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for the Better Care Fund/ Local Government Association

Final Report

1 November 2019

Halton Intermediate Care Review

Introduction.

This review of Intermediate Care services in Halton commenced in June 2019 with a short 'diagnostic' phase. The review was conducted alongside a LGA 'Peer Challenge" and 'Organisational RAID' programme that examined different aspects of the Intermediate Care system in the Borough. This summary should be read in conjunction with the outputs of those other work programmes.

The assignment took place over the course of 4 months and included 16 days fieldwork conducted on site including interviews with key stakeholders, visits to Intermediate care facilities, visits to local acute hospital trusts, attendance at stakeholder board meetings, engagement with LGA peer review team and the facilitation of two workshops. The outputs from the diagnostic phase of this work are described in the following section and the discharge home to assess pathway (D(h)2A) which was co-produced with the system is attached as a descriptor and flowchart.

Monthly progress updates have been provided to the stakeholder board and to the LGA co-ordinator during the assignment.

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Executive Summary

1.0 Assignment Brief

The agreed LGA workplan for this review (June 2019) recommended that the review take place in three stages, a short diagnostic phase, then to bring forward some proposals for actions that could be taken by the system to address issues identified in the diagnostic phase, followed by some support for implementation.

The diagnostic phase was completed in June and, at the request of the system, covered 6 discrete areas described below:

a) Service Provision, including quality. -
The review identified that Halton Intermediate Care services have achieved **broadly consistent outcomes** for people over the last 6 years, namely, about 1/3rd retain independence with no additional care input, another 1/3rd retain independence with formal care support with the remaining 1/3rd receiving a range of other interventions. ***However,*** the number of referrals into the service has reduced over the same period and the number of people receiving an intermediate care service has reduced by 1/3rd.

b) Eligibility Criteria for Intermediate Care Services.

The review suggests that the criteria used in Halton is broadly in alignment with the criteria used in many other systems for similar services. However, in the absence of properly described care pathways, the broad nature of the criteria for the full range of Intermediate Care services means that it is likely that people are being misdirected within the system of care.

c) Access Criteria:
The review observed that the access criteria to elements of the Intermediate care services, ostensibly via a single point of referral, was, in reality, more complex, an observation also made by previous reviews. One consequence of this is a lack of clarity, particularly within the acute Trusts typically used by Halton residents, about the means to access different service responses. This could be assisted by the co-production of a suite of care pathways for people and a simplification of the access routes.

d) Pathways:
The review particularly noted the absence of a properly described "home first' pathway from the main hospitals service the Borough, Warrington and Whiston (St. Helens). Pathway routes into other elements of care at the Intermediate Tier were found to be described more as 'service specifications' rather than pathways of care for people.

e) Contracts and Performance:
This review has observed that seeking to manage flow through pathways in complex

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adaptive systems via contractual mechanisms is likely to be sub-optimal. There are too few mechanisms for the system to employ in the event of a particular service under-performing. In other , commercial, contractual relationships, under performing contractors face the risk of replacement by other contractors in the market or face financial sanctions. For this range of services these sanctions are almost impossible to envisage being applied.

f) Success Criteria:
The overall conclusion of the initial phase of the work was that Intermediate care services for Halton residents have become 'stuck' with many people experiencing unacceptably extended lengths of stay in both acute hospital settings and also within intermediate care services themselves. The key success criteria therefore would be to improve out of hospital flow with the twin aims of:

i) Increasing the proportion of people returning to their own home to complete residual elements of assessment.

ii) Ensuring that the bedded intermediate care facilities were able to focus their rehabilitative efforts only on those people whose needs could not be safely managed in their own home.

2.0 Actions following on from the Review:

The review confirmed the significant demand pressures being exerted on the services which are contributing to much poorer flow through the different elements of the service than was the case 6 years ago. Improving flow for both acute and community services should be both a performance and quality aim for the system.

