NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Discharge to Assess: Intermediate Care Service

February 2020

Pride in our care

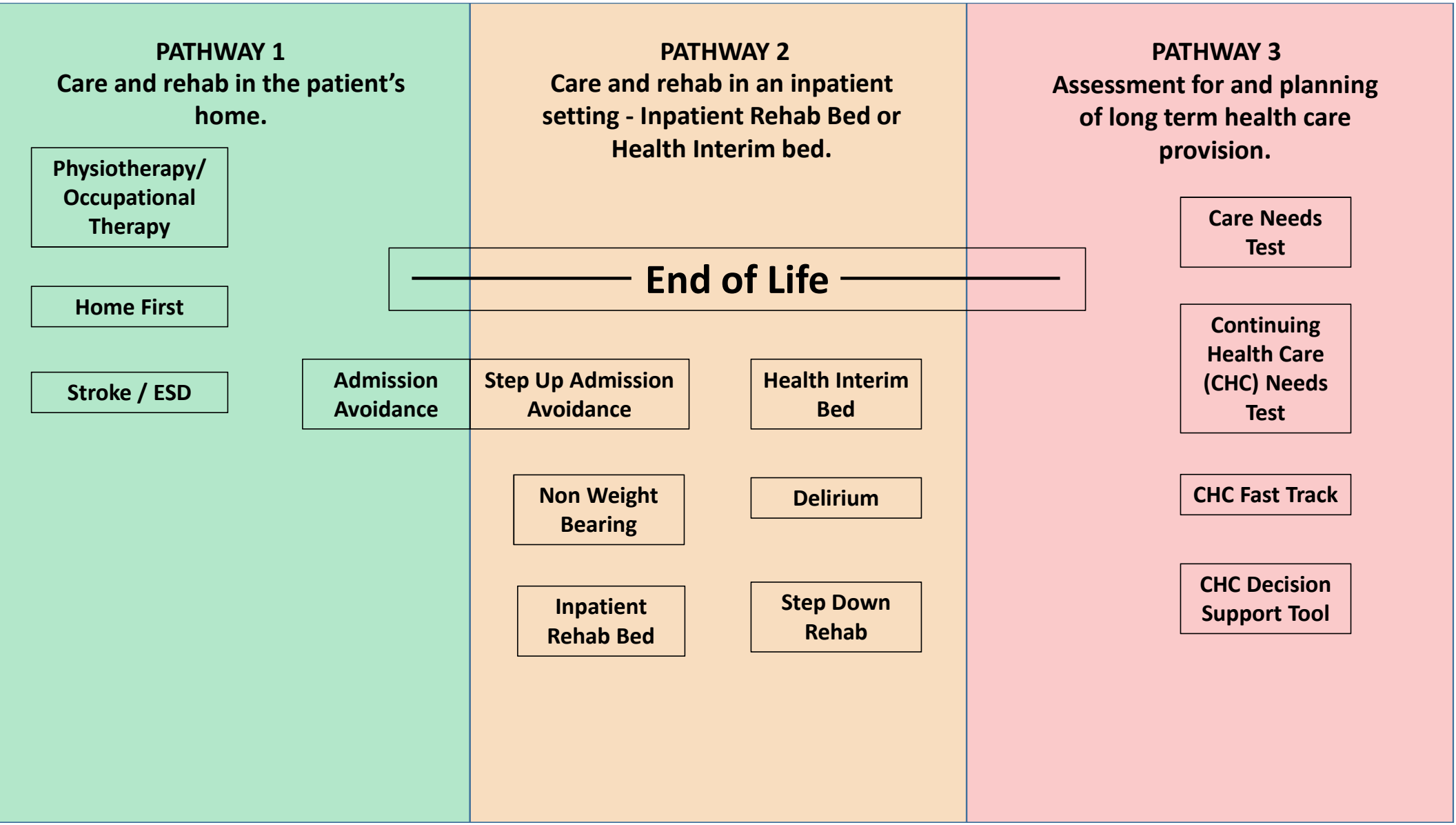
D2A/Intermediate Care: The Vision

To deliver an outstanding, patient-focused, specialist care and therapy community health service, which collaboratively optimises a person's potential to achieve their individual goals.

