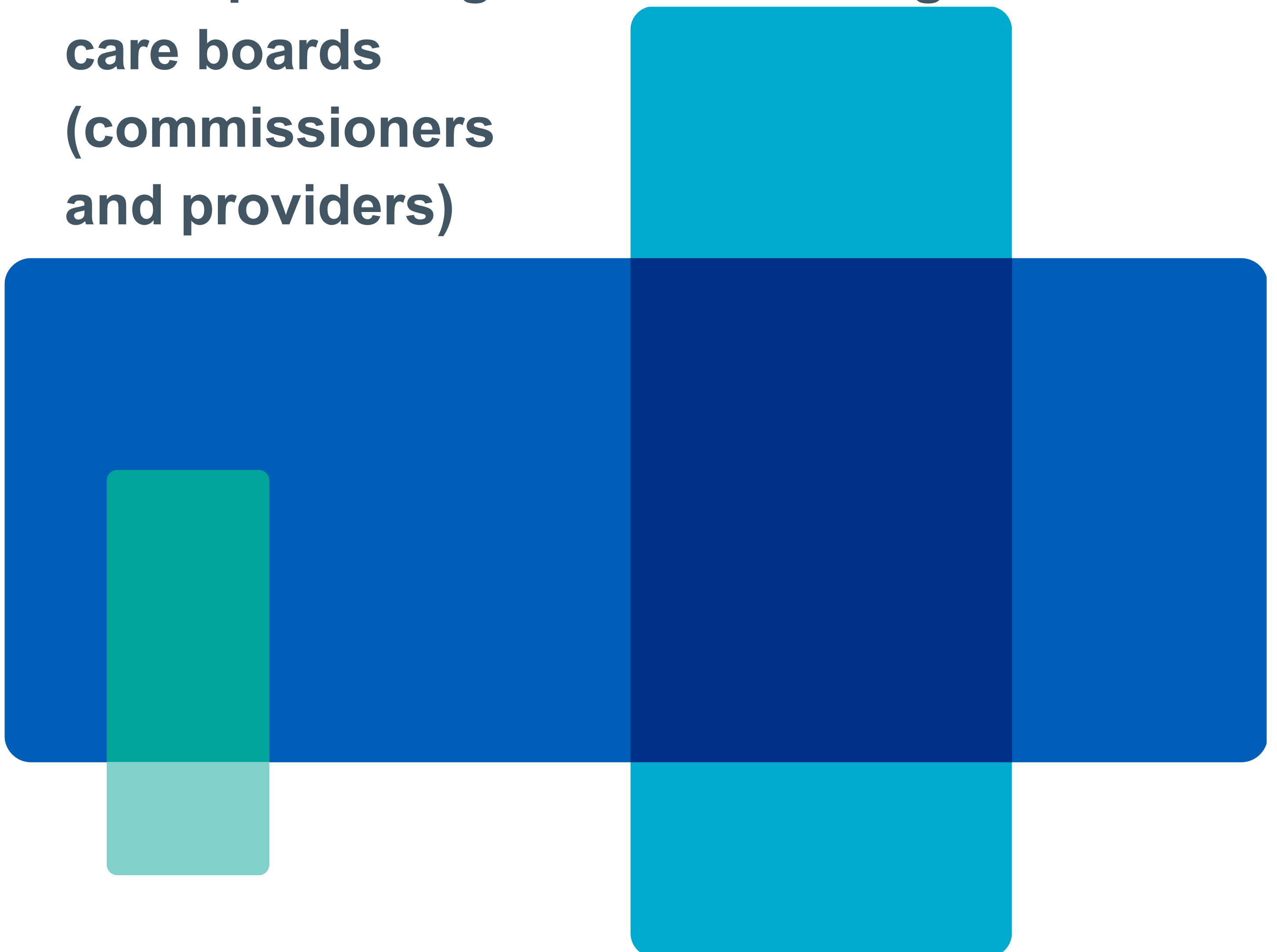
Classification: Official

NHS England

Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge

Good practice guidance for integrated care boards (commissioners and providers)



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Introduction

Enabling people to stay well, safe and independent at home for longer has been a long-standing policy objective of the NHS. National guidance on intermediate care[1] was issued in 2009[2] and this framework builds on the work that has taken place so far[1,2,3,4] to provide a renewed focus.

This framework consists of best practice guidance and a number of recommended actions that systems should consider in connection with their intermediate care services, and implement where appropriate locally and affordable within available budgets.

This framework is focused on step-down intermediate care – time-limited, short-term (typically no longer than 6 weeks) health and/or social care provided to adults (aged 18 years or over) who need support after discharge from acute inpatient settings and virtual wards to help them rehabilitate, re-able and recover.

Implementation of step-down intermediate care as outlined here is expected to result in improved outcomes, experiences and independence of people discharged, reduced avoidable hospital readmissions, and reduced avoidable/premature long-term care provision. Further expected benefits include improved flow and discharge from acute and community hospitals, freeing-up NHS hospital capacity for those who need it most.

Step-down intermediate care involves community-based assessments and interventions provided to people in their own home (home-based; discharge pathway 1), or in short-term community bedded settings (bed-based; discharge pathway 2). Home-based intermediate care is the default pathway as per the 'home first' approach (a person's home is their usual place of residence). Someone may be discharged from bed-based to home-based intermediate care to continue their intermediate care. For the majority of people in acute hospitals, a simple discharge home without the need for step-down intermediate care is the most appropriate pathway (discharge pathway 0).

Intermediate care services can be entirely health care, entirely social care, or ideally have elements of both delivered by multi-disciplinary teams working in integrated ways. They may be commissioned by the NHS, and/or by local

[1] NICE definition of intermediate care; SCIE definition of intermediate care
[2] Intermediate Care – Halfway Home
[3] LGA High Impact Change Model
[4] Hospital discharge and community support guidance

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authorities, and delivered by a range of providers across the health, social care, housing, independent and voluntary sectors.

Appropriate capacity should be commissioned (within available budgets) for people with step-down intermediate care needs, including people with particular conditions, needs, protected characteristics, or those living in particular circumstances, to prevent exclusion or sub-optimal care. This includes (but is not limited to): people living with frailty, mild cognitive impairment, dementia or delirium, palliative and end of life care needs, mental health conditions, learning disabilities, autism, obesity (including bariatric patients), younger adults, and people living in an unsafe environment, in prison, experiencing homelessness, or at risk of homelessness.

This work sits within the context of the wider effort to improve discharge planning, in-hospital flow, implementation of virtual wards, and other related initiatives.

Although **not covered within** this framework, Integrated Care Systems (ICSs; from this point forwards referred to as 'systems') will continue to commission (within available budgets):

- Appropriate step-up intermediate care capacity for people in the community experiencing a crisis or other deterioration in their physical and/or mental health and wellbeing – as set out in Delivery plan for recovering urgent and emergency care services, by expanding and better joining up care at home services such as Urgent Community Response and virtual wards.
- Appropriate step-down intermediate care capacity for people who need help to rehabilitate, re-able and recover after discharge from mental health inpatient settings (note: people with mental health needs in acute/physical inpatient settings are covered within this framework).

