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TELFORD & WREKIN COUNCIL HEALTH & WELLBEING BOARD

DATE: 06 JUNE 2018

INTERMEDIATE CARE PROVIDED THROUGH THE BETTER CARE FUND (BCF) –ONE YEAR ON

REPORT OF – JONATHAN EATOUGH, ASSISTANT DIRECTOR: GOVERNANCE PROCUREMENT & COMMISSIONING; ANNA HAMMOND DEPUTY EXECUTIVE FOR COMMISSIONING & PLANNING (PRIMARY CARE)

PART A) – SUMMARY REPORT

1. SUMMARY OF MAIN PROPOSALS

1.1. This report outlines the progress made over the last 12 months of the intermediate care service

1.2. This approach enables us to work towards a fully integrated intermediate care service which aims to prevent admissions to an acute hospital, supports residents to live in the way they choose and reduce dependency on services.

2. RECOMMENDATIONS

The Board is asked to note the progress made and the action plan for the coming year and how it will support the integrated delivery of the cross-cutting priorities of the Health and Wellbeing Strategy.

3. IMPACT OF ACTION

It is intended that this programmes of work will contribute to improve health & wellbeing outcomes within the borough.

4. SUMMARY IMPACT ASSESSMENT

COMMUNITY IMPACT	*Do these proposals contribute to a specific HWB Priority?*	
	Yes	The Intermediate care plan contributes to all of the Health and Wellbeing priorities.
	Will the proposals impact on specific groups of people?	

	Yes	All borough residents who required a period of intermediate, reablement support predominantly the 75+ frail and elderly population. Appendix A shows the criteria for that applies to accessing services through the BCF.
TARGET COMPLETION/DELIVERY DATE	Yearly plan refreshed annually	
FINANCIAL/VALUE FOR MONEY IMPACT	*Yes*	*The Intermediate Care beds and enablement packages are funded by the 2018/19 Better Care Fund pooled budget at a value of £1.7m. The length of stay and the Pathway ratios will have an impact on costs if they vary from the planned targets; performance will be closely monitored to address any resource implications as soon as possible.* *A robust plan for Intermediate Care and close partnership working will help ensure people's needs can be met whilst also ensuring the most efficient use of the resources available.* *TAS 22.5.18*

LEGAL ISSUES	Yes	Under the Health and Social Care Act 2012 the Health and Wellbeing Board has a duty to ensure that providers of health and social care services are working collaboratively by way of in an integrated approach and Section 3 of the Care Act 2014 reinforces this duty. Telford & Wrekin Council is under a duty to carry out its care and support functions in a way that facilitates and promotes integrating services with those of the National Health Service or other health related service. The Better Care programme should assist with the discharge of these duties by emphasising collaboration and integration in its approach also. IR 24.5.18

EQUALITY & DIVERSITY	Yes	Joint Strategic Needs Assessment intelligence informs intentions to ensure resources are targeted appropriately to improve health and wellbeing and reduce inequalities.
IMPACT ON SPECIFIC WARDS	No	See above.
PATIENTS &/OR PUBLIC ENGAGEMENT	Yes	The voice of the person is key to the whole process and is captured along the journey along with that of their family or advocates
OTHER IMPACTS, RISKS & OPPORTUNITIES	No	Strong collaboration working with NHS commissioners in the CCG and NHS England is essential to delivering progress against the Health & Wellbeing strategy priorities.

PART B) – ADDITIONAL INFORMATION

5 INFORMATION

5.1 In order to improve the functioning of the Intermediate Care Team commissioners utilised NICE guidelines for Intermediate Care and the National Audit Intermediate Care (NAIC) report in 2017 to carry out a review. The Council, CCG, Shropshire Community Trust, SaTH, independent and voluntary providers formed a Task and Finish group to review the pathways, interfaces, care types, hours and bed numbers and overall enablement principles to create an Intermediate Care Action Plan and an Operational Framework