D2A/ICT: Overview summary

Discharge to Assess/Intermediate Care supports the patient in the community in the most suitable setting for their functional need, ensuring safe, effective and efficient care and rehab to enable the patient to maximise their potential for independence, including early discharge from hospital and admission avoidance.

Pathway 1 is care and rehab in the patient's home.
Pathway 2 is care and rehab in an inpatient setting - Inpatient Rehab Bed or Health Interim Bed.
Pathway 3 is assessment for and planning of long term health care provision.


PATHWAY 1
Care and rehab in the patient's home.
PATHWAY 2
Care and rehab in an inpatient setting - Inpatient Rehab Bed or Health Interim bed.
PATHWAY 3
Assessment for and planning of long term health care provision.
Physiotherapy/ Occupational Therapy
Home First
Stroke / ESD
End of Life
Admission Avoidance
Step Up Admission Avoidance
Health Interim Bed
Non Weight Bearing
Delirium
Inpatient Rehab Bed
Step Down Rehab
Care Needs Test
Continuing Health Care (CHC) Needs Test
CHC Fast Track
CHC Decision Support Tool

D2A/ICT: Governance

Operational	Clinical
Established line management structure.	At least weekly multi-disciplinary meetings for caseload review and update. 2 x weekly on Inpatient Rehab wards.
Strategic Leadership and Management including Transformation and Service Line Reporting.	Daily 'board rounds', using Red to Green (R2G) tool.
Operational Leadership and Management – Team Leaders / Governance / Senior Care Co-Ordinators / Therapy / Team Meetings.	Team Leads and Ops Managers are registered clinicians (nursing and therapy).
Policies, Standard Operating Procedures, Professional Standards.	Robust DTOC management, internally and with external partners.
Supervision and Appraisal.	Weekly Long Length of Stay analysis.
Prioritisation of referrals.	Mandatory training for all roles includes Medicines Management (clinical and non-clinical) and Medical Emergency Recognition for all staff.
Robust clinical triage and Trusted Assessor for P2.	

CQC Criteria

WELL-LED

Escalation processes.
Monthly Team meetings and Governance meetings.
Clinical lead for each team.
Learning culture from incidents.
Appraisal and supervision.

RESPONSIVE

Single point of referral for P1 and P2.
Trusted Assessor for P2.
Clinical triage within 24hrs of referral.
Daily IDS huddle attendance.
Fluid borders to meet demand.

SAFE

Audits.
Weekly MDT.
Team resilience.
In-service training and staff competencies.
Staff development workshops.
Clinical support.
Daily team OPEL rating.
Agile working on SystmOne.
Care Planning.
Auto scheduling.
Out of hours care.
coordination for P1.

EFFECTIVE

Criteria led discharge.
Expected discharge dates set at admission.
Weekly long length of stay patient review
Weekly MDT.
Red2Green/daily board round
SAFER principle.
Collaborative working with JET.
Regular operational meetings with ASC.

CARING

Patient surveys and feedback.
Carer surveys and feedback.
Patient centred care plans.
Goals led service.