The review recommended that the current intermediate care offer in relation to discharge pathways out of acute hospital care becomes better aligned to nationally recognised current Discharge to Assess Pathways particularly in the adoption of 'Home First' pathway options, emphasising the importance of good inter-disciplinary planning for people within these pathways with clearly set therapeutic goals.

Establishing formal care pathways and organising service responses along those pathways can be seen as a means of better supporting the existing contractual arrangements that exist for services operating at the intermediate tier. Over time, it may well be that the system finds contractual arrangements are no longer necessary as the focus on organisations providing services shifts towards appropriate pathways of care and improving outcomes for people.

The review concluded that a practical first step would be to design (co-produce) a 'discharge home to assess' (D(h)2A) pathway for Halton residents who would be in-patients at Warrington and Whiston Hospitals. This recognised that there were currently no written pathways (or 'pathway descriptors' - or pathway maps) in use.

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The establishment of a 'home first' pathway and the process of co-design with key stakeholders from the system (both from within the acute Trusts and from community health, social, and other care services) were felt to be small scale practical actions that could be used as 'proof of concept' with the objective of scaling up over time. This in turn has the aim of creating some improved flow in the bedded units by diverting people who, in the absence of the remodelled D(h)2A pathway, would have defaulted to one of those beds.

In terms of 'co-production', a series of workshops were conducted with key stakeholders in the Halton, Warrington and St Helens system(s). The product of the workshops were the redesigned discharge home to assess pathway descriptor and flow chart which the system has agreed to adopt initially on one exemplar ward at Warrington Hospital and one ward at Whiston Hospital respectively.

3.0 Links to Other Work & Roadmap for Future Action.

The principal aim of the assignment, to co-produce a D(h)2A pathway supported by a 'standard operating protocol (SOP)' was achieved but can be seen as a starting position which allows the system to modify the pathway, and the associated service requirements in the light of it's use. Importantly it also allows the system to consider redesigning other, associated pathways in similar ways, most notably access to the bed bases, pathways into and out of the RARs team and the reablement service (and the relationship between the reablement service and community domiciliary care provision).

Clearly the organisational "RAID", LGA peer review and challenge have provided some recommendations of the types of service developments that the system would wish to consider, many of these recommendations compliment the outputs from this review.

Towards the beginning of the assignment the system requested that, at its conclusion, some indication should be given highlighting potential areas for future work by the system. In the following section I have highlighted three specific, inter-linked opportunities that the system may wish to consider prioritising for further work.

1. Initiating a 'joint commissioning' approach to designing (or co-producing) an integrated intermediate care service with clearly described care pathways with the different service offers organised along them.

2. To focus on continuing to develop and enhance therapeutic, recovery led services operating in person's own home.

3. With a locality focus, taking advantage of the developing primary care network 'hubs' to ensure that all the assets that exist within the localities of the Borough can be harnessed, alongside specialist professional care and support services, to maximise the independence of people living there.

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3.1 Co-Produced Pathway design & Recovery - Led Services.

At the D(h)2A design workshops it was clear that there is an appetite amongst frontline staff from across the whole spectrum of care and support services in the Borough to have further opportunities to work on developing and/or refining pathways of care . Three pathways in particular were identified:

- Pathways through reablement
- Pathways through the bed bases (Ward B1 at Halton Hospital in particular)
- Pathways into Domiciliary Care for people who's reablement needs have been met or who have no reablement needs.

The establishment of the D(h)2A pathway has already highlighted some of the ways in which an enhanced reablement offer will be required in the future, there are clearly many different ways in which this could be accomplished. As a starting point, staff attending the workshops began to articulate opportunities for closer working between the reablement service and community therapy services (especially those operating as part of the RaRs service), up to and including integrating the services. Staff also identified opportunities for enhancing reablement capacity by exploring the future use of Bridgewater healthcare assistants who are locality based.

Alongside the enhancement of the reablement offer, staff were really clear about the need to review the use being made of the current intermediate care bed-base. this review has already identified that the likelihood that many people who use the current bed base should have their ongoing needs more appropriately met in their own home or other venue of care. There is clearly an opportunity for the system as a whole, including the acute Trusts, to redesign pathways through the current bed base that place significantly more emphasis on the therapeutic needs of people who may need such a facility. For this reason, there is a compelling case to suggest that the proposed redesign process should be facilitated by community therapy staff.

