REPORT TO:	Health Policy & Performance Board
DATE:	23rd February 2021
REPORTING OFFICER:	Strategic Director, People
PORTFOLIO:	Children, Education and Social Care Health and Wellbeing
SUBJECT:	Intermediate Care Services in Halton
WARD(S):	Borough-wide

1.0 PURPOSE OF REPORT

1.1 To provide the Board with an update on Halton's Intermediate Care Services Review and progress towards the development of a new model for Intermediate Care in the Borough.

2.0 RECOMMENDATION

RECOMMENDED: That the Board

(1) Note contents of the report and associated appendices.

3.0 SUPPORTING INFORMATION

Introduction

3.1 For a number of years, Intermediate Care (IC) Services within Halton has comprised of four services, as follows:-

- Rapid Access Rehabilitation Service (RARS);
- Oakmeadow (Intermediate Care Unit);
- Halton Intermediate Care Unit (HICU); and
- Reablement

Services have been resourced by multi-disciplinary teams of clinicians, nurses, therapists and social care staff, who provide rehabilitation services for people needing rehabilitation, to promote independence, prevent unnecessary hospital and care home admissions and facilitate discharge from Hospital.

3.2 In 2019, Halton commissioned a review of IC Services comprising of:-

- an independent review, via the Local Government Association (LGA), by Dennis Holmes ***(see Appendix 1)***;
- a North West Association of Directors of Adult Social Services (NW ADASS) Peer Review (***see Appendix 2)***; and
- an 'organisational raid' to Rochdale, to view the service pathways and models operating in that borough.

Essentially, in summary, the work identified the following issues/recommendations in relation to IC Services in Halton:-

- Adopt a more community focused 'home first' model providing services in people's own homes – this essentially incorporates the 'reablement first' and 'discharge to assess' approach with a focus on recovery through functional assessment and intervention work;
- Develop a pathways approach to hospital discharge;
- Reduce length of stay in short-term bed based services and therefore increase capacity, allowing for a reduction in actual bed numbers;
- 'Reset the system' by addressing issues in long term care provision; and
- The Peer Review suggested HICU (Ward B1) was more aligned in its functioning and physical space as an 'in-hospital' service and was not intermediate care.

An action plan was developed, with a system wide oversight group, and various work streams commenced, including work on reviewing the IC criteria and associated pathways and a 'case for change' in respect to a future model for the delivery of IC services in Halton.

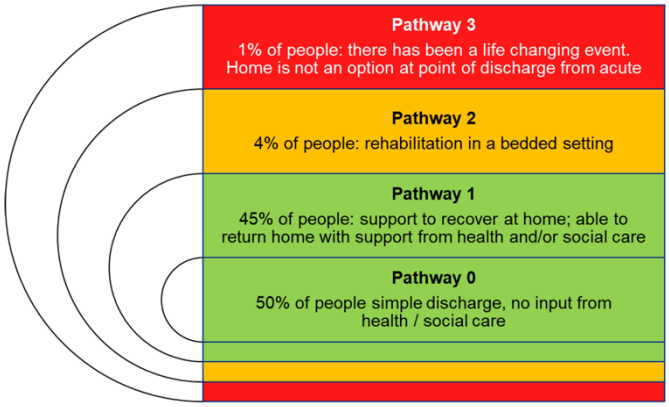
However, this work was 'paused' in March 2020, due to the priority focus being the management of the Coronavirus pandemic.

3.3 **Impact of the Coronavirus Pandemic**

As a result of the Pandemic and the need to ensure health and social care services could continue to effectively respond, there was a need to rapidly review service provision and introduce new ways of working.

As such, a key element of this was the national introduction of the COVID-19 Hospital Discharge Service Requirements on 19th March 2020.

