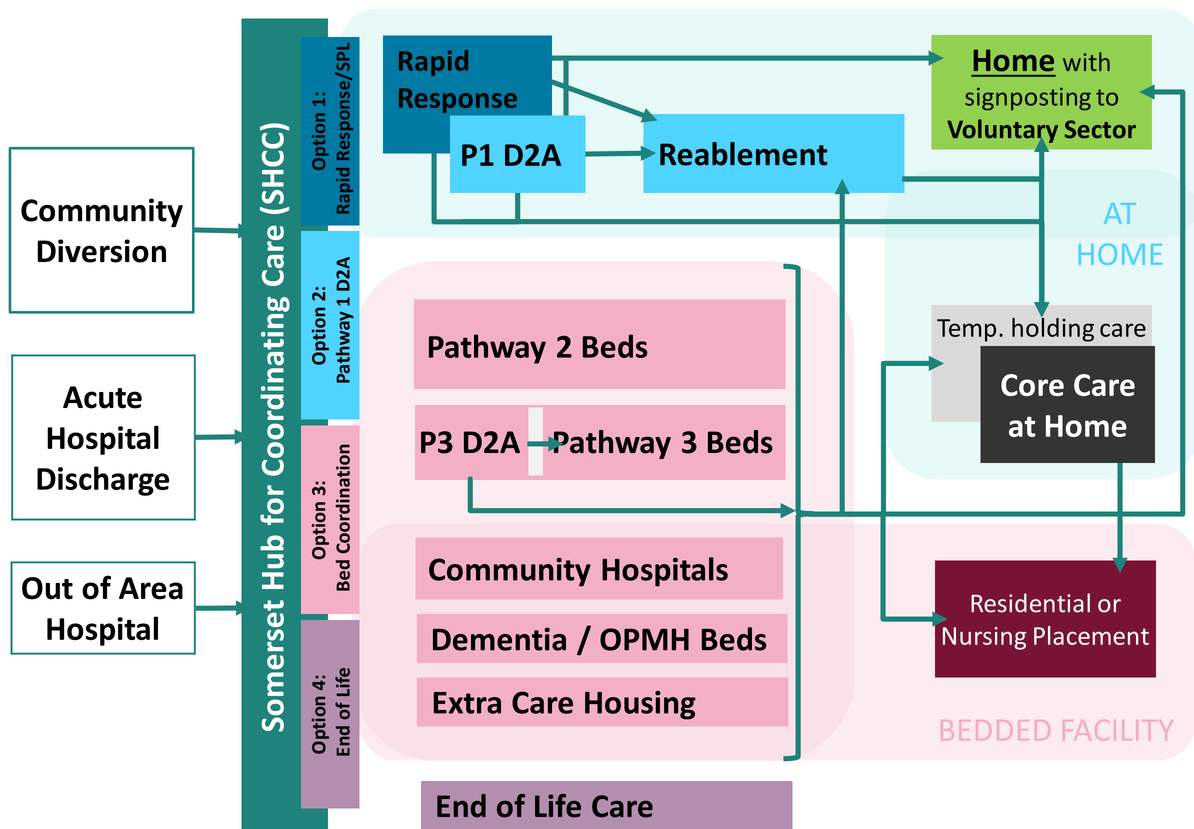
3. Background

3. The term 'intermediate care' is used to describe services in the community that provide short term period of stabilisation, assessment, and reablement with the view to maximising a person's independence and, where possible, keep them at home.

Intermediate care services can either:
provide support to people who are medically optimised following an acute episode of care. This is referred to in this document as 'supported discharge'; or
provide support to people in the community who are in danger of needing an acute episode of care if an intermediate health or reablement intervention is not provided. This is referred to in this document as 'diversion', as it diverts people away from needing an acute hospital.
Intermediate care also includes End of Life provision for those people whose primary need is the short-term provision of care and comfort at the end of their lives.

3. The current model for intermediate care was implemented as the system's response to the Covid-19 pandemic crisis, following NHSE/I guidelines on hospital discharge. The model's concept and design had already been drafted and agreed at system level with senior health colleagues in February 2020, and the onset of the pandemic acted as a catalyst for its rapid implementation.

The diagram below shows which services are included and how people flow through them.



Whilst a number of the pathways and operating principles where already in place in Somerset's Home First service, the revised model ensured that:

a) all supported discharge decision making is removed from the hospital wards

and instead made by a multidisciplinary team within a discharge lounge.