Finally, all stakeholders interviewed in the course of the review, staff engaged in the workshops and the LGA peer review have all identified an urgent need to seek to improve flow into and through domiciliary care in the Borough. Ensuring a sufficiency of domiciliary care support is a long term strategic challenge for ***all*** local partners, not solely for the Local Authority, with virtually all elements of 'flow' ultimately depending on the eventual availability of care in the home. It is a long term strategic challenge because of the complex interplay of financial, workforce and geographic factors which require a co-ordinated response by all system partners. Without a co-ordinated strategic approach to ensuring sufficiency, redesigned pathways of care through domiciliary care services are unlikely to be more than marginally effective at improving flow.

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3.2 Locality Hub Opportunities.

It is recognised that system planning in relation to the creation of 'locality hubs' is at a very early stage, however, the opportunities presented by this particular strategic initiative are potentially significant.

Many other systems around the country, by virtue of either their scale or historic service configuration (or both in many instances), have a strategic wish to move to a population health management arrangement based around local primary care hubs, incorporating a range of integrated health, care and support staff. In many instances that strategic intent proves difficult to implement, in many instances requiring the large scale reorganisation of services and their associated workforce as well as addressing significant practical challenges around infrastructure.

In contrast, the geography and scale of Halton as well as its current service configuration suggests that organising around 4 discrete locality hubs is an attainable goal.

Organising the core intermediate care pathways (some of which are highlighted in the previous section) and associated service offers around locality hubs has a number of potential advantages which can be designed in:

- Community 'ownership' of patients needing acute hospital care - potential to move to an 'in-reach' model of care management.
- Easier community clinical oversight by GP's - ability to have greater focus on 'step up' into intermediate care services than at the present time.
- Locality MDT lead professional infrastructure would be in place, essentially becoming 4 'single local points of contact' - removes the need for extensive referral infrastructure.
- Capability to organise reablement and domiciliary care into the hubs, potentially ensuring more seamless flow between the two
- Expert locality knowledge of locality MDT likely to more effectively bring into play the whole range of community assets to support people to live independently.
- Has the potential to significantly shift the emphasis from the organisation responsible for a particular service towards the locality responsible for overall care and support.

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4.0 Recommendations

1. Setting about any redesign or reconfiguration programme generally requires some governance infrastructure and some practical apparatus to organise the associated work programmes. The stakeholder board arrangement for this assignment seems to have worked well and the system may wish to consider the continuance of that governance structure to oversee whichever work programmes suggested by this review and the LGA peer review that the system agrees to progress.

2. In taking any work programme forward, it will be helpful if the system can identify some project or programme management capacity to provide practical support in the design (co-production) of pathway(s) and service configurations suggested in this report.

3. Project management support would enable the facilitation of further workshops engaging front line staff (which seem to have worked well as part of this assignment) and could provide a model for bringing forward detailed proposals for those pathways set out in S 3.1.

4. Some project management infrastructure would also help in supporting the practical implementation and operation of new care pathways as well as helping to monitor and report their effectiveness.

5. At a strategic level, there is a need for key elements identified in this review (set out in S3) and the LGA peer review to be brought together and presented to the appropriate local forum with the intention of system leaders formulating a plan of action in response. This will hopefully ensure that these recommendations can be incorporated into the wider strategic vision for Halton residents.