In essence, this guidance provided a renewed focus on the Discharge to Assess model based on four clear pathways for discharging patients from hospital, as shown below:-



3.4 Systems and processes within our local Acute Trusts needed to be realigned to support this approach. In Halton, the Care Management Service, including resources from the existing Capacity and Demand Team and RARS, were merged and redesigned to support the approach. This was to ensure that a capacity and demand led approach could be taken, in order to create sufficient and robust capacity to manage a predicted spike in hospital admissions.

3.5 One of the unexpected outcomes of the Pandemic in Halton and the approach needing to be taken was the ability to 'reset' the system in respect to being able to create capacity within Intermediate and Domiciliary Care Services and change pathways and associated processes.

3.6 The reconfigured services within the Borough and the alignment with Acute Trusts have had a high degree of success in creating capacity within service areas, from which we have taken learning to help support the development of a new approach to IC within Halton. For example:-

- Rapid assessment and a speeding up of the pathway through IC bed based services utilising discharge to assess approaches has significantly reduced both the number of people in these bed bases and reduced length of stay.
- The Reablement first approach has facilitated more people out of hospital into the community with support. Processes through the service have reduced length of stay and therefore increased available capacity.
- Focus in the acute sector on daily management of people has enabled earlier identification of people in process and advanced planning to achieve discharge, when medically ready and safe to do so.

3.9 Although it is recognised that we are still in the depths of the Pandemic and the system is under some considerable pressure, we felt that we needed to capitalise on the success creating capacity in the system had brought us and as such felt it was appropriate to revisit the recommendations of the previous IC review, taking into account the impact that the Pandemic has had on current structures, processes and pathways and move forward, at pace, with the development and implementation of a new model/approach to IC in Halton, which would deliver necessary and appropriate services.

3.10 As such, work has been taken forward via the IC Review Steering Group (Multi Agency group), chaired by Halton's Director of Adult Social Services, supported by an IC Model Development Group and although work hasn't been progressed as quickly as liked, due to operational pressures, positive progress has been made and we are on schedule to introduce a new model for Intermediate Care from 1st April 2021.

New IC Model

3.11 One of the main elements of the new model is the planned introduction of a Single Point of Access (SPA) for IC Referrals (from Hospital and the Community), both those requiring support within the community and those requiring a bed.

3.12 The aim of the SPA will be to ensure people receive the necessary interventions for those needing rehabilitation, to promote independence, prevent unnecessary hospital admission and facilitate discharge from Hospital.

The key objective of the SPA is therefore to ensure the seamless, safe management of referrals for people requiring Adult Community Services, either to potentially prevent an admission, support early discharge or coordinate care 'closer to home.'

An integral part of the SPA will be its Rapid Response Function (RRF).

Benefits to Service User of introducing the SPA include:

- Reducing the number of inappropriate referrals into services: right care first

time.
- Reducing duplication of assessments and visits to people's homes through better care co-ordination.
- Facilitating discharge and preventing unnecessary admissions.

Benefits to the Halton system of the SPA:
- Alternative referral route for GPs and healthcare professionals.
- Simplified, efficient referral process which includes assessment and planning of care.
- Reduces the time currently spent by the referrer in identifying and arranging appropriate treatment, care and support across a range of disciplines.
- Improved access to a range of services.
- Communication of agreed plan of care back to referrer and to GP if not the referrer.
- Supports people to stay at home and minimises the need for admission to hospital.
- Increase activity in community services as a result of GPs referring into SPA rather than admitting people to acute hospitals.
- Having the seamless sharing of data and information across services/organisations.
- Increase face to face clinical time.
- Reduces the amount of Delayed Transfers of Care.

3.13 The SPA will be resourced by a multi-disciplinary team consisting of clinicians, nurses, therapists, dietician, administrative and social care staff and at the time of writing this report further work is being carried out on the exact numbers and skills mix required, in addition to the hours of operation.

The SPA will hold the role of "care co-ordinator" until the relevant onward referrals have been made/individual discharged from SPA. An individual will have a named care co-ordinator from within the SPA.