5.2 NIAC reported that for a borough our size we should be expected to have 35 beds Intermediate Care beds occupied at any one time with an average of 28days. We would be expected to manage 30 discharges per week. These discharges should be Pathway 1(home with a domiciliary enablement package) Pathway 2 (Short stay in a nursing reablement care home) and Pathway 3 (discharged to a nursing bed for further assessment) and the ratio per pathway is to be a 60/30/10 % split in pathways with 60% pathway 1 and so on. Therefore the beds would support 40% of discharges from hospital and admission avoidance ‘step up’ care- an alternative to hospital admission

5.3 There was also a financial need to reduce the number of commissioned beds. NHS Resilience monies from 2016/17 was not available in 2017/18. The CCG funded this at risk last year. This left a significant shortfall in the funding of Intermediate Care beds in

2018/19. Improving performance - reduction in usage and length of stay- was required to manage the functions within BCF Pooled Budget resources.

5.4 At the time of the NIAC report we had many challenges and these benchmarks seemed difficult to achieve. We were averaging around 45-55 beds at any one time across the borough with lengths of stay in excess of 38 days. There were quality issues with discharge processes and the person/ patient experience was not joined up. The multi-disciplinary team were also unable to recruit and retain staff due to the demand for qualified occupational and physiotherapists across the whole region. Contracts were fixed term, to match the temporary funding available for this project, and this also had a negative impact on recruitment. Some posts still remain vacant today as they do in other West Midlands Councils, although some recruitment has now been successful.

5.5 A Task and Finish group was set up to improve the situation. This was made up of providers, therapists, commissioners, social workers and practitioners. The group evaluated the patient experience and flow, the challenges in all teams and along the way and designed an Improvement Action Plan and an Intermediate Care Team Operational Framework (Appendix B & C). The Framework clearly sets out processes to be followed ; response times and responsibilities for actions in order to achieve the goals for Quarter 1 of 2018/19 of no more 35 beds with an average length of stay of 28 days

5.6 At the same time the requirement for provider support was re-tendered and we gained two further Pathway 1 providers and secured a block bed contract with one provider for 20 beds. This meant that we had capacity to take people into Pathway 1 within 24 hours and had beds located in one location to maximise the time therapists could spend with people reabling rather than travelling around the borough. There are weekly MDT conference calls which include the providers, to manage flow and any quality issues. We have a Community Matron who acts as a Trusted Assessor with our care home and supports swift discharge.

5.7 At the time of reporting, we are utilising an average of beds with an average length of stay of 25 days. There has been a transition from the old to the new bed based provider, and good weather but this shows good progress to date. We are also in line with the 60:30:10 ratio so more patients are discharged home with care for enablement at home.
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5.8 The next 12 months will bring challenges as the people we care for are increasingly old and frail. . ‘Home First’ will always be best but this sometimes may be difficult. The domiciliary care sector highlight that recruitment and retention of staff is difficult. We also need to maximise the staff resources and skills in enabling people and reduce double handed care. We plan to do this with the introduction of ‘Smarter (single handed) Care’ training and supporting recruitment.

5.9 Further development of the Intermediate Care Team though an Integrated Discharge Team function and Frailty Team in PRH supported by the STP will add momentum to the progress in integrated working

5.10 We have agreed a new process flow as attached at Appendix D and this is just going through a final round of ratification with partners ShropCom and SaTH.

5.11 Performance Monitoring is attached at Appendix E.

5.12 In summary, Intermediate care is an ongoing pressure that is extremely demanding on all resources across the partners. With a robust, regularly monitored plan and team working it can be delivered in a way that is both efficient and meet the needs of all the patients/people who access the service.

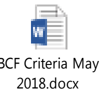
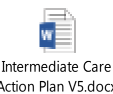
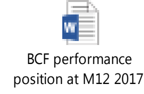
ADDITIONAL INFORMATION

None

PREVIOUS MINUTES

None

APPENDICES:

Appendix A BCF Criteria  BCF Criteria May 2018.docx **Appendix B IMPROVEMENT ACTION PLAN**  Intermediate Care Action Plan V5.docx	**Appendix C OPERATIONS FRAMEWORK V 7** **Appendix D NEW PROCESS FLOW** **Appendix E PERFORMANCE MONITORING**  BCF performance position at M12 2017.

Report prepared by:

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