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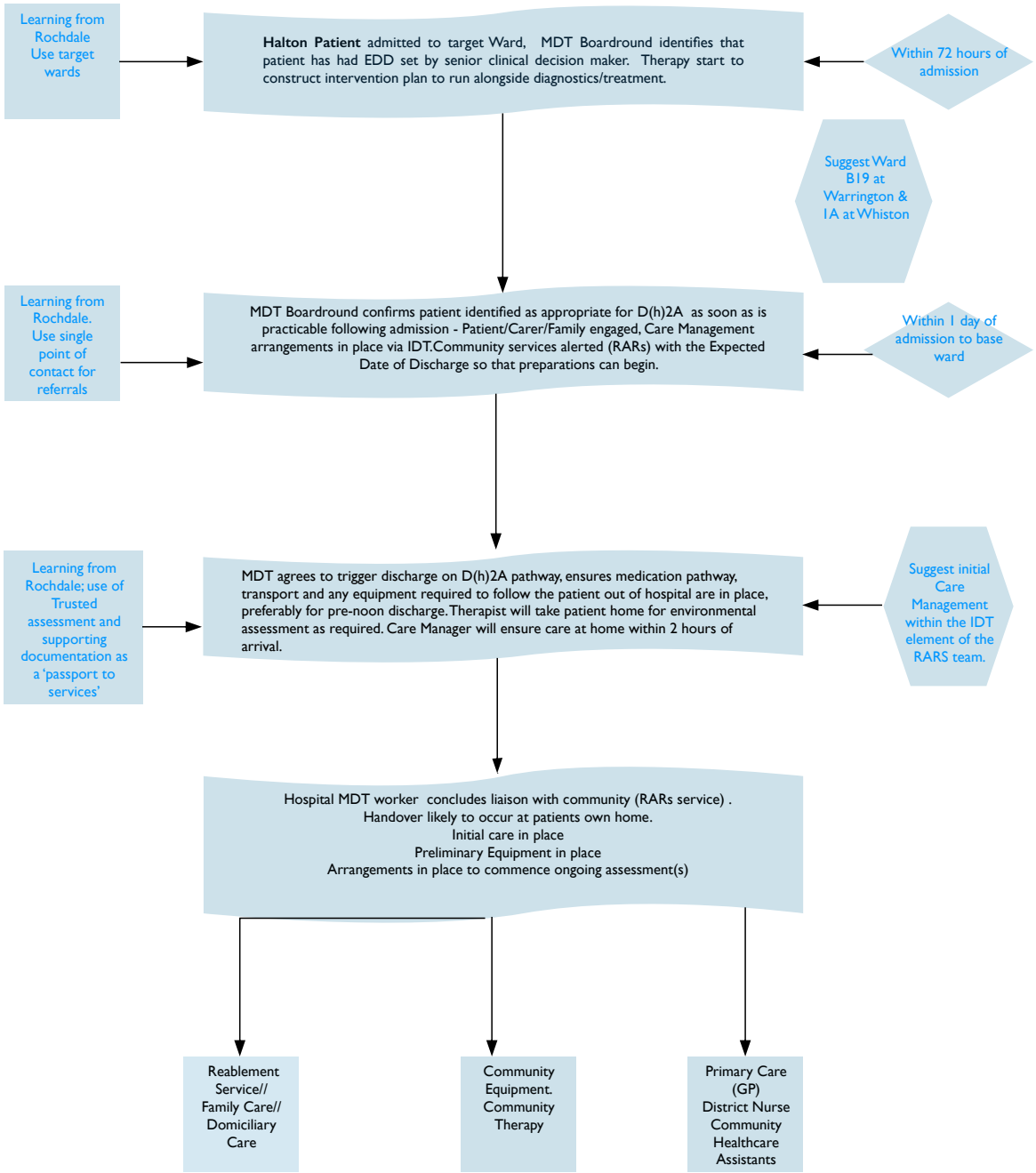
Appendix 1

Halton D(h)2A Schematic Pathway (Draft 2)



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Appendix 2.

Halton System.

Discharge (Home) to Assess Pathway Descriptor.

October 2019.

1.0 Introduction - The Aim of Discharge (Home) to Assess. (D(h)2A - Pathway 1).

The overall *principle* underpinning all discharge to assess pathways (and reflected in the substantive Emergency Care Improvement Support Team 'Quick Guide' on D2A), is that no decision about a patients long term care needs is made in an acute setting and, as a default, systems should aim to ensure that patients should be supported to return to their own homes to complete assessment processes.