Whilst this framework is aimed at Integrated Care Boards (ICBs), it is designed to support them in working with the full range of health and social care partners in their area to improve step-down intermediate care, whether commissioned by the NHS or by local authorities or jointly.

NHS England would like to thank and acknowledge the support of a wide range of health and social care organisations, professionals and subject matter experts involved in developing this guidance, including Association of Directors of Adult Social Services, Local Government Association, Department of Health and Social Care, Department for Levelling Up Housing and Communities and a range of stakeholders from NHS ICBs and trusts, local authorities, care providers, professional bodies and voluntary organisations.

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Learning from the frontrunners

This framework builds on learning from eight sites across the country which have been trialling new approaches for people to access high quality[5] step-down intermediate care. These include six national discharge frontrunners:

- Leeds Health and Care Partnership.
- Warwickshire Care Collaborative.
- One Croydon Alliance.
- Sussex Integrated Care System.
- Humber and North Yorkshire Integrated Care Board.
- Four Localities Partnership – part of Greater Manchester.

And two additional pilot areas:

- Walsall Healthcare NHS Trust.
- East Kent Health and Care Partnership.

More information on the frontrunners and additional pilot areas can be found at Annex A. From this point forward, all sites will be referred to as 'frontrunners'.

Key learning from the frontrunner programme has been grouped into **four priority areas**:

Priority area 1: Improve demand and capacity planning

The frontrunners have developed joint executive leadership and system agreements across health and social care partner organisations to ensure shared decision making and governance arrangements. Joint demand and capacity planning has been essential to determine the 'right sizing' of intermediate care services to meet people's needs. Ensuring a flow of data from all partners into the care transfer hubs is key to operationalising this.

Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model

Mapping the existing workforce has been key to understanding if professionals are able to give the right care in the right place. Maximising therapy input, supported by new and blended roles, has helped to reduce community rehabilitation and reablement waiting times and increase capacity to support a greater number of people.

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[5] NQB definition quality: safe, effective, responsive/personalised, caring, well-led, sustainable, equitable.

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Priority area 3: Implement effective care transfer hubs

Executive leadership and visibility of care transfer hub operations at partnership board level is critical to improve system flow. An integrated multi-disciplinary team across the health, social care and voluntary sectors within the hubs is key to ensuring all partners are involved in delivery.

Priority area 4: Improve data quality and prepare for a national standard

The frontrunners have developed integrated IT systems to share data, ensure visibility and assist with operational demand and capacity modelling to deliver services within their joint project boards. This has required overcoming information governance issues through data sharing agreements and training.

Informed by this learning and additional insights from other systems, recommended actions for systems to take (both ahead of and during winter 2023/24, and between now and March 2025) are provided under each section of this framework and brought together in summary tables (see Recommended actions ahead of and during winter 2023/24 and Recommended actions between now and March 2025). Systems should consider and implement these where locally appropriate and affordable within available budgets.

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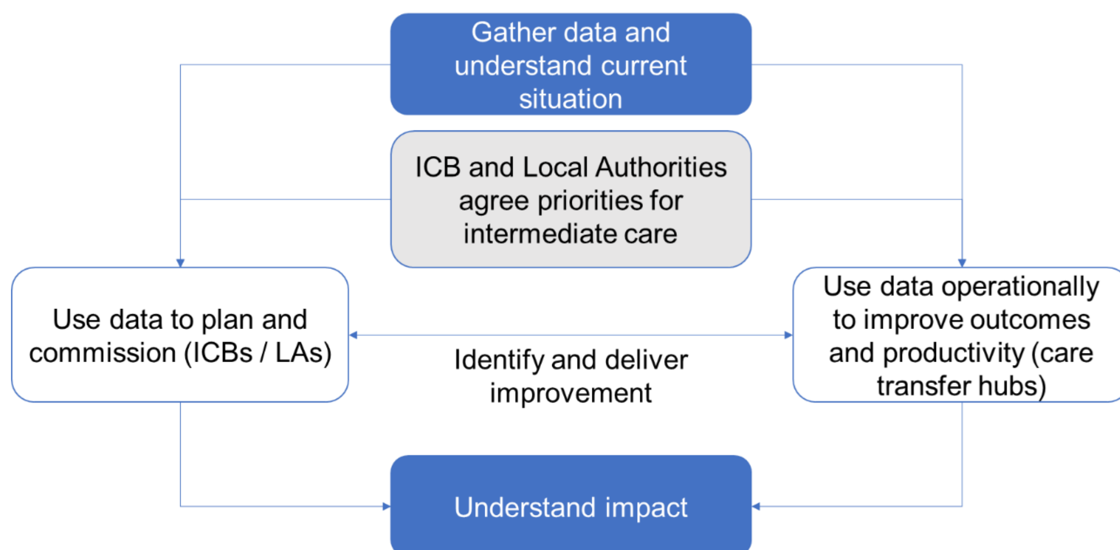
Priority area 1: Improve demand and capacity planning

Systems should have a demand and capacity plan for intermediate care, created between the ICB, local authorities and other partners. The senior leadership of all partners will understand, recognise, and have agreed the plan. The demand and capacity plan should be used to create an action plan for reducing or eliminating gaps between demand and capacity and to support decision-making in care transfer hubs.

Demand and capacity planning helps ensure an appropriate level of capacity in a system is commissioned and provided, within available budgets over 365 days of the year, with flexibility to manage surge pressures. The plans should be based on needs of the population, rather than previous referral patterns which historically may have been driven by available capacity. Effective demand and capacity planning will also consider flow through intermediate care, including assumptions about length of stay. See Figure A for the demand and capacity cycle.

Figure A: Using data to plan, commission and improve outcomes and productivity



Gathering data to plan and commission services

Intermediate care services are commissioned and provided differently across England. It is important to undertake demand and capacity planning within an Integrated Care System (ICS) footprint, stratified down to health and wellbeing board footprints (used for Better Care Fund planning) and, if relevant, to neighbourhood-level.