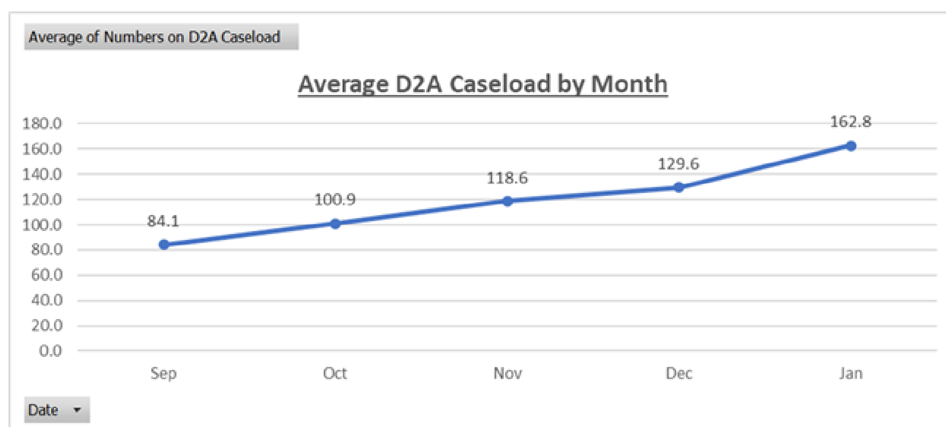
b) responsibility for managing the supported discharge pathways is separated from the acute discharge function and instead managed out in the community.
c) A central Somerset Hub for Coordinating Care is set up to provide a single point for coordinating and managing capacity across all the intermediate care options.
d) All community beds, including Home First Pathway beds, community hospital beds and Older People's Mental Health beds, act as one bed base with a defined hierarchy of use and are coordinated and monitored from one place.
e) The previous Home First reablement pathway (Pathway 1) is converted to a 'Discharge to Assess' model, introducing a period of assessment after discharge to determine ongoing reablement or support needs.
f) A single performance dashboard capturing key performance indicators (KPIs) and flow indicators is in use across the model.
g) A Head of Intermediate Care was appointed as a jointly managed post between Somerset Foundation Trust and Somerset County Council.

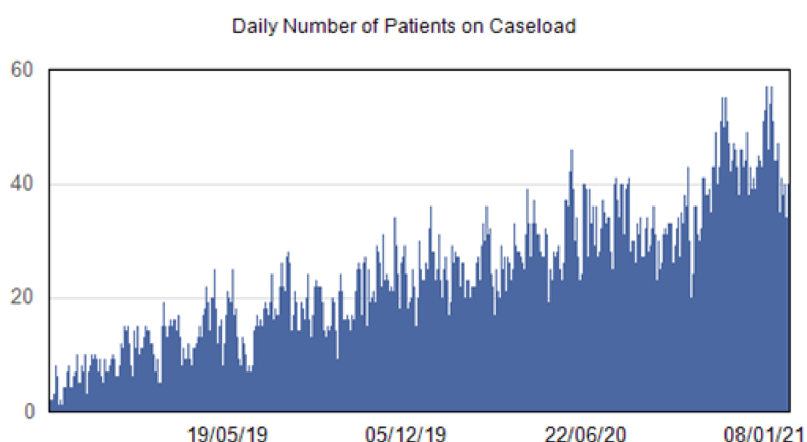
3. In summer 2020, the Somerset system agreed to expand the Intermediate Care model over winter 2021 investing a total of £3.2M to deliver:

- A doubling of capacity of rapid response from 10 slots per day to 20
- A doubling of capacity of D2A from 13 slots per day to 26
- A doubling of night sits to serve both D2A and rapid case loads
- A continued investment in acute discharge lounge functions
- An increased staffing capacity in the bed coordination hub
- An additional 10 Pathway 3 beds

The investment intentionally focused on expanded capacity to support people to remain at home and avoid an acute admission, or to return home following an acute stay. National best practice on discharge recommends as many as 90% of all patients requiring support on discharge should return home. It is proven that this leads to better outcomes and prolonged independence in older people. In August Somerset was averaging 50% of all supported discharges returning home and the system collectively agreed to increase this to 75% by expanding the pathways home.

3. A snap shot view of the average case load in both Rapid Response and D2A shows the impact of the expansion in supporting people at home.





3. The second wave of the pandemic has led to more frail and elderly people being admitted to hospital, as well as younger people with underlying health conditions. The acute hospitals have reported a higher level of acuity of patients who are admitted and increased average length of stay. This has led to increased dependency of those who need support on discharge.

3. Our reablement providers on our D2A Home pathway have successfully supported Covid+ patients to return home and our Community Hospitals have provided care in side rooms for Covid+ discharges who need to recover in a bedded unit.

3. Intermediate Care has needed to manage closures in bedded facilities due to covid outbreaks across the winter. In response to this reduction in capacity, the Council has commissioned additional temporary beds within care homes. These have been used for covid negative patients who require bedded support on discharge for rehab and assessment, prior to determining long term support needs. is a challenge to provide appropriate levels of rehab in these additional beds.

4. Consultations undertaken

4.1. Not applicable

5. Implications

5.1. People who spend time in interim bedded facilities have less opportunity to

maximise their independence than those in pathway 2 or 3 beds due to limited capacity in community therapy and Adult Social Care teams already supporting an expanded Intermediate Care Model. Therefore, these beds are only used in escalation purposes when other options are not available to support timely discharge.

5.2. £3.2M of system funding to expand service for winter 20/21. Evaluation of the use of this funding is currently taking place and a business case for ongoing investment in the model is being developed.

6. Background papers

6.1. UK government paper Hospital Discharge Service: policy and operating model (21 August 2020)
Hospital discharge service: policy and operating model (publishing.service.gov.uk)