Intermediate Care Geographical area Inpatient units and Teams

Peterborough Intermediate Care Team

Peterborough ICU
Based at City Care Centre
Community inpatient unit

Hunts Intermediate Care Team

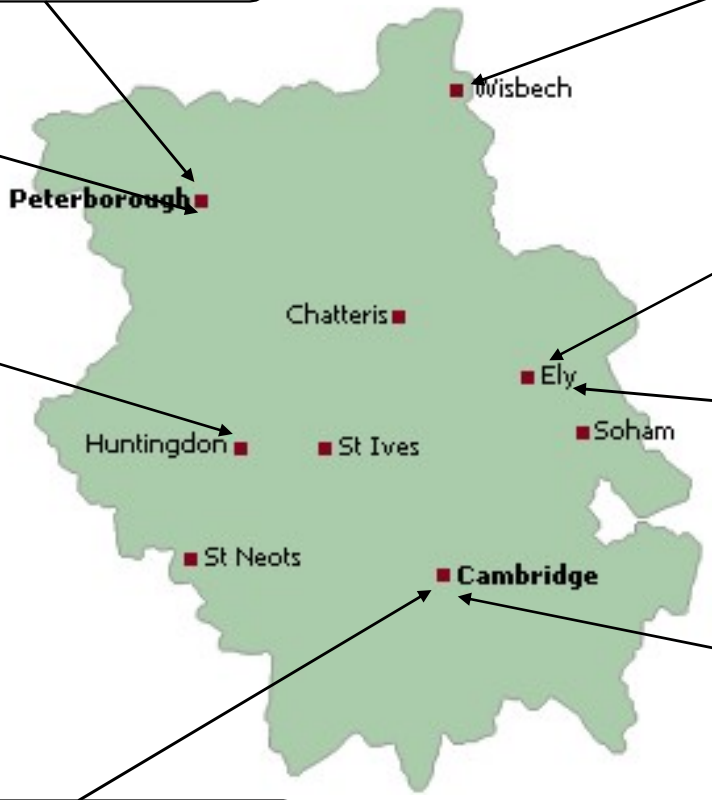
Cambridge Intermediate Care Team

Trafford Ward
Based at North Cambridgeshire Hospital
Community Inpatient Unit

East Cambs and Fenland Intermediate Care Team

Welney Ward
Based at the Princess of Wales Hospital
Community Inpatient Unit

Lord Byron Wards
Based at Brookfields Hospital
Community Inpatient Unit



Service Referral Criteria

- **Patients who are clinically fit to leave hospital OR**
- **Patients who can be prevented from being admitted to an acute hospital AND are:**
- Adults aged 18+ registered with a Cambridgeshire and Peterborough GP.
- People rehabilitating following acute medical or surgical health conditions where it is anticipated that their functional status will improve.
- This may include:**Patients on the ESD pathway for stroke.**
- Patients with infections including acute exacerbations of long term conditions e.g. COPD.
- Resolving delirium.
- Following orthopaedic trauma.
- Following acute treatment that has resulted in the need for some support with their daily living activities that they would otherwise be independent e.g. chemotherapy cycles.
- Patients with clear rehabilitation goals and a clear discharge plan from the pathway.
- Patients with the ability to engage in goal setting retain and carry over rehabilitation techniques taught to them in order to continue with progression.
- **Patients at the end of life who require care.**

Service Exclusions

- Patients who need long term care packages.
- Patients whose existing care package meets their needs.
- Patients who require permanent placement into a nursing or care home.
- Patients whose needs can be met by Local Authority reablement services because the primary need is not related to an acute health medical or surgical illness.
- Patients who have an acute mental health need or who have a psychiatric crisis.
- Patients who require maintenance for a long term condition.
- Patients whose only need is medicines management.

Interdependencies:

- JET
- Neighbourhood Teams
- Social Care
- Voluntary sector
- GPs
- Care agencies
- CHC team
- Specialist services such as Neuro Rehab, Tissue Viability, Continence etc.

Pathway 1 – Care and Rehab at home

- Business Case became operational in October 2017.
- Began using electronic patient record in July 2018.
- Around 120+ patients in Pathway 1 plus 24 Health Interim beds at any one time.
- Patients receive specialist health assessment and rehab at home, ICWs have competencies to manage patients with high acuity levels.