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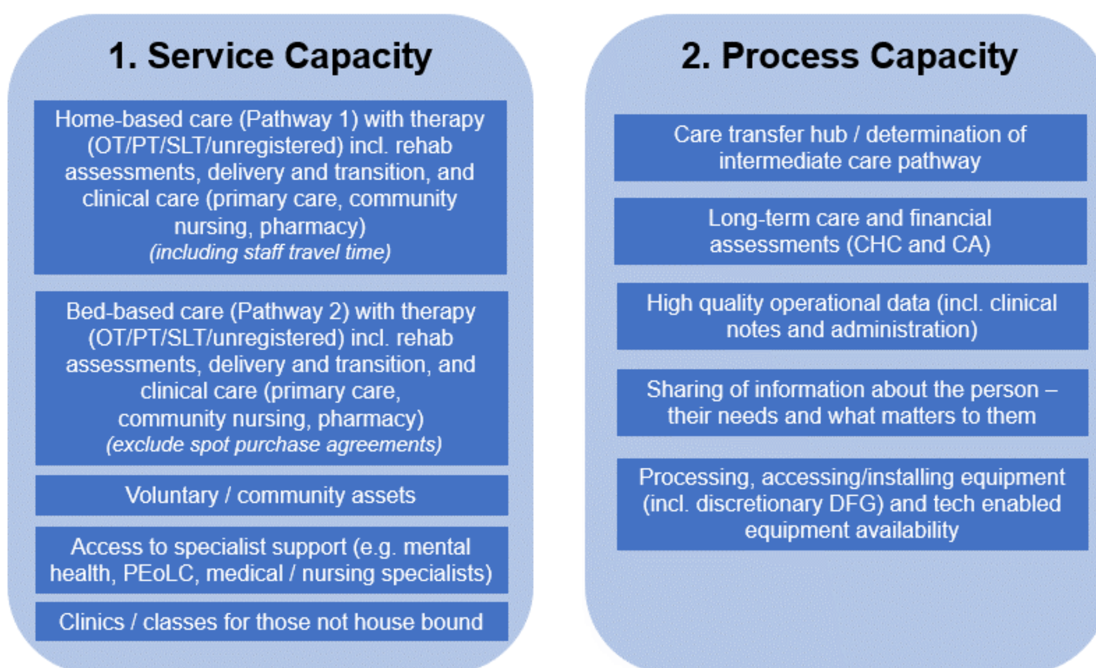
Recommended Action (winter 2023/24): Commissioners across health and care should agree projections of demand based on need, identify capacity commissioned, identify additional capacity required, and work with providers to identify how best to deliver it.

Types of capacity

The plans should set out expected demand for intermediate care, based on the available data and assumptions agreed between all partners. The plans should also set out the capacity available in services and consider any changes that could be made to improve productivity and value for money. Available capacity will include that available to the NHS and local authorities, including through the voluntary and community sector and private sector.

It may be helpful for systems to consider capacity across two types: service capacity and process capacity. Indicative examples of both are included in Figure C below. The efficiency of specific process steps and the productivity levels in each step will determine if there is process capacity that can be unlocked. Data will be required across both types of capacity analysis, with a need to think about workforce resource, skills and access to interventions. Capacity within long-term services will also be considered alongside to ensure smooth transition at the end of the intermediate care provision.

Figure C: Examples of types of capacity



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Data required

Sources of data that can be used to understand demand and capacity include:

- Better Care Fund (BCF) demand and capacity plans (health and wellbeing board-level). These include step-up/down and mental health-specific services.
- ICB planning returns data vs. actual (including relevant community service waiting lists and hospital discharge pathways).
- Community Bed Audit.
- Any other relevant plans for expenditure on intermediate care service capacity within the ICS footprint (e.g. for 2023/24 the Market Sustainability and Improvement Fund (MSIF)).
- Health inequalities data (quantitative and qualitative).
- Operational data – including nationally available data (e.g. Acute Discharge, Community Discharge and Virtual Ward SitReps, Capacity Tracker) and locally available data from all capacity types set out in Figure C.
- Information on current productivity and the potential for improvement.

Recommended Action (now until March 2025): Develop a single approach to ICS demand and capacity planning for intermediate care across BCF and NHS planning footprints.

By March 2024, systems should fully align their demand and capacity plans for intermediate care between the BCF and ICB planning processes/returns for 2024/25.

As well as identifying any gaps in services to meet people's needs, local areas should consider whether there is appropriate capacity to assess and make decisions about people's immediate needs prior to discharge, undertake assessment of people's longer-term needs and eligibility (including Care Act assessments and CHC assessments) during the period of intermediate care, and share the data needed to inform timely decisions and support safe transfer of care.

Tools and resources

A number of published models are available that systems may find useful including the Discharge Pathways Model to support 'right-sizing' of home-based and bed-based capacity to meet the demand for rehabilitation, reablement and recovery and open-source software tools such as IPACS – Improving the Flow of Patients between Acute, Community and Social Care to support strategic decisions on capacity allocation along complex discharge pathways.

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Systems are to be mindful of the wider UEC Recovery Plan targets for both Category 2 ambulance performance and 4-hour A&E performance. They should take their agreed local acute bed occupancy rate ambition into account to ensure improvements create adequate system flow.

Increasing productivity

Recommended Action (winter 2023/24): Look at new processes and structures to improve productivity, and work with partners to identify ways to maximise capacity.

The frontrunners looked at new processes and structures to improve productivity (e.g. effective care transfer hubs, reduce administration time, reduce duplication through new blended roles, etc.), and at how optimal pathways can be used to ensure more people go home in a timely manner (discharge pathways 0 and 1).

Community bed-based services have undertaken a maturity self-assessment which has helped to identify actions that could increase productivity and increase capacity. Discharge delays in community beds can decrease bed-based capacity for intermediate care and therefore need to be understood and addressed.

Some frontrunners have agreed to commission contingency capacity (up to 15%) to enable localities to adjust capacity to respond to demand. Others have integrated rehabilitation/reablement with wider community services so, if more hospital discharge capacity is needed over winter, other teams can be called on to support. Frontrunners have found that a focus on 'home first' has reduced the use of spot purchased short-term community beds which is not good practice in general.

Further guidance on workforce productivity is available under Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model.

Agreeing actions and determining system impact

Recommended Action (winter 2023/24): Agree and track delivery of actions for improvement based on the high impact actions, using the modelled demand and capacity analysis.

Agreeing actions for improvement

It is important that pathways for people leaving hospital are improving outcomes for people, and measuring outcomes will support this aim.

Capacity should be planned and commissioned in advance. Systems should agree actions collaboratively and build the required action plan to estimate when new

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capacity will be available and when improvements will start to support a better understanding of true demand and capacity. The resulting action plans will require close management, with clear milestones, deliverables and measures, to ensure improvements are timely and effective. Systems should factor in the time required to deliver change, like developing facilities, market-shaping, building necessary skills, and agreeing funding arrangements.

Continued executive oversight and sponsorship plays a crucial role, and it is important to include patient/carer representatives for enhanced co-design and input.

Systems should have an equalities impact assessment for implementation of new intermediate care practices. When designing intermediate care services, systems should engage with local communities and under-served populations to ensure that they are not inadvertently disadvantaged. Consideration should be given to specialist intermediate care pathways for specific population groups such as those experiencing homelessness. Population Health Management should also be embedded across the system.

Recommended Action (now until March 2025): Utilise the Health Inequalities Improvement Planning Matrix when designing, implementing and evaluating intermediate care services, considering CORE20PLUS5 population groups.

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Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model

The new community rehabilitation and reablement model (which should be read alongside this framework) aims to increase capacity and access to high quality therapy-led[6] rehabilitation for people discharged on intermediate care pathways from acute inpatient settings and virtual wards.