The overall *objective* of the pathway is to minimise the person's stay in acute care and to maximise their independence with care at their home, thereby:

- Supporting timely discharge from acute hospital care.
- Maintaining the independence of the individual.
- Reducing the frequency, duration and/or intensity of long term packages of care.
- Achieving a net neutral impact on health and social care expenditure and
- To complete assessments of need in a setting that reflects the capacity of the individual to build on their strengths and abilities to maximise their potential.

The pathway is ***deliberately*** not written to set out criteria that patients must meet for inclusion, rather, the pathway assumes that ***all patients*** should be considered for inclusion on the pathway and exclusions then applied contingent on the nature of the persons circumstances and the views of the MDT. There will be circumstances where the discharge needs of the patient are so straightforward that onward care planning is relatively straightforward. Some systems refer to these very straightforward pathway requirements as 'Pathway 0'.

Patients for whom it is clear that their overall needs cannot be safely met in their home environment at the point at which their medical needs no longer need to be met in an acute hospital setting, are likely to require being discharged to be assessed in an alternative bedded facility, the nature of which will depend on the complexity of their needs. These are usually referred to as D2A Pathway 2 and 3 with the lower number referring to lower levels of complexity.

1.1 Underlying Principles:

In the process of setting out this process descriptor, based on two workshops and co-produced with key stakeholders in the Halton system, a number of desirable underpinning principles and ambitions emerged, these can be summarised as:

- An ambition to improve the patient experience of acute care by reducing avoidable lengths of stay in acute care.
- An ambition to increase the numbers of people returning to complete assessments in their own home.
- A desire to make the Discharge Home to Assess pathway as easy (understandable and straightforward) to use as possible for those people using it and their relatives and carers and, importantly, for staff in acute and community settings.
- A desire to streamline the process (including documentation) and to minimise the number of 'handoffs' (referrals) within and between different services within both acute and community settings.

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- A desire to work with staff to accommodate greater levels of uncertainty and risk for some professional groups associated with the adoption of this pathway. (Agreed Risk thresholds).
- A desire to establish a 'Standard D(h)2A Operating Protocol' for Halton residents that capable of adjustment and amendment, to sit among a suite of properly designed intermediate care pathways.

2.0 Pathway Descriptor.

Attached is a flowchart which aims to summarise, for ease of reference, the following pathway descriptor. The pathway commences within the acute hospital(s) setting. Several enabling features (and processes) need to be in place on the wards within the acute Trust(s), without these enabling features and processes no D2A pathway or process can be expected to function effectively (or, in most instances, at all).

2.1 In Acute Hospital Care[1]

- Early (within 72 hours of admission) establishment of an Expected Date of Discharge (EDD) to provide a focus for discharge planning.
- The engagement of a Multi Disciplinary Team (***Must*** include IDT at Whiston and Halton IDT at Warrington Hospital) to co-ordinate these efforts. MDT representation should reflect a balance of clinical leadership, including senior decision makers, nurses and therapists alongside social care colleagues.
- It is within the earliest MDT ***board round*** following admission that Discharge Home to Assess patients can be identified[2] and progress through the pathway commenced.
- For D(H)2A patients the MDT should ensure that the earliest contact is made with the relevant community health and social care community teams with expected discharge dates so that they are prepared in advance.

Internal Triggers to progress discharge

- ***Addressing Medical issues:***
  - Are there any ongoing medical /nursing needs for the patient that ***can only*** be provided in an acute hospital? If not, progress with D(H)2A pathway.
  - Identify any medical care that could be continued at home, for example, IV antibiotics, home oxygen, diuretics etc. which would facilitate movement on the pathway.
  - Can the patient eat and drink to keep nourished?

- *Addressing Mobility issues:*
  - Has the patient sufficient mobility to be cared for in their own home?
  - An environmental visit is arranged with a therapist to oversee the person managing in their home environment (environmental assessment including stairs and falls risks) and to initiate an overall therapy plan.
  - Therapy provide aids/equipment to make them safe and reduce falls risk.
  - Home visit may determine whether the person would benefit from a falls clinic or ongoing community physiotherapy?