3.14 As referenced in paragraph 3.12 there will be a RRF of the SPA which will provide place based, multi-disciplinary proactive community support to help people remain at home **or** return home as soon as possible from hospital.

This RRF will respond when people are:-
- Experiencing a crisis.
- At risk of hospital attendance/admission or residential care admissions.
- Medically safe to be treated/cared for in a community setting.
- In need of assessment/intervention with two hours (safe to wait for up to 2 hours).
- Returning home from hospital and who may need extra support.

3.15 The service will provide immediate treatment, encompassing a rapid holistic assessment (covering clinical, therapy and pharmacological elements where appropriate) and co-ordinate healthcare, social and voluntary interventions in the community to enable people with frailty to be supported at home including care homes.

The main elements of the RRF will be:

- Clinical triage
- Initial triage of presenting people by an appropriate clinician
- Treatment and admission avoidance care plans
- Advanced care planning involving DNACPR and PPC
- Clinical medication review
- Optimising physical function
- Discharge plans
- Supporting self-care and peoples education

3.16 The plan is that the RRF of the SPA will manage people on virtual ward principles. The virtual ward will operate in the same way as a normal hospital ward; the difference is the person will stay comfortably and safely in their home.

People will be admitted and discharged from the virtual ward whilst they are at home, proactively case managed, or targeted to prevent deterioration in condition and avoid admission to hospital. The person's condition will be assessed and monitored on a daily basis, or more frequently if required, by a multi-disciplinary work force including input from a Consultant in the Care of Older People. People will remain on the virtual ward from 24 hours up to an average of two weeks, dependent upon the complexity of the care needs, and will then be discharged to the most appropriate community service.

In cases where effective treatment cannot be achieved, the person will be referred to A&E, frailty assessment unit or acute frailty hub, as appropriate for the degree of deterioration in health.

3.17 The long term ambition would be for those individuals with complex requirements to be referred onto and managed via the Primary Care Hub MDTs, however until these are developed further individuals would remain on the service for up to two weeks receiving the necessary interventions.

It is recognised that the introduction of a new model from 1st April 2021 will not be the end of developments and it is anticipated that during 2021/22 further work will take place to assess the potential to expand the SPA to include Community Nursing and Community Therapy referrals from Hospital and the community, as well as linking in with the Primary Care Hub developments referenced above.

4.0 POLICY IMPLICATIONS

4.1 Associated changes in processes/operating procedures will be required to support the new approach/model and these are in development.

5.0 OTHER/FINANCIAL IMPLICATIONS

5.1 Any changes in approach/model provision are being made from within current resources available.

5.2 At the time of writing this report discussions are ongoing with colleagues within NHS Halton Clinical Commissioning Group, Bridgewater Community Health NHS Foundation Trust and Warrington & Halton Hospital's NHS Foundation Trust regarding the future contract arrangments which will be introduced to support the new model.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Children & Young People in Halton
None identified.

6.2 Employment, Learning & Skills in Halton
None identified.

6.3 A Healthy Halton
The effective and efficient provision of IC Services in Halton is directly linked to this priority.

6.4 A Safer Halton
None identified.

6.5 Halton's Urban Renewal
None identified.

7.0 RISK ANALYSIS

7.1 We need to capitalise on the opportunity the Pandemic has provided us with i.e. the creation of capacity within Intermediate and Domiciliary Care Services and change pathways and associated processes. This will ensure that the IC Service in Halton is in a strong position to be able to effectively deliver necessary and appropriate services to those who require it within the Borough.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 None identified.

9.0 LIST OF BACKGROUND PAPERS UNDER SECTION 100D OF THE LOCAL GOVERNMENT ACT 1972

9.1 None under the meaning of the Act.

Appendix 1: LGA - Halton Intermediate Care Review

Appendix 2: NW ADASS - Peer Review Report on Intermediate Care