Throughout this document, where the term ‘community rehabilitation’ is used, it includes therapy-led reablement interventions to support people to recover and retain function. While the new model focusses on increasing community rehabilitation and reablement capacity for people discharged from acute settings, it may be applicable to a wider range of intermediate care services. It also does not preclude the provision of other services that would be required as part of holistic intermediate care services to support the recovery of people.

Implementing the new model through workforce approaches

Implementation of the new model will require an approach:

- To build capacity and capability in community settings through workforce planning, training and organisation.
- To increase efficiency through new ways of working.
- Enabled by system (including clinical/professional) leadership, with a focus on behaviours and culture.
- Application of digital solutions where required/appropriate.

Recommended actions that will help systems make the greatest difference ahead of and through winter 2023/24, and up until March 2025 are provided throughout this section and below:

Recommended Action (now until March 2025): Identify an Allied Health Professional (AHP) lead to progress implementation of the new model (both within the hospital and in the community).

Recommended Action (now until March 2025): Undertake a baseline assessment to determine how far the system is from the new model.

Recommended Action (now until March 2025): Identify actions to progress the new model and build on the baseline assessment.

[6] Therapy-led refers to professional oversight rather than line management which will be organised at a local level as appropriate.

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Recommended Action (now until March 2025): Ensure the programme is docked into appropriate governance structures for oversight of progress, including clinical/professional leadership and executive ownership.

Workforce planning

Workforce planning across the system will be needed to increase community rehabilitation and reablement capacity through the new model. This requires:

- A baseline assessment of current workforce numbers and skill mix for both the registered and unregistered therapy workforce viewed against current activity.
- Identification of the competencies and workforce required to meet the demand and needs of the population, aligned to the new community rehabilitation and reablement model.
- Modelling the impact of training strategies and job planning.
- Early consideration of the behavioural and cultural changes required to change practice, and the clinical and professional leadership required to enable implementation.
- Partnership working to develop the workforce plan, including consideration of all relevant organisations with the capacity and capability to deliver care such as housing, voluntary and independent sector providers.

Workforce plans and training should be included within the ICB workforce strategy, people plan and governance processes to ensure ownership at ICB executive level and within relevant provider organisations.

Any workforce changes introduced should be monitored against demand forecasts and evaluated for their impact on outcomes and quality, including safety and timeliness in access.

In line with Developing workforce safeguards, all community providers should ensure three components are used in their staffing processes: evidence-based tools (where they exist), professional judgement, and outcomes. Further tools and guidance can be found in the Integrated Workforce Thinking Guide.

Recommended Action (winter 2023/24): Initiate workforce mapping exercise to identify available resources and skill mix to inform winter planning.

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Recommended Action (winter 2023/24): Review activity undertaken by therapists that could be undertaken by support workers (e.g. the assessment, fitting and checking of an agreed range of equipment; and follow-up visits)[7].

Recommended Action (now until March 2025): Continue workforce mapping exercise to identify available resources and skill mix to inform demand and capacity planning for 2024/25 (in line with the NHS Long Term Workforce Plan) and longer-term service planning.

Ensuring resources are in the right settings

Having timely access to the right expertise in community settings is essential to a responsive model. Implementing the model requires a greater proportion of the therapy workforce in community settings, so that staff are able to work through care transfer hubs to determine discharge pathways and then assess people for rehabilitation needs in their homes (usual place of residence) or in short-term community bedded settings as soon as possible after their discharge.

Example: Rotational workforce model – a workforce model involving the rotation of therapy staff between hospital and community settings can enable staff to gain exposure to different parts of the pathway, broaden their skillset, resolve challenges across the pathway and reduce duplication. It may also improve knowledge and confidence to deliver in community settings and address behavioural and cultural challenges. If cross-organisational, this can be supported by digital staff passports which enable staff to be deployed into other organisations.

Harrogate and District NHS Foundation Trust: Rotation of therapy workforce

The Acute Response and Rehabilitation in the Community and Hospital (ARCH)* Unit at Harrogate and District NHS Foundation Trust rotates the therapy workforce between acute and community settings with staff working 4 months in acute and 8 months in community.

** ARCH is a part of the adult community service, which is a part of Harrogate and Rural Alliance (HARA). It also supports the Hospital at Home offer with input from a care of the elderly consultant and support from North Yorkshire Council and NHS intermediate care beds as well as the hospital.*

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[7] As supported by the Chartered Society of Physiotherapy, the Royal College of Occupational Therapists, the Royal College of Speech and Language Therapists, and the Chief Allied Health Professions Officer.

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Example: Reallocation of resources to different parts of the pathway – the reallocation of therapy staff to different parts of the pathway may require consultation with staff. It may be helpful to implement a rotational strategy as the initial step to build confidence and knowledge. The approach may be enacted through cross-organisational agreements and Memorandums of Understanding.

Barnsley Hospital NHS Foundation Trust: Reallocation of therapy workforce

Barnsley Hospital NHS Foundation Trust reviewed their registered therapy workforce and reallocated staff from medical wards to community settings to increase capacity for assessment within communities. The arrangement was enacted through a Memorandum of Understanding between the relevant hospital and community provider while retaining staff on their existing provider contracts.

Flexible deployment of resources

The flexible deployment of resources to utilise expertise at the right point in the pathway, increase capacity at surge periods, and deliver 7-day access, will require:

- **Effective coordination processes** – a central hub of coordinators can support a system to direct the workforce and expertise to the right place in the community, enable in-reach into hospitals for timely discharge, and support communication and information sharing amongst the workforce interacting with the person.
- **Enabling infrastructure** – a workforce bank can support a system to increase capacity by onboarding people who want to work flexibly, are looking for additional hours, or are looking to gain more experience. It can utilise capacity from across sectors including the independent sector and could include students and volunteers. Systems should take measures to allow greater mobility of staff across boundaries and sectors through collaborative banks in line with the NHS Long Term Workforce Plan. A list of agreements can be found here.

Recommended Action (winter 2023/24): Ensure workforce banks are used to support rehabilitation across the health, social care, independent and voluntary sectors.

Recommended Action (winter 2023/24): Review staff on current banks to identify any competencies that could be used to undertake activities and increase rehabilitation capacity.

Expanding the therapy support workforce

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Expanding the therapy support workforce can be achieved through reviewing current utilisation, and developing plans to maximise opportunities for delivering care under the oversight of registered therapists. This can release capacity from the registered workforce to manage complexity and provide advice, supported by effective job planning.

Under the model, the therapy support workforce will be adequately trained, supported and supervised to undertake the activities delegated to them to ensure high quality rehabilitation that is timely, safe and person-centred.

Information to assist with the attraction, recruitment, retention and development of the community rehabilitation support workforce is provided in the Community Rehabilitation Support Workforce Resource Pack. This includes guidance on delegation, accountability and supervision to ensure compliance with regulatory requirements in the interest of public protections and safety. The Health Education England Allied Health Professional (AHP) Support Worker Competency, Education and Career Development Framework provides further guidance for systems to support the expansion and development of AHP support workers.

