Appendix C

Operational Framework: Intermediate Care In Telford & Wrekin V7

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Intermediate Care Group	7.1	May 2018

1.0 Background

Community Intermediate Care beds and home care provide part of a community resource to enable local health and social care services to provide admission prevention and rehabilitation to Persons aged 18 and over outside of acute hospital settings.
The primary place for every person to be supported for both ‘step up and step down’ should be in their normal place of residence. ‘Home First’ should be the ethos of every person involved in the Intermediate Care Service

Beds should be considered within the context of a ‘step-down’ service which is aimed to support people with complex long-term conditions from acute hospital treatment into a transitional nursing/therapy service to improve function and independence.
Beds should also be considered within the context of ‘step-up’ service to support people with short term treatment or low acuity needs from General Practice, that don’t require secondary care interventions, and will benefit from intense short term nursing/therapy services to improve function/independence with an end outcome of transferring back to the care of their General Practice and their normal place of residence.

This framework encourages staff employed by SaTH, Telford and Wrekin Council, ShropCom and the Service Provider to work together in a person centred model of care. For this model to work effectively, it is essential that clear governance responsibility and accountability is in place. (Appendix 1)

This operational framework has been developed to provide the direction, structure and guidance for organisations involved in the care for a person in a step down/step up facility, both sharing a collective responsibility and mandate to deliver the best, high quality health care to the population served.

2.0 Purpose

The purpose of this joint operational framework is to:

- Identify clear lines of responsibility and accountability for staff within each area
- Identify appropriate governance structures to ensure high quality, safe services to all Persons
- Ensure all risks are managed appropriately
- Offer appropriate support and safeguards to staff and all organisations

3.0 Aim

To optimise where possible the use of reablement home care services. Where this is not possible, Community rehabilitation beds are in an ideal position to provide transitional, nursing and therapy support to enable the person to be stabilised and rehabilitated following an acute episode of illness and to return home at the earliest opportunity with community support. In-Person stays are expected to be no longer than 21 days (where clinically appropriate) to ensure that all opportunities to provide rehabilitation in the Person’s own home are optimised.
The objectives being:

- To facilitate a return to independent living for the Person
- To provide a coordinated package of therapy, social care and nursing care as appropriate
- To provide a smooth transition to ongoing community care provision
- To reduce inappropriate admission into long-term institutional care

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- To work to prevent readmission to hospital
- To facilitate safe early discharge from hospital where short term intervention is required
- To provide early therapy and nursing for People as directed from General Practice will benefit from these interventions

4.0 The Service

4.1 Acceptance Criteria Rehabilitation

To provide rehabilitation and enablement interventions to support discharge from hospital for individuals with ‘uncomplicated’ discharge care needs including care packages i.e. where optimisation is expected within the six week timescale, the person must:

- Be registered with a T&W CCG GP practice.
- Aged 18 years or over
- medically stable and does not require an acute hospital bed
- have given informed consent to participate in rehabilitation programme
- have a confirmed clinical diagnosis which is deemed suitable to be managed in a community rehabilitation bed and is clearly documented in the case-notes (or at least a provisional diagnosis with a reasonable degree of certainty)
- have a known onward destination for discharge and estimated date of discharge
- have been identified as requiring ongoing needs
- have ongoing therapy /treatment goals that are measurable and time specific

4.2. Step Down
Persons will have been assessed by in the hospital situation for Discharge and Rehabilitation and /or further assessment, by utilising the Trusted Assessor function, against the eligibility criteria and level of need.

4.3. Step Up
Persons will have been assessed as requiring further community treatment, observation and support, but not as requiring acute hospital admission. The admitting professional here will be the ShropCom Rapid Response Nurses, with GP agreement and the SaTH Frailty Team in the Emergency Departments, with decision making clinician agreement.
All access to a step up/step down bed will be made by through the Brokerage Team based in Telford and Wrekin Council, they will hold the overall accurate bed state.
When ‘Step up’ the admitting professional eg Rapid Response Nurse, SaTH Emergency Department Occupational Therapist, remain the Case Manager until formal handover to other professionals