- ***Addressing Social Support and other issues:***
  - What matters to the patient and what does the patient want?
  - How much help is needed and who will provide it?
  - Is anyone able to stay overnight on discharge to provide support on the day of discharge?

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[1] (Contains extracts from South Warwickshire Clinical Pathway Model)

[2] See section 2.2 for some parameters for the identification of patients most appropriate for this pathway.

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- Psychosocial & any Carer Needs:

- ***Precautions:***
- If there are concerns that the home environment visit may expose safety issues then retain the hospital bed for a few hours until the OT has called in to give the outcome of the assessment.
- Be prepared for re-admissions, this is inevitable in this group of If the patient is re-admitted it should be to the same team so the discharge momentum is carried through. It is not necessarily a failure of discharge.
- Do not hesitate to discharge the patient again on the day of readmission if you are confident of your assessment.

- ***Care Management:***
- It is essential to provide ***active care management*** for patients following the discharge home to assess pathway, this should enable follow up contact and a telephone check up the day after discharge so that support for patient and carers is maintained, new issues may be identified that can be pro-actively managed in advance to avoid a crisis and unplanned out of hours admissions.
- Social Assessment, reablement (implementation of therapy plans), any community nursing interventions as well as direct care should be commenced as soon as is practicable and, in the case of meeting direct care needs, ***within 2 hours*** of the person returning home.

- ***Supporting Features - Incorporating Observations from Rochdale.***
- Single point of contact for D(h)2A pathway to be initiated.
- Trusted Assessor/ Assessment within and between Therapy and other Services.
- Supported by brief discharge summary information sufficient to initiate care and support at home
- Standard and bespoke Community equipment easily accessible by different professional groups.
- Organisation of Ward activity to focus on D(h)2A (Rochdale 'home in a day team' - Physio/OT & Support planner).
- *Alignment and staffing of Reablement services to support within 2 hours of discharge and for a minimum of 2 weeks afterwards*
- *Therapy support to and leadership of Reablement Service.*

2.2 *Identifying patients for discharge to assess*

In other systems this has been achieved by undertaking a case file review, for example, this might start by a retrospective review of patients admitted over the age of 85 years. After reviewing the case notes each patient can be allocated to one of the boxes in the 2x2 matrix below (Clinical Audit Template). The data can provide information about the characteristics of patients who could have benefitted from inclusion on the D(H)2A pathway (and, importantly, those who could not). It is important to be challenging, perhaps, by involving an external partner in the case file review.

Going forward, the total number of patients managed on D(H)2A & the number of success appropriate to and managed on the D(H)2A pathway should be plotted on a daily run chart to understand variability and step changes in how the system is functioning. The aim should be to see a gradual increase in use with the gap between the two lines reducing over time and less variability between days.

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	Managed in discharge to assess	Not managed in discharge to assess
Appropriate for discharge to assess	**Success** (expect some readmissions , admit to the same team & maintain the discharge momentum)	**Missed opportunity** (patient not identified or services not available)
Not appropriate for discharge to assess	**Wasted capacity** (patient did not require more than a simple discharge)	**Success** (appropriate inpatient or day care)
	Potential clinical risk (patient's clinical needs could not be met at home)	

3.0 Acute MDT to Community MDT.

In the previous section emphasis was placed on the importance of a ward based, multi-disciplinary team (MDT) agreement on those patients for whom Discharge Home to Assess is likely to be the most appropriate pathway to follow as part of the discharge plan.

Whilst the person remains under treatment in acute care, this pathway envisages that a member of the ward based MDT retains accountability for ensuring that all the features set out in S2 of this descriptor are appropriately addressed as discharge planning progresses towards the Expected Date of Discharge. Members of the MDT in the respective acute Trust(s) need to determine who is best placed to manage this pathway process, in many instances this is likely to be a Therapist.

3.1 Role of the RARS team.

Contact needs to be made with the Halton RARS team (contact details??) at the earliest opportunity to alert the team that a patient in acute care has been identified for the D2A (Home) pathway and the EDD shared along with any other preliminary information that might be helpful.

3.2 Arrangements for Discharge.

It's important to remember that this pathway is envisaged to be used for people who have had their presenting episode of acute care need treated but are deemed to have recovered sufficiently to complete the remainder of any assessment(s) required back in their own home. As the discharge planning process proceeds toward the EDD it is essential the practical arrangements for timely discharge are in place, this is likely to include:

- A therapist to accompany the person back to their own home to undertake preliminary assessment of the person in their own home.
- Transport appropriate to the persons needs being available to get them home at an appropriate time of day.
- Discharge medication and Discharge letter arrangements are in place.
- Preliminary equipment needs will be met.

Active prior liaison with the community MDT (RARS team) will clearly be essential in relation to these features.

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3.3 Documentation:

A summary of the person's care and treatment in the acute setting (alongside a summary of other key information) will need to be made available to the Community MDT (RARs service) either prior to or at the handover of the person once they are back in their own home. (this needs to be sufficient to satisfy basic regulatory requirements but be brief enough to enable timely completion and/or transmission. (Work is taking place during the remainder of October to agree this summary).

3.4 Handoff(s).

This pathway, as described, envisages only one handoff, from a member of the acute hospital MDT (likely to be a therapist) to a member of the community MDT (RARS service, also likely to be a therapist).

Accountability for care co-ordination (care management) transfers at the point it is agreed that the persons needs can be safely managed in their home environment.

Once this agreement is reached the accountable worker from the community MDT will ensure that the immediate practical care arrangements will be met and that the arrangements for the necessary ongoing assessment at home are in place.

The Halton reablement service and, potentially, demand and capacity team, clearly have important roles to play in supporting people transiting this pathway. In line with the underpinning principles, this is felt to be most appropriately co-ordinated by the accountable RARS worker.

4.0 Supporting Features for Early Implementation.

This pathway descriptor summary has been co-produced with key stakeholders in the Halton system, it represents an initial set of principles and actions which provide a framework for a small scale 'test of change'.

For the system to gain confidence that the pathway can be used effectively (and therefore scaled up), it is proposed that:

a) Its use is initiated on **2** exemplar wards in the first instance, Ward A2 at Whiston Hospital and Ward B19 at Warrington.

b) There was a belief that, for a variety of reasons, the system may find that, in the first instance, more people re likely to be able to smoothly access the pathway from Whiston (since they are more likely to live in Widnes where it was felt providing care at home within 2 hours of discharge was more achievable than in Runcorn). However, it was felt to be important that all efforts were made to embed the pathway at Warrington hospital even if numbers of people accessing the pathway were small to begin with.

c) The availability of reablement services to support this pathway is essential. To create some additional capacity within the team (to accommodate people using this pathway, in addition to the existing cohort of people needing reablement) it is likely that a proportion of current work within the team will need to transfer to the independent sector provider(s). The demand and capacity team will have an important role to play in this and the system will need to monitor if additional costs are being incurred in the short term.

d) In further support of this, the system may wish to consider whether more efficient and effective methods could be adopted to ensure better utilisation of domiciliary care hours, with the aim of releasing more care hours through managed reductions in long term packages.

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e) To support the implementation of the pathway, some changes may need to be made to the range of basic and key equipment available to be accessed quickly from community bases, some changes may need to be made to the way some specific items of equipment may need to be pre-ordered as a precaution and some relaxation of the equipment prescribing requirements may also be needed.

f) Finally, to enhance the opportunity to successfully implement this pathway and to progress the scale of its implementation, system leaders will need to carefully consider ongoing project management arrangements. It is likely that this will require the full-time oversight of one person working with an extended group of key stakeholders to hold to the objectives of this work programme. In addition, it is likely that the system will wish to adjust the pathway in the light of its use and that this project is likely to become one element of a larger programme of work (yet to be described) aimed at larger scale system redesign.

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