Systems can expand their use of apprenticeships, in line with the NHS Long Term Workforce Plan. This will increase workforce capacity whilst also providing a training route.

Increasing efficiency

Increasing efficiency can be achieved through a competency-based approach. This allows a system to optimise its workforce based on skills available through the registered workforce, support workforce and wider community resources, aligned with the competencies identified through the workforce planning exercise.

Releasing capacity from the registered therapy workforce will enable registered therapists to focus on specialist and bespoke interventions, and to manage complexity. Approaches to release this capacity include (but are not limited to):

- Enabling support workers and individuals in similar roles to undertake specific activity, where appropriate and agreed in line with a therapy-led approach.
- Streamlining processes and protocols to reduce waste and duplication of assessments.
- Pan-professional development where, whilst being specialists in respective professions, professionals can develop core skills across other disciplines to ensure a person gets the maximum support from each contact.
- Improving coordination of specialist expertise into delivery when required.
- Increasing access to administrative support.

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- Using digital solutions (ensuring health inequalities are considered) to enable remote delivery of rehabilitation, and to improve remote access to registered therapist input, reducing travel time and ensuring advice and specialist expertise is accessible in a timely manner.

Recommended Action (winter 2023/24): Release therapist capacity by: utilising digital interventions for remote assessment, advice and delivery where appropriate; making use of administrators for administration and coordination activities; and streamlining referral processes.

Recommended Action (winter 2023/24): Work collaboratively across the system to identify actions required to reduce double-handed care, where safe and appropriate, and optimise handling approaches.

Developing training strategies

In line with a competency approach, all staff involved in delivering community rehabilitation assessments and interventions should be appropriately trained to undertake the activities required of them. This training should take into account the changes in behaviours necessary to deliver the new model and its guiding principles, including that support is person-centred and holistic.

All staff should be aware of the need for equity of access and provision, so that no one is excluded from step-down intermediate care or receives sub-optimal care based on whether they:

- Have a particular condition.
- Have particular needs.
- Have a protected characteristic.
- Live in particular circumstances.

Development and use of an agreed competency framework across systems and partners will improve efficiency and flexibility in the use of resources, enable standardisation of the skill mix and improve the outcomes and experiences of people.

Following workforce planning, reviewing current local training programmes against known skills gaps will help to identify opportunities for additional provision across the system. These can be delivered through use of educator roles.

Accessing relevant skills, expertise and community assets

Rehabilitation assessments and interventions delivered in line with the new model will be therapy-led (i.e. overseen by a registered therapist who will offer advice,

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support and guidance as required), with strategic oversight for quality, including safety. Delivery will be by a multi-disciplinary and multi-agency workforce, working in integrated ways, deployed flexibly and in a timely manner according to the needs of the individual.

Staff may need to pull in relevant skills and expertise from across neighbourhood and place levels, including but not limited to:

- GPs, geriatricians and rehabilitation medicine specialists.
- Community teams: nurses, pharmacy professionals, mental health and dementia teams.
- Other allied health professions.
- Specialist teams, e.g. palliative and end of life care, learning disability and autism.
- Local authority housing and homelessness teams.

Wider community support will enhance and supplement the rehabilitation process and activities, and may help to address health inequalities, including but not limited to:

- Families, friends and unpaid carers.
- Community and faith groups and centres.
- Leisure and sports facilities and workforce.
- Volunteers.

Further guidance on community resources is available from NHSE and SCIE.

Changing behaviours and culture

Work with the frontrunners and engagement with systems and stakeholders, supported by NHS England's Behavioural Science Unit, has identified a number of themes to support delivery of the framework and new model:

- The importance of **leadership** – in establishing a shared vision, role-modelling behaviours and creating a safe culture of innovation and shared ownership of risk.
- Recognition that **trust** is required across organisations, but ambiguity about what this means in practice – what should you trust particular people to do? when should you challenge rather than trust?
- Organisational **culture and values** matter, especially when working across organisational boundaries. However these will only make a difference if they can be translated into behaviours which foster improvement.

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- The person needing intermediate care and their carers may also have a different attitude to risk. People with their **individual needs, preferences and circumstances** are the most important voice in, and should be at the centre of, all decision-making during the assessment, planning and delivery of intermediate care.

Further detail, including examples of solutions or good practice, can be found at Annex B.

Recommended Action (now until March 2025): Identify and address the behavioural change needed locally to support implementation of the new model.

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Priority area 3: Implement effective care transfer hubs

What is a care transfer hub's role in intermediate care?

A care transfer hub is a focal point for coordinating discharge for people with new or increased needs who require post-discharge health and/or social care and support (i.e. those on discharge pathways 1, 2 and 3). All complex discharges into intermediate care will therefore be managed by the hub.

In general, a person likely to have complex discharge needs is referred to a care transfer hub by ward staff, who begin discharge planning from the point of admission and describe relevant information about the person's needs. Hub staff then determine the most appropriate discharge pathway, taking a 'home first' approach. Where the person would benefit from intermediate care, the hub contacts the most appropriate local team to determine the rehabilitation needs as soon as possible in order to plan in advance to coordinate the short-term interventions that will be needed after discharge.

Care transfer hubs may operate at trust, place, or system-level depending on what makes sense locally. Each should comprise a multi-disciplinary and multi-agency team of health, social care, housing and voluntary sectors partners, with strong links into care providers.

Walsall: Care transfer hub integration

Walsall are fully integrated across health and care and share an integrated IT system. This has been key to the success of their care transfer hubs, creating a seamless process from step-up to step-down intermediate care services as well as exits from intermediate care. Currently social care, mental health, acute and community health are included, with work towards adding primary care and the voluntary sector.

Developing care transfer hub capability

Central to the success of a care transfer hub is the coordination of staff from the participating agencies and professions within a single management arrangement, alongside close working with providers of care and support.

Today, hubs are at different levels of development and will evolve from pre-existing integrated discharge arrangements. National guidance, developed in 2022, is available to support systems in identifying the key features of an effective care transfer hub and provides good practice examples of well-developed hubs.

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Priority actions for systems

Nine areas of focus have been recommended to support the development of care transfer hubs in advance of winter 2023/24. Health and care systems are encouraged to review the arrangements in place within their hubs and use the list of priority actions to support further development of their capabilities.

Recommended Action (winter 2023/24): Governance structures – Embed structures including having a Senior Responsible Officer (SRO), clear internal escalation routes and reporting into relevant boards.

Recommended Action (winter 2023/24): Core team – Establish effective workforce mix within the integrated group of organisations that forms the care transfer hub.

Recommended Action (winter 2023/24): Links with hospital staff – Ensure hospital staff are aware of function, communication routes and processes, with strong links to pharmacy and transport.

Recommended Action (winter 2023/24): Links with onward care providers – Ensure strong links into broader health and care networks including specialist care provision, community health sector and social care sector.

Recommended Action (winter 2023/24): Streamlined assessment processes – Implement trusted assessments to reduce duplication wherever possible and ensure the information is shared appropriately through the pathway. Ensure hubs have the authority, processes and staffing mix to make appropriate and effective decisions about packages of care, based on patient need.