- In ‘Step Up ‘ Person is *likely* to be able to be discharged from the community bed to their usual place of residence or another destination within 14 days of admission
- In ‘Step Down’ Person is likely to be able to be discharged from the community bed to their usual place of residence or another destination within 21 days of admission

5.0. Home and Bed Based Intermediate Care
To prevent hospital admission Intermediate Care interventions will take place at home or in a Community Bed in situations such as:

- An acute exacerbation of long term illness

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- Chronic Obstructive Pulmonary Disease
- Diabetes
- High blood pressure or
- Acute illness including chest infection, urinary tract infection
- Period of delirium, see above
- Uncomplicated falls
- Acute progression of a long term condition.

5.1 Exclusion Criteria for Bed Based Intermediate Care

1. Any individual that does not meet the acceptance criteria
2. Beds shall not be used where the need of the individual is not health related
3. Any individual where their care needs are the responsibility of the Council and is social care related, i.e. respite care, housing related; this list is not exhaustive
4. Any individual who is palliative or has a 'Do Not Attempt Resuscitation' in place
5. People who are awaiting placement or long term care package only
6. People with complex mental health needs whose needs cannot be managed within the named home, or when an additional transfer is not in the persons' best interests.
7. People with specialist rehab needs such as major stroke or other acquired brain injury
8. People awaiting CHC DST assessment or ongoing funding
9. People with palliative care needs
10. People requiring services/interventions that can be only delivered by Secondary Care.

6.0 Pre transfer and Admission – within the first 24 hours

SaTH staff will work with the person to design a Person-centred care plan, which can be commenced by the provider immediately on the individual's arrival from hospital. They will continue with these goals and actions until they are assessed by a ShropCom therapist. They will assess and set goals with each Person outlining key milestones and expectations with promotion of self-medication wherever possible.

On transfer, baseline records will be established by the provider and ShropCom staff who shall undertake an initial assessment of activities of daily living in order to commence care planning. Records will include all contact names and relevant/ important details using agreed documentation. This includes an initial risk assessment to identify high risks such as moving and handling dependency and risk to skin deterioration where appropriate. Dressings will be taken down, assessed and recorded if appropriate to the Person individual care plan. Initial care planning will identify short term measurable goals and expected discharge goals in preparation for discharge planning.

7.0 Medical/Nursing Cover

Medical cover for Persons will be provided by local GPs with whom the Person will register temporarily. Where a community bed is indicated, the Nursing Home and ShropCom Nurses will work collaboratively to provide nursing care to the Person including admission avoidance, plans for discharge and any other holistic needs.

8.0 Therapy Cover and Social Work Cover

Therapy and social work cover will be provided by ShropCom and Telford &Wrekin Council. The staff will work in collaboration with all individuals involved in a person's care to ensure the optimum service is provided to the person and timely throughput is supported. Initial Social

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Work and Therapy assessments will identify projected onward support needs post discharge from the initial expected discharge goals.

9.0 Pharmacy

Some people may bring their own medication into (with a GP list of medication for step up people) the Nursing Home or in the case of hospital 'step down', in the form of To-Take- Out Medication (TTO) provided by the hospital pharmacy service. A recorded assessment for self-medication will be undertaken at the initial assessment, Persons with capacity and capability will be encouraged to administer their own medication in line with guidance on medication storage and administration. Assistive technology will be available for issue for medication management. This will be reviewed by the provider /nursing team daily or if deterioration/therapy is deemed to affect this capability. A minimum of two weeks TTO's must be provided by SaTH (or other discharging hospital), on discharge in order for a Person to be accepted for step down care.

10. Discharge home from hospital with a reablement Care Package

Services are to be delivered in accordance with the contract specification and as summarised in Appendix 1

Brokerage will issue the provider with a completed Fact Finding Assessment (FFA) as soon as it becomes available. The Provider acknowledges this within 2 hours and arranges care to start within 48 hours.

The Provider and their team of reablement carers will work with the person to deliver the care specified in the care plan and in consultation with the person. The emphasis must always be on the person being supported to 'reable' and carryout tasks themselves. The provider is to engage in weekly progress teleconferences to discuss their reablement clients, feedback on progress, discuss any changes in the care packages and to agree an end of service date. Therapists will work closely with the carers when planning the service end date.