Geographical coverage and service use heat map for Pathway 1

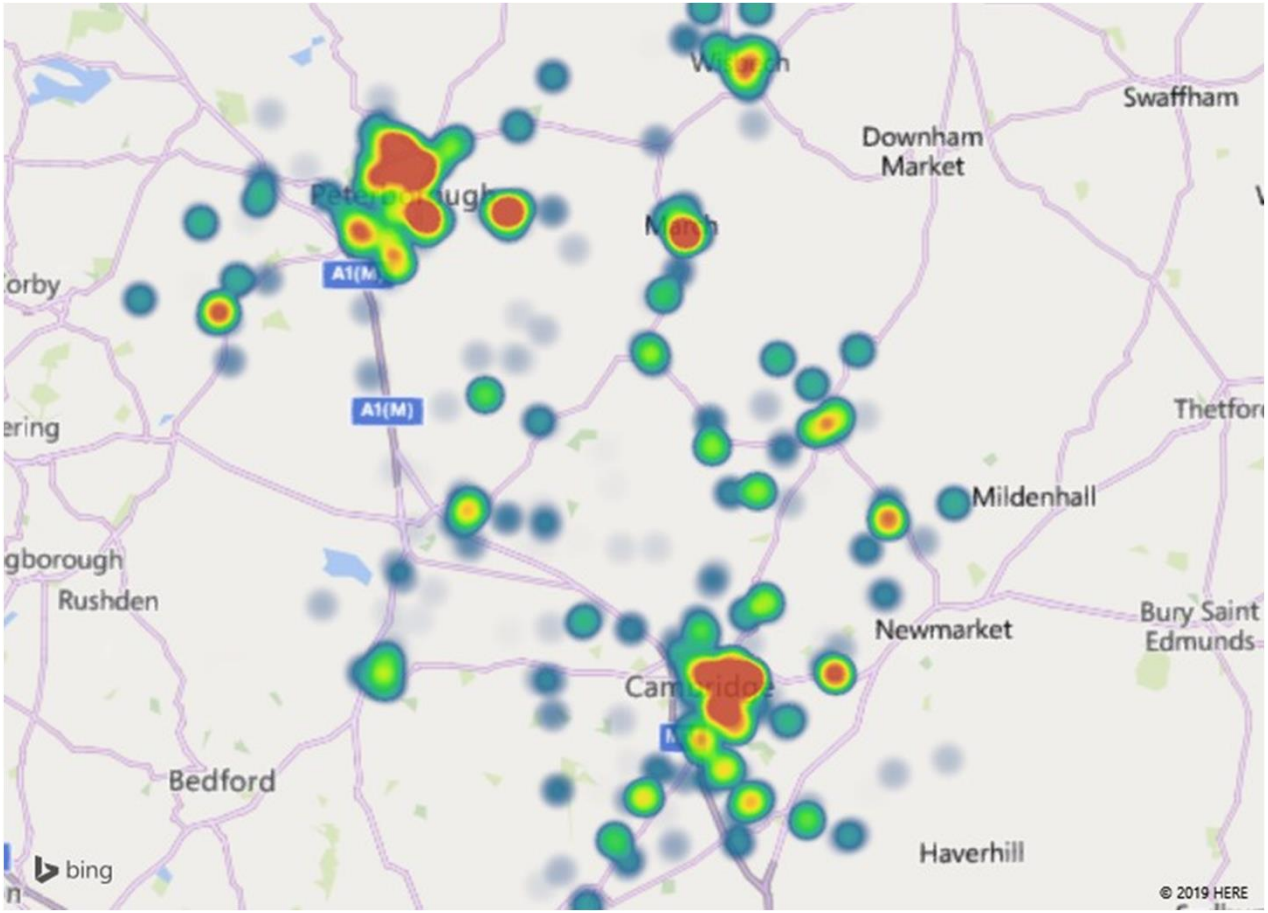
Peterborough: GPs in Peterborough, Oundle and Wansford.

Cambridge: GPs in Cambridge

East Cambs and Fenland: GPs in EC&F.

Huntingdon: GPs in Huntingdonshire.

NB: Teams work across borders to match capacity and demand.