Recommended Action (winter 2023/24): Case management and patient tracking – Clear processes for case management from before medical optimisation until discharge, and escalation of challenges.

Recommended Action (winter 2023/24): Early discharge planning – Develop proactive processes that provide timely information to care transfer hubs of likely care needs as part of discharge planning from the point of admission.

Recommended Action (winter 2023/24): Seven-day operations – Optimise the operating hours of the care transfer hub to ensure delays to transfer of care are minimised, with operations 7-days per week where possible.

Recommended Action (winter 2023/24): Data – Effective use of capacity and demand data and appropriate information governance arrangements in place to support sharing of data and information

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Medium-term actions for systems

In addition to the priority actions, additional medium-term actions are recommended to systems to support care transfer hub development by March 2025:

Recommended Action (now until March 2025): Explore alignment of the care transfer hub with existing triage/community coordination functions (such as single points of access) that support admission avoidance.

Recommended Action (now until March 2025): Develop measures to monitor the timeliness and effectiveness of the care transfer hub in supporting people to access post-discharge health and/or social care and support, including step-down intermediate care.

Recommended Action (now until March 2025): Build networks between neighbouring care transfer hubs to standardise discharge processes and enable faster repatriations between hubs.

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Priority area 4: Improve data quality and prepare for a national standard

Preparing for a national standard

NHS England is developing a new national standard for rapid discharge into intermediate care, as set out in the Delivery plan for recovering urgent and emergency care services. However, data in this area are not standardised, consistent and are often collected at a local level in multiple formats. This limits the understanding of the timescales and processes that support optimum discharge into intermediate care.

Improved data will inform the approach to a new national standard. The steps in this framework will facilitate rapid improvements to data quality, coverage and completeness at system, regional and national-level, with care transfer hubs acting as custodians of operational system-wide demand and capacity real-time data.

Embedding real-time data into day-to-day operational working

Recommended Action (winter 2023/24): Embed system-wide visibility of data across all partners into day-to-day operational working with clinical leadership in care transfer hubs.

Visible data

In February 2023, NHS England set out an expectation for ICSs to develop integrated data and population health analytics. Building an integrated care system intelligence function provides a roadmap for evolving shared business intelligence and developing analytics capacity and includes a system workforce improvement model.

The intermediate care frontrunners have developed and implemented system-wide live dashboards to show capacity, flow, delays, and outcomes. They are embedding the use of this visible, real-time data into day-to-day operational management of their systems, to optimise patient flow, and to facilitate demand and capacity planning and performance monitoring. Care transfer hubs will be critical to this information oversight and to ensure the transition between hospital and home is as seamless as possible.

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System visibility tools

Leeds Health and Care Partnership use their tool to support evidence-based decisions at all levels. These focus on managing system pressure, improving the efficiency of services, and enabling the most independent outcomes for people. The technology solution brings data together from across the system and visualises it with the key insights to understand system pressure. This is underpinned by active leadership ensuring the right people are reviewing the data and working collaboratively to make data driven decisions and get to the root of the problem.

Humber and North Yorkshire Integrated Care Board are using digital tools and revised pathways to improve flow and reduce discharge delays. The use of OPTICA - NECS gives shared visibility of all people using acute and community services and tasks relating to their discharge, with the application supporting the health and social care MDT to share information and collaborate effectively at person-level. Further expansion is planned into acute and community services to support admission avoidance and maximise the use of out of hospital resources.

Data-sharing agreements

Recommended Action (winter 2023/24): Ensure data sharing arrangements align to the NHS England Information Governance Framework.

Robust and appropriate system-wide sharing of data enables validation between all parties, ensuring there is a single version of the truth for demand and capacity planning and quality assurance. Data-sharing agreements in place should be fit for local purposes and meet information governance (IG) requirements alongside appropriate IG training for staff.

In September 2021, NHS England published a framework for sharing care records across integrated systems. This includes templates for data-sharing agreements and IG record-keeping.

Sharing data across boundaries

Frimley Health NHS Foundation Trust has worked with local partners to develop a Health and Social Care Information Sharing Agreement framework which has been subjected to review by solicitors and Kings Counsel and is described by them both as being lawful and fit for purpose. It provides a clear framework for the secure sharing of personal confidential data across health and social care systems. The framework enables the real-time use of risk stratification data at the point of care for people with the most complex needs.

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The Dorset Intelligence and Insight Service (DiiS) is a collaborative project to deliver a live linked health and social care dataset across Dorset ICS. The aim is to make health and social care open, easy to access and available, to create actionable insights. It is being used to support data-led service improvement and planning at a system and organisational level. The DiiS is now being used every day by health and care professionals to support evidence-based decision-making.

Evaluation and ongoing monitoring of the impact of interventions

Recommended Action (now until March 2025): Continue to evaluate the improvements made to increase capacity of intermediate care services to ensure that these are effective for people, staff and the system.

Use data for quality assurance

Using data to measure the outcomes and experiences of people using local services, both qualitative and quantitative, enables systems to evaluate the impact of intermediate care interventions.

Data collection, benchmarking and audit of intermediate care interventions enable continuous review against agreed planned impact and outcomes. This supports continuous learning and improvement, evaluation and reducing unwarranted variation in practice.

Audits may look at a variety of elements including resources, the impact on access and health inequalities, clinical variation, and unmet need. The NHS Benchmarking report on intermediate care includes example indicators that systems may use for auditing purposes.

Oxford: Model dashboard for people experiencing homelessness

Oxford is one of 17 test sites in England developing data dashboards for specialist intermediate care focused on people experiencing homelessness. The dashboards capture patient experience, outcomes and cost effectiveness for public services, including the NHS. They employ a range of metrics, including patient demographics, patient flow, housing and health outcomes, quality adjusted life years (QALYs) and annual resource usage. This allows comparison of trend data against benchmarks, serving as a valuable management tool for intermediate care to drive long-term service improvements. In Oxfordshire, this shows how increasing bed capacity in residential step-down has led to improved health and wellbeing outcomes; accompanied by 25% decrease in emergency admissions and 56% decrease in ED attendance.

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Developing the data

Data skills and digital tools

Investment in building data skills and capacity is vital. Data as business intelligence will be a key component of the implementation support available to systems and providers. NHS England is working with the Chartered Society of Physiotherapy to deliver health informatics e-learning resources for Allied Health Professionals (AHPs) which are due for release in early 2024.

Moving towards an improved dataset

NHS England will set out an intermediate care minimum dataset for individual records to evidence the impact of interventions on outcomes, aligned to initiatives including proactive and personalised care, virtual wards and initiatives to develop client-level datasets within social care settings.

The approach will not specify the use of a particular system or tool but provide a blueprint for functionality, building on local approaches that have already been implemented with success.

All systems are recommended to work towards individual datasets.