11 Discharge Process to a Community Bed

Services are to be delivered in accordance with the contract specification and as summarised ion Appendix 2

Brokerage will issue the care home manager with a completed Fact Finding Assessment (FFA) as soon as it becomes available. The Provider is encouraged to make use of the Trusted Assessor to help manage discharge to save physical visits where possible. Upon arrival at the care home, the manager and their team of reablement carers will work with the person to deliver the care specified in the care plan and in consultation with the person. The emphasis must always be on the person being supported to 'reable' and carryout tasks themselves. The manager is to engage in weekly progress teleconferences to discuss their reablement clients, and problems with progress. The manager is an integral part of the discharge planning process.

Decisions for discharge/transfer from the community bed will always be made with the person and the Multi-Disciplinary Team (MDT). The MDT should be a team of health and social care professionals consisting of Nurses, Physiotherapists, General Practitioner, Occupational Therapists and Social Worker (Mental Health Practitioner, where appropriate) input which provides a comprehensive assessment of a Person's health and social care needs and his or her desired outcomes in line with the Health and Social Care Act (2014).

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The MDT assessment should draw on the individual and those who have direct knowledge of the individual and their needs. It should also make use of existing specialist assessments and should make referrals for other specialist assessments whenever this is appropriate in the light of the individuals care needs. Once a decision has been made, the MDT team will identify a Lead Worker to be responsible for the ongoing planning and subsequent communication of the discharge/transfer.

The expected date for discharge will be documented in the Person's case notes by the Lead Worker following agreement with the Person, carers and all members of the multi-disciplinary team. (Appendix 2)

All information surrounding discharge planning must be documented in the Person's notes/medical records. It is the responsibility of all staff involved with discharge and discharge planning to ensure that this is achieved.

11.2 Discharge Planning MDT Meeting to move a person from a community bed to the normal place of residence

Designated MDT meetings should take place within 48hrs of admission and on a twice weekly basis, on site in the bed provision.

The aim of the MDT is to:

• Co-ordinate a multidisciplinary assessment
• Identify medical, physical, social and psychological problems
• Formulate a plan of care including appropriate rehabilitation
• Directly implement treatment recommendations made by the multidisciplinary team

The meeting should include:

- Health care report
- Social care report
- Therapy report, with an updated Barthells Score
- The Person's and relatives/advocates views
- Ongoing rehabilitation plan (including goals to be achieved prior to discharge)
- Discharge plan

Concise actions should be noted and distributed.

The MDT meeting should have a basic core attendance to include:
- Nurse in Charge/ Senior person (Provider)
- Allocated Social worker (T&W LA)
- Therapy support (ShropCom)
- British Red Cross Hospital Discharge representative
- Carers Liaison worker
- Mental Health Professional

On an Ad Hoc basis, where clinically appropriate:

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- Representation from the community nursing team (community matron/ district nurse)
- A representative from the CCG (Opt in)
- Rapid Response Nurse
- Representatives of SaTH Discharge, Therapy and/or Frailty Teams
- GP
- Quality Team from any Partner CCG, ShropCom, T&W LA,SATH
- Other expert practitioners eg Speech and Language Therapy, Dietetics

The outcome for each Person discussed should include:

- Review of action points from the previous meeting (if applicable)
- Management plans for the Person
- Identification of actions to be completed with responsibility allocated to a member of the team with expected timescales
- Identification of agreed goals prior to discharge
- Completion of documentation for each Person at every meeting
- Identify a review date
- Estimated Discharge Date
- Identification of ongoing services post discharge.

