Intermediate Care & Frailty Service

Introduction

The overall vision of the One Halton Place Based Plan 2019 – 2024 is:

Working better together to improve the health and wellbeing of the people of Halton so they live longer, healthier and happier lives.

The Plan identifies six key priorities, one being, improving the quality of life of Older People.

Although the aims and objectives of the Intermediate Care & Frailty Service will support this specific priority, it should be noted that the Service will not just support Older People it will support Adults, age 18+ and by doing so help improve the overall health and wellbeing of Adults in Halton so they live longer, healthier and happier lives.

Single Point of Access (SPA) – Aim, Objectives & Benefits

One of the key aspect of the new Service will be the introduction of an SPA.

The aim of the SPA is 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.'

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.

The SPA will be resourced by a multi-disciplinary team consisting of clinicians, nurses, therapists, administrative and social care staff. 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.

The SPA would have access to all necessary health and social care records.

The SPA will accept referrals from:

- Hospital Discharge & Other Specialist Hospital Teams in the circumstances outlined below:
  - Discharge to Assess Model Pathways
    - Pathway 1 (Reablement/D2A)
    - Pathway 2 (Intermediate Care Bed)
  - Complex Community Patients - Frailty

- Community sources (GPs, Social Care, Voluntary Agencies, Health Care Professionals e.g. District Nurse, Community Matron and NWAS via a Paramedic, not NHS111 route)

SPA flowchart below:-

SPA Flowchart (Final May 2021).docx

The Intermediate Care & Frailty Service, including the SPA will operate 7 days a week from:-

- 8am – 8pm: Monday – Friday
- 9am – 5pm: Saturday/Sunday

NB. Cut off point for new referrals: 6pm Monday – Friday & 3pm Saturday & Sunday.

Acceptance Criteria into the Service for Referrals

1. Age 18+; and
2. Registered with a Halton GP **or** Resident of Halton Borough.

NOTE: This criteria is inclusive of Service Users with a mild to moderate Dementia diagnosis/ individuals with learning disabilities.

Pathways into Community Services

Reablement Service

Halton Borough Council's (HBC's) Reablement Service is a multi-disciplinary team (MDT), which works with people of Halton to maximise their independence following an illness or disability.

The service aims to ensure all people in need of support receive a full functional assessment within their own home before any long-term care provision is commissioned. The Reablement Service will support with activities of daily living and promote independence through therapeutic interventions.

Community Based Multi-Disciplinary Interventions will be provided when:

- The home environment is suitable/conducive for assessments/interventions by MDT (Physio, OT, Nurse, Therapy Assistant or Social Care);
- The individual does not require 24 hour care support during Intermediate Care interventions, but may require a Reablement care package in own home during Intermediate Care Service intervention;
- The individual does not require nursing supervision/interventions over a 24-hour period, but can access nursing dependent on need

Adopting a strengths based approach, each person will have an agreed personalised plan (based on the amended derby score) describing care and therapy interventions that will contribute to the achievement of individual goals, maximizing independence and well-being at every opportunity.

It is expected that the Reablement Service will complete most episodes of care within 4 weeks.

Oakmeadow

HBC's Oakmeadow Intermediate Care Unit provides Intermediate Care Bed Based Services to support people to regain or retain their former level of independence following a period of ill health or a change in circumstances.

Oakmeadow will provide Bed Based Multi-Disciplinary interventions when:-

- The home environment is not suitable/conducive for assessments/interventions by a Multi-Disciplinary Team (MDT);
- The individual requires 24 hour care support during Intermediate Care interventions;
- The individual may require nursing supervision/interventions;
- Requires some investigations/interventions that aren't available in the community e.g. GP overview etc; or
- Requires a period of assessment following discharge from hospital or other care setting e.g. transitional care to determine long term care needs/placement.

The length of time someone requires such services is based on assessed need but the aim would be to complete episode of care at Oakmeadow/determine long-term care and support requirements within two weeks of admission.

Community Rapid Response (CRR)

The CRR 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 CRR will respond when people are:-

- Experiencing a crisis.
- At risk of hospital attendance/admission or residential care admissions (all types of care home settings).
- 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.

The CRR will be available 8am – 8pm Monday to Friday and 9am – 5pm Saturday and Sunday and aims to provide a response within two hours of an **urgent** referral and within 24 hours for all other referrals.

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 CRR 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

CRR – Management of Individuals

The service 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.

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.

No further intervention required and discharged from SPA

Following screening of the referral by the SPA, if no referral is appropriate to either Reablement, Oakmeadow or CRR the individual will be discharged from the SPA.

Circumstances where this may occur are listed below:

- ***Not Medically Stable*** e.g.
    - Service User requires Acute hospital admission e.g. suspected fracture, chest pain;
    - Service User requires medical interventions which are not available in the Community;
    - Practitioner's clinical judgement based on information available e.g. history and observations.

- ***Independent***
- ***Onward referral*** e.g.
    - Voluntary Sector support;
    - Respite Care, Long Term adaptation or reinstatement of a long term package of care only required