OneLondon: Care record programme

OneLondon is piloting access to the London Care Record to 28 care homes with a phased roll out over the next few years. The London Care Record, which uses Cerner HIE, helps to meet the challenges that care providers face in accessing appropriate health information to meet resident's needs. Access is contingent on meeting Data Security and Protection Toolkit standards, technical training and information governance training. Piloting has shown a marked reduction in time spent calling GP practices and hospitals, as well as faster discharge, treatment times and reduced visits to A&E.

Reducing the data burden

NHS England is committed to supporting local teams to work towards automated data extraction from online systems, and to creating opportunities for systems to access data to benchmark the efficacy of their commissioning practices.

Systems are advised to familiarise themselves with plans to roll out a Federated Data Platform over the coming years which will enable NHS organisations to bring together operational data – currently stored in separate systems – to support staff to access the information they need in one safe and secure environment. Alongside the Faster Data Flows initiative, set out in the 2023/24 priorities and operational

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planning guidance, this project forms a key component of the evolution of the data architecture to a less burdensome position.

A list of data tools, resources, standards, definitions and other useful data publications can be found at Annex C.

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Oversight and support

Governance

The frontrunners ensured joint executive leadership and system agreements were in place across partner organisations, through shared decision-making and governance. They determined that leaders need to develop and agree a system-wide approach for step-down intermediate care that puts people's outcomes and experiences at the centre, with a 'home first' ethos and focus on high quality care. This helped ensure capacity is in the right place for local demand and system flow.

Recommended Action (winter 2023/24): Embed processes and procedures that enable partner organisations to share operational accountability for the planning and delivery of intermediate care.

Approaches to collaborative working across the system differed across frontrunner sites – some were led by providers, and others by commissioners; both approaches are valid if systems have ensured there are clear governance processes and accountability lines for the delivery of intermediate care, including performance, quality, finance and risk tolerance.

Locally, systems should follow National Quality Board guidance on quality governance[8] and align any quality assurance and improvement aspects of step-down intermediate care to this.

Improvement support

Systems have been allocated into one of three urgent and emergency care tiers based on local insight and performance, which determines the level of improvement support they will receive – from the highest level of bespoke support to a universal support offer.

Systems have undertaken a maturity self-assessment for several high impact interventions that will deliver urgent and emergency care pathway improvements and have chosen around four high impact initiatives to focus on for winter 2023/24. Systems have been invited to participate in improvement modules for the high impact initiatives they have selected. The improvement modules for intermediate care, community hospital flow and care transfer hubs will support implementation of this framework.

[8] Shared Commitment to Quality); National Guidance on System Quality Groups; National Guidance on Quality Risk Response and Escalation

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Further guidance, tools and resources, including case studies, to support implementation of this framework are available on the intermediate care workspace on the FutureNHS Collaboration Platform. Contact england.intermediatecare@nhs.net to request a joining invite.

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Recommended actions ahead of and during winter 2023/24

Priority area 1: Improve demand and capacity planning	
1.	Commissioners across health and care should agree projections of demand based on need, identify capacity commissioned, identify additional capacity required, and work with providers to identify how best to deliver it.
2.	Look at new processes and structures to improve productivity, and work with partners to identify ways to maximise capacity.
3.	Agree and track delivery of actions for improvement based on the high impact actions, using the modelled demand and capacity analysis.
Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model	
4.	Initiate workforce mapping exercise to identify available resources and skill mix to inform winter planning.
5.	Review activity undertaken by therapists that could be undertaken by support workers (e.g. the assessment, prescription, fitting and checking of an agreed range of equipment; and follow-up visits).
6.	Ensure workforce banks are used to support rehabilitation across the health, social care, independent and voluntary sectors.
7.	Review staff on current banks to identify any competencies that could be used to undertake activities and increase rehabilitation capacity.
8.	Release therapist capacity by: utilising digital interventions for remote assessment, advice and delivery where appropriate; making use of administrators for administration and coordination activities; and streamlining referral processes.
9.	Work collaboratively across the system to identify actions required to reduce double-handed care, where safe and appropriate, and optimise handling approaches.
Priority area 3: Implement effective care transfer hubs	
10.	Governance structures – Embed structures including having a Senior Responsible Officer (SRO), clear internal escalation routes and reporting into relevant boards.
11.	Core team – Establish effective workforce mix within the integrated group of organisations that forms the care transfer hub.
12.	Links with hospital staff – Ensure hospital staff are aware of function, communication routes and processes, with strong links to pharmacy and transport.
13.	Links with onward care providers – Ensure strong links into broader health and care networks including specialist care provision, community health sector and social care sector.

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14.	Streamlined assessment processes – Implement trusted assessments to reduce duplication wherever possible and ensure the information is shared appropriately through the pathway. Ensure hubs have the authority, processes and staffing mix to make appropriate and effective decisions about packages of care, based on patient need.
15.	Case management and patient tracking – Clear processes for case management from before medical optimisation until discharge, and escalation of challenges.
16.	Early discharge planning – Develop proactive processes that provide timely information to care transfer hubs of likely care needs as part of discharge planning from the point of admission.
17.	Seven-day operations – Optimise the operating hours of the care transfer hub to ensure delays to transfer of care are minimised, with operations 7-days per week where possible.
18.	Data – Effective use of capacity and demand data and appropriate information governance arrangements in place to support sharing of data and information.
Priority area 4: Improve data quality and prepare for a national standard	
19.	Embed system-wide visibility of data across all partners into day-to-day operational working with clinical leadership in care transfer hubs.
20.	Ensure data sharing arrangements align to the NHS England Information Governance Framework.
Oversight and support	
21.	Embed processes and procedures that enable partner organisations to share operational accountability for the planning and delivery of intermediate care.

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Recommended actions between now and March 2025

Priority area 1: Improve demand and capacity planning
1. Develop a single approach to ICS demand and capacity planning for intermediate care across BCF and NHS planning footprints.
2. Utilise the Health Inequalities Improvement Planning Matrix when designing, implementing and evaluating intermediate care services, considering CORE20PLUS5 population groups.
Priority area 2: Improve workforce utilisation through a new community rehabilitation and reablement model
3. Identify an AHP lead to progress implementation of the new model (both within the hospital and in the community).
4. Undertake a baseline assessment to determine how far the system is from the new model.
5. Identify actions to progress the new model and build on the baseline assessment.
6. Ensure the programme is docked into appropriate governance structures for oversight of progress, including clinical/professional leadership and executive ownership.
7. Continue workforce mapping exercise to identify available resources and skill mix to inform demand and capacity planning for 2024/25 (in line with the NHS Long Term Workforce Plan) and longer-term service planning.
8. Identify and address the behavioural change needed locally to support implementation of the new model.
Priority area 3: Implement effective care transfer hubs
9. Explore alignment of the care transfer hub with existing triage/community coordination functions (such as single points of access) that support admission avoidance.
10. Develop measures to monitor the timeliness and effectiveness of the care transfer hub in supporting people to access post-discharge health and/or social care and support, including step-down intermediate care.
11. Build networks between neighbouring care transfer hubs to standardise discharge processes and enable faster repatriations between hubs.
Priority area 4: Improve data quality and prepare for a national standard
12. Continue to evaluate the improvements made to increase capacity of intermediate care services to ensure that these are effective for people, staff and the system.