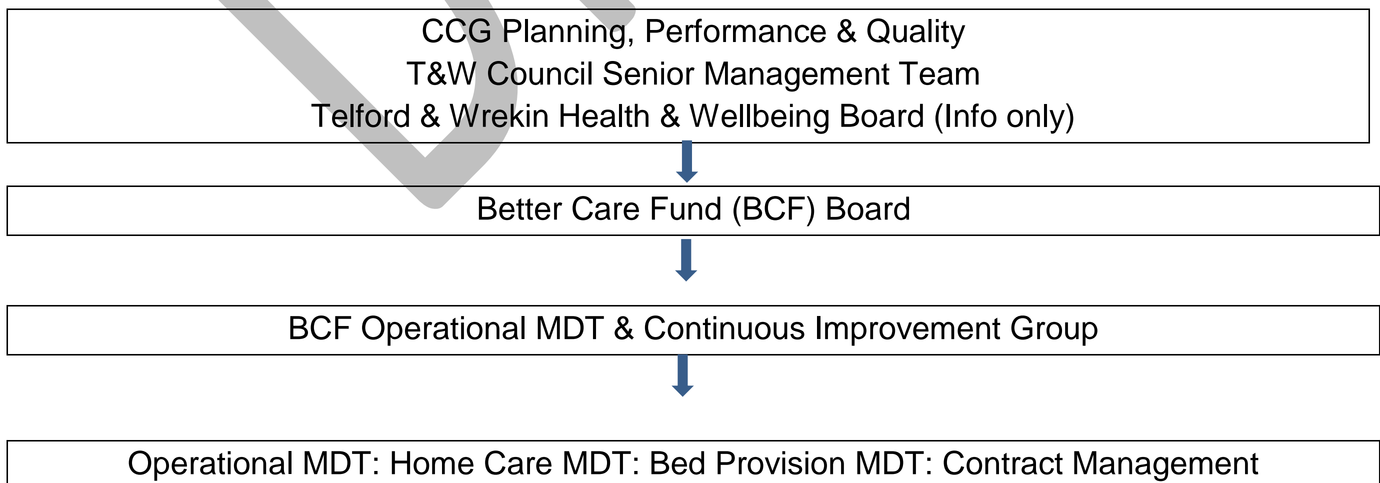
A discharge date will be set at the first MDT meeting taking into account Person needs.

MDT members are responsible for cascading any decisions and actions made following the meeting to their colleagues as appropriate. They are also responsible for ensuring feedback on progress is given for the next meeting if they are not attending.

12 Accountability Arrangements

Each professional involved with the Person's care has individual responsibility and accountability for their actions under their own professional code of conduct and have a duty of care to their Persons accordingly.

The Governance Structure is as follows:



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Appendix 1 – Pathway 1 – Home care

	Pathway 1 -Home care goals set by the person with the Hospital prior to discharge		
	Provider	**ShropCom**	**Council**
	Respond to new care request within 2 hours with start date within 24hrs of initial contact		**Work with SaTH to ensure FFA is complete before sharing**
Day 1-7	Person out of bed and dressed: Carry out a risk assessment and file in the persons support plan kept in persons home Carer delivers care in accordance with person's specific goals and records progress daily within the care support Night Support recorded as appropriate	FFA triaged by therapists and assessed if appropriate. Inform person Review goals with person Bartells Score assessed and recorded	Ensure provider has FFA and Contract within 48 hours and arrange key safe access where required
		Therapy assessment of person Day 1, 4 and 7 or as required	If required Mental Capacity and Best Interest Decision MDT Consider an Advocate
	MDT discussion and planning Review plan and discharge from intermediate home care service with person, family and carers Ensure Person, family, carers are in receipt of verbal and written information which is documented on the Casefile, regarding enablement and funding ** engage in weekly conference call to assess persons ongoing need - increase or decrease of care hours actioned and agreed**		
Day 8-14	Delivers care in accordance with goals and records progress daily within the care support plan held in the person's home Night Support recorded as appropriate	Review and update goals with person and family Order any ongoing AT equipment. Start to talk to person about the reablement care ending	Check contract is in place to cover remaining period of support
Day 15-21	Review progress and report any care package changes to Brokerage consider reduction of care and discuss with Therapist	Prepare person for discharge from the service and agree date or ongoing services and meet with relatives and care Provider to ensure this is agreed.	
	Continue daily working on goals	Prepare Support Plan for Discharge and liaise with Care Provider for communication to person and family. Send to Brokerage if further care required Identify if care is BCF or ongoing Long Term care	