Pathway 1: National Audit of Intermediate Care Results

PATIENT REPORTED FEEDBACK

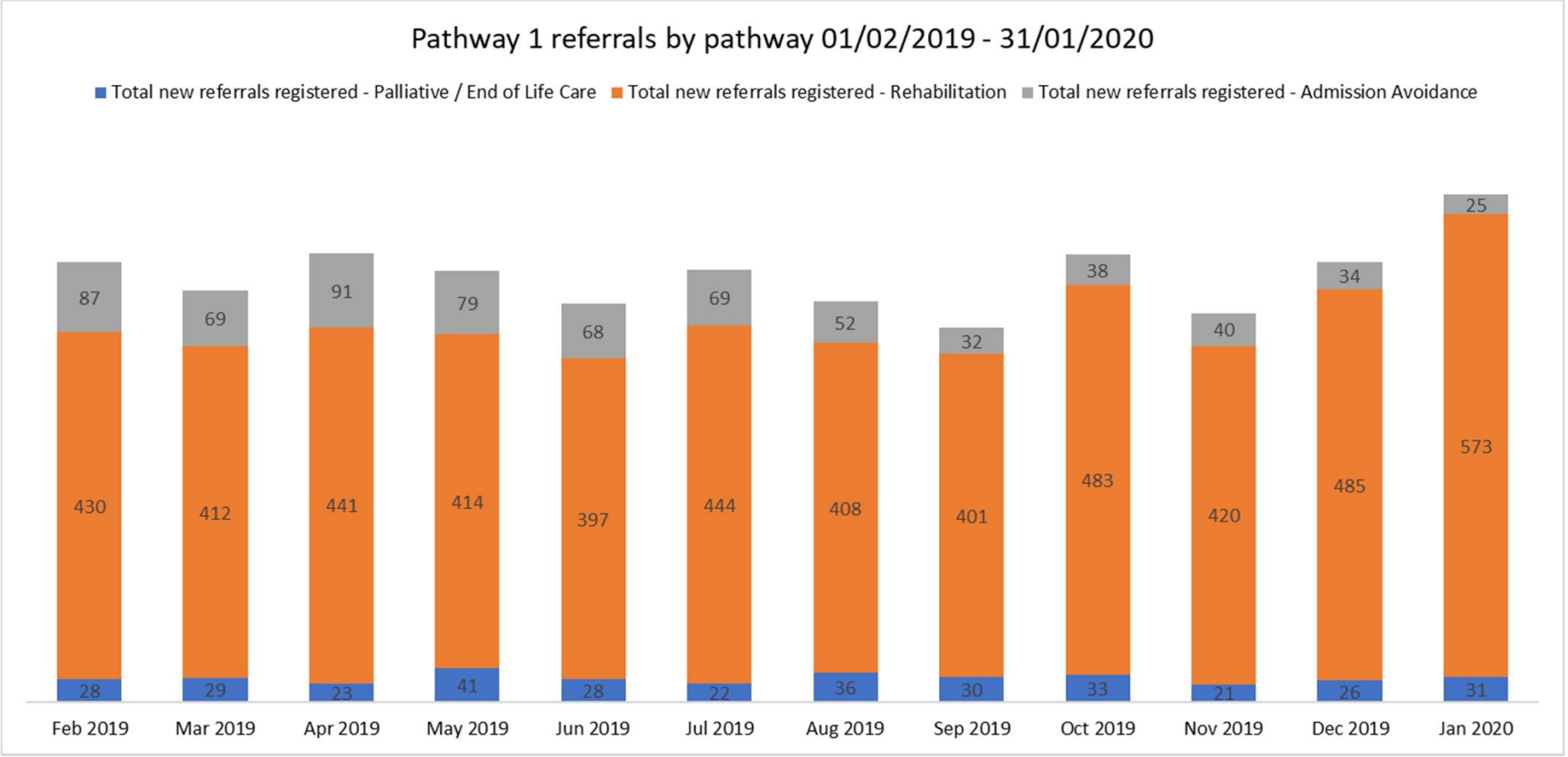
WHAT WE DID WELL (ABOVE NATIONAL AVERAGE)

- The length of time patients felt they had to wait for our service.
- Patients felt that they were aware of what their goals were.
- Patients felt that they were involved in decisions about their care, support and treatment.
- Patients felt involved in decisions about their care when ICT was stopping.
- Patients felt that families were given the correct information they needed to help care for them.
- Patients felt that staff discussed with them whether they needed further health or social care support after ICT stopped.
- All patients felt they were treated with respect and dignity.

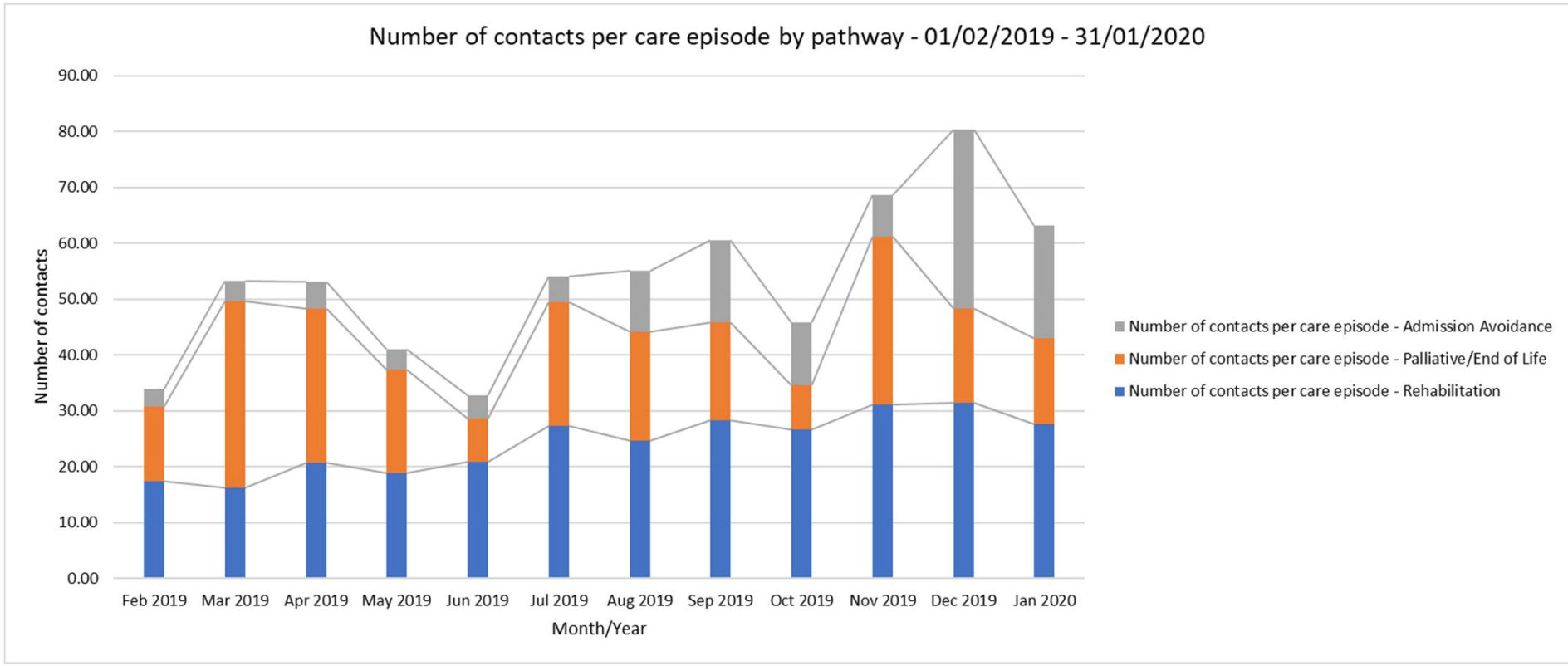
WHAT WE DIDN'T DO SO WELL AT (BELOW NATIONAL AVERAGE)

- Patients felt that visit times were not always convenient for them.
- Patients felt that we could not always answer important questions well enough.
- Patients felt that since leaving the service their ability to maintain social contact had not improved.

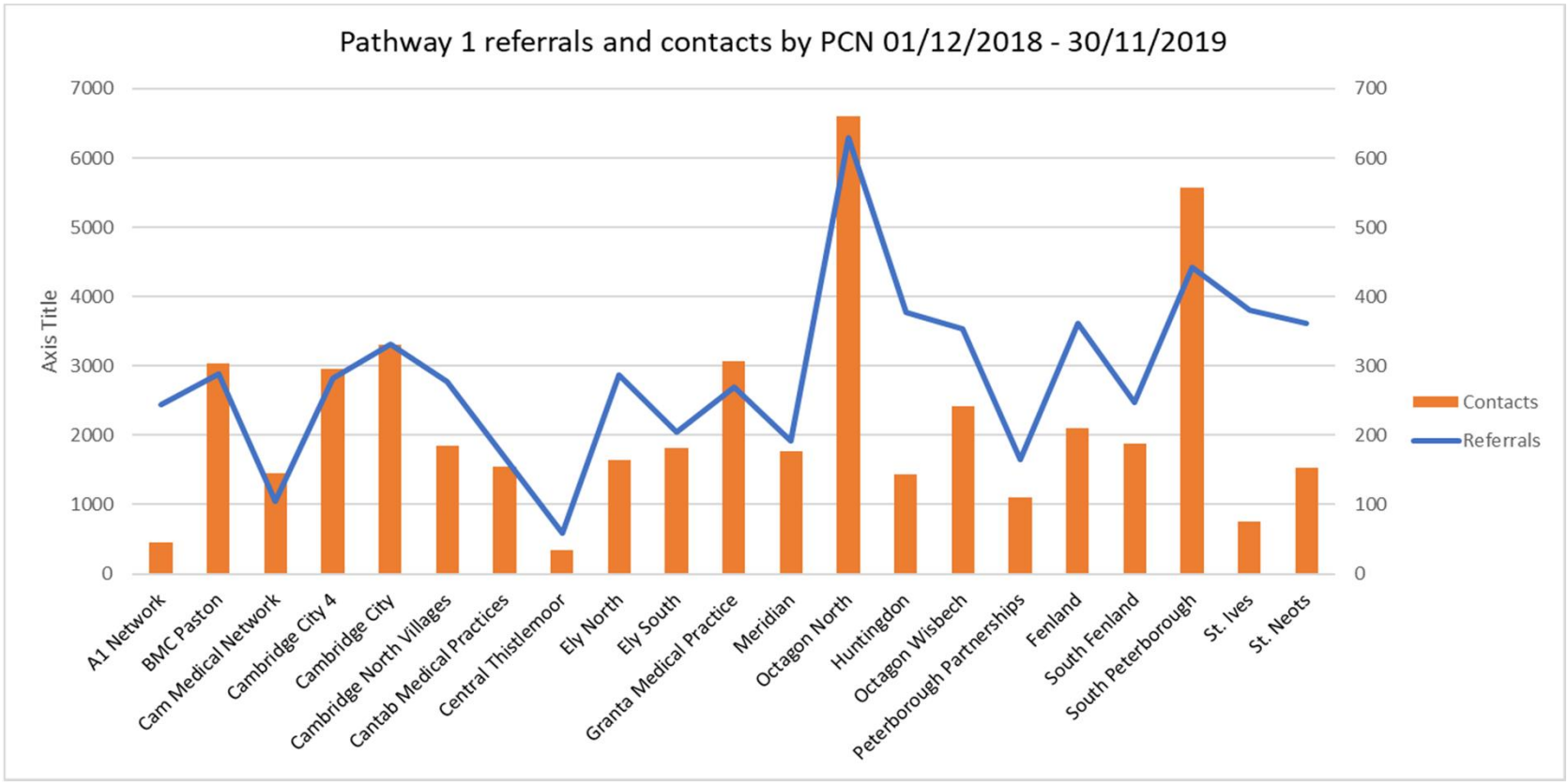
Pathway 1 referrals by type