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Annex A: Frontrunners

NHS England is working with eight sites across the country which have been trialling new approaches to intermediate care, including six national discharge frontrunners and two additional pilot areas. The national discharge frontrunners are:

- **Leeds Health and Care Partnership** – launched their HomeFirst Programme in May 2023 with a vision of a sustainable, person-centred, 'home first' model of intermediate care across Leeds that is joined-up across health and care and promotes independence.
- **Warwickshire Care Collaborative** – launched their Discharge Community Recovery Programme in April 2023 following system-wide agreement of the need to move from a community bed-based to a flexible mix of home-based and community bed-based intermediate care.
- **One Croydon Alliance** – appointed two joint SROs for intermediate care (one from health and one from social care) and are creating acute, community and social care teams with integrated IT, financial systems and leadership.
- **Sussex Integrated Care System** – are working to test the better use of digital tools and data that will improve flow, workforce and reduce discharge delay; a digital dashboard will deliver patient level and aggregated management level information.
- **Humber and North Yorkshire Integrated Care Board** – are creating a pilot system version of OPTICA-Community for providers delivering in hospital and post-discharge community care to identify and rectify unfulfilled discharge tasks and match services with individuals about to be discharged and following discharge.
- **Four Localities Partnership (part of Greater Manchester)** – are developing strategies to expedite care and discharge within the dementia care environment.

The additional pilot areas are:

- **Walsall Healthcare NHS Trust** – has been running an intermediate care service since 2017 which is fundamental to the timely discharge of adult patients from hospital. They now aim to focus on and strengthen their 'home first' ethos. The service will be outcome-focused with goal setting and a reduced reliance on traditional domiciliary care to avoid the over-prescription of care.
- **East Kent Health and Care Partnership** – are scoping existing short-term services to enable a pooled budget to be set up between health and social care by September 2023. A provider collaborative and lead commissioning by the council will deliver the services.

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Annex B: Behavioural science interim themes

Work with the frontrunners and engagement with systems and stakeholders, supported by NHS England's Behavioural Science Unit, has identified the following emerging themes to support delivery of the framework and new community rehabilitation and reablement model:

Leadership

Working with and engaging staff

- Creating a narrative around the importance of the role of community services and the interface with both acute and primary care.
- Empowering staff to feel part of decision-making and solutions.
- Promoting the benefits to people from therapists being in the community.
- Leadership working with staff to reduce variation in practice, ensuring the workforce is being used in line with their competencies, at the right point in the pathway, in the right setting.

Sussex Integrated Care Board held a support worker conference aimed at building momentum and empowering the support workforce.
Harrogate NHS Foundation Trust has a rotational model which has improved staff understanding of community services, built confidence and reduced staff anxiety when delivering in the community.

Trust

Building trust

- Leadership and distributed leadership models across the NHS and social care are an essential pre-requisite to build trust, improving joint working and efficiency.
- Having the right leadership in post can cultivate a team who work together well from a variety of backgrounds and professions.
- Shared understanding of roles, responsibilities and accountabilities, and of standards and competencies will improve trust in decision-making and support multi-disciplinary and multi-agency team working.
- Jointly funded posts can support an environment of trust and improve partnership working.

Developing relationships and partnerships

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- Developing networks in the rehabilitation workforce across settings to strengthen relationships.
- Building strong partnerships between the NHS, local authority, housing, voluntary and independent sectors, and with academies and schools.

A growing number of systems are adopting approaches of co-locating health and social care workforce with the aim of creating more joined up pathways and streamlined delivery.

Culture and values

Embedding a rehabilitation approach

- Ensuring movement and activity on wards to reduce deconditioning is the responsibility of all ward team members.
- Embedding a rehabilitation culture across the pathway and across key roles that interact with and support people to rehabilitate, re-able and recover or regain function.

Understanding of cultural differences across settings/sector

- Working together to achieve a common purpose is key to new ways of working and maximising use of resources across settings/sectors.
- Co-location of staff improves communication and understanding of roles across sectors/professions.
- Ensuring a unified message from organisational leadership enforces a ‘home first’ approach across ward and community settings.

Working with and engaging staff

- Ensuring any training reinforces the behavioural changes that are needed.
- Building competence and confidence in delivering in communities will improve staff retention and utilisation.

Embedding person-centred approaches

- Person-centred leadership to move to a ‘what matters to you?’ approach.
- Develop a clear public-facing message about a ‘home first’ approach and use of a mixed and skilled workforce for rehabilitation.

The Academy at Kent Community Health NHS Foundation Trust offers unique accredited routes into health careers, providing work-based and academic learning.

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Leeds Health and Care Partnership have launched their HomeFirst 'I Statements' which describe what people who use intermediate care services, and their carers, can expect to feel and experience from the care and support they deliver. The Partnership are also undertaking a survey to understand people's experiences of using their intermediate care services.

Attitudes to risk

Developing positive attitudes towards risk

- Promoting a positive risk taking and continuous learning environment and eliminating any blame culture.
- Engage friends, family and carers to support positive risk taking and focus on what is best for the individual.

Many systems are looking to community leadership roles, e.g. Chief AHPs in trusts and local authorities, and advanced practice roles in the community to drive behavioural and cultural change. Some of these are jointly funded.

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Annex C: Data tools, resources, standards and definitions

Data tools and resources

- Community Discharge SitRep Full Technical Specification, NHS England.
- NHS National Data Platform (Foundry) Onboarding Guide, FutureNHS Collaboration Platform.
- Tableau – system leads should email the Analytical Products Team at england.analyticsproductsteam@nhs.net for access.
- Information on Faster Data Flows and the Federated Data Platform – on page 18 of 2023/24 NHS Priorities and Operational Planning Guidance.
- Information Governance Framework, NHS England.
- Building an Integrated Care System Intelligence Function, NHS England.
- Intermediate care data community of practice, FutureNHS Collaboration Platform – for access to tools, case studies (including further details of those in this framework) and other resources, including access to data-specific webinars for business intelligence leads. Contact england.intermediatecare@NHS.net to request a joining invite.

Building business intelligence and analytics skills

- Health informatics e-learning resources for Allied Health Professionals (AHPs), NHS England working with the Chartered Society of Physiotherapy – this programme, which is being developed in consultation with other AHP professional bodies, is due for release in early 2024.

Data standards and definitions

- NHS Data Model and Dictionary, NHS England.
- Adult social care data hub, NHS England.
- The Caldicott Principles for good information sharing, National Data Guardian.
- Information Governance Guidance, NHS England.
- NHS Data Security and Protection Toolkit (DSPT), NHS England.

Other publications

- Data Saves Lives: reshaping health and social care with data, Department of Health and Social Care.
- Making Community Rehabilitation Data Count, Community Rehabilitation Alliance.

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