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	If no discharge plan agreed at day 16 contact Brokerage	If the persons condition is optimised, Continuing Health Care (CHC) checklist if now for Long Term Care Review goals with person Check/chase equipment order MDT discussion and planning Finalise end of service Date discuss with person Contact and meet with relatives, carers
Day 21		**End intermediate home care service**

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Appendix 2 – Pathway 2 and Pathway 3
Discharge Planning for 21 day stay 'STEP DOWN' to Intermediate care bed

	Pathway 2 & 3 - GOALS SET that will enable the person to feel safe to their usual place of residence return home		
	Provider	**ShropCom**	**Council**
	Maximise use of trusted assessor to Assess. Accept same day referrals and up to two per 24 hours where safe to do so		**Work with SaTh to ensure FFA is completed fully**
Day 1-7	Out of bed, out of room, dressed, work on set goals moving and interacting - using enablement facilities, eating and drinking as agreed. Participate in weekly bed meeting	Inform person, family carers of Estimated Date of Discharge (EDD) Review goals with person Bartells Score assessed and recorded	**Contract or block bed notification issued**
		Therapy assessment of person at Pathway 2, Day 1, 4 and 7 Pathway 3, Day 3 and 7 or as required	Mental Capacity and Best Interest Decision MDT Consider an Advocate
		MDT discussion and planning Review EDD with person, family and carers Ensure Person, family, carers are in receipt of verbal and written information which is documented on the Casefile, regarding enablement and funding	
Day 8-14	Continue daily working on goals ensure any changes reported to therapist and Council – establish is early discharge viable	Review and update goals with person Carry out access visit Order equipment	Check contract is in place to cover remaining period of support
Day 15-21	Continue daily working on goals ensure much more independence that previous week	Contact and meet with relatives Prepare them for discharge Discharge MDT discussion (include provider and Red Cross) twice a week Review EDD with person, family, carers	
	Continue daily working on goals Order medication Arrange transport with relatives, friends and British Red Cross	Prepare Support Plan for Discharge Send to Brokerage if further care required Identify if care is BCF or ongoing Long Term care If the persons condition is optimised, Continuing Health Care (CHC) checklist if now for Long Term Care. Review goals with person Check/chase equipment order MDT discussion and planning Finalise discharge Date discuss with person Contact and meet with relatives, carers Finalise home preparations, consider British Red Cross for preparing home.	
Day 21		Return Home with assessed support if required	

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Appendix 3 - Discharge Plan for 14 day 'STEP UP'

'Admission Avoidance'

	Period of assessment outside of the acute setting by whole the MDT to facilitate decision making about long term support.		
	Provider	**ShropCom/SaTH**	**Council**
	Maximise use of trusted assessor to Assess. Accept same day referrals and up to two per 24 hours where safe to do so		**Work with SaTh to ensure FFA is completed fully**
Day 1	Ensures that Treatment Plan is followed. Fluids, diet and medication is administered Personal Care needs are attended Management of skin integrity	Treatment Plan written by Rapid Response Nurse and Medical Order from GP or Emergency Department(ED) Practitioner with examining Doctors order. Rapid Response Nurse – Case Manager SaTH ED Practitioner hands over Case Management responsibility to Community ShropCom Professional. Nursing /Treatment, Plan/Goals Set Initial EDD set and shared with person, relatives and carers Referral to Therapists verbal/followed up by written All documentation completed	**Contract or block bed notification issued**
Day 2- 5	Follow Nursing and Therapy orders As soon as possible, out of bed, dressed, mobilised as specified by Treatment and Support plan	Seen by ShropCom therapist - goals and plan set to ensure early treatment Rapid Response Nurse/ case manager- Referral to Brokerage if further domiciliary home care is required	Act on referral as required for next stage planning
Day 6-14	Ensure person is out of bed, dressed, mobilised as specified by Treatment and Support plan accessing reablement facilities	Active Discharge Planning MDT discussion in provision EDD reviewed daily Goals reviewed daily Equipment anticipated and ordered ready for home discharge Further/changed Medication if required Transport Home, consider relatives, friends, British Red Cross	Brokerage searching for ongoing community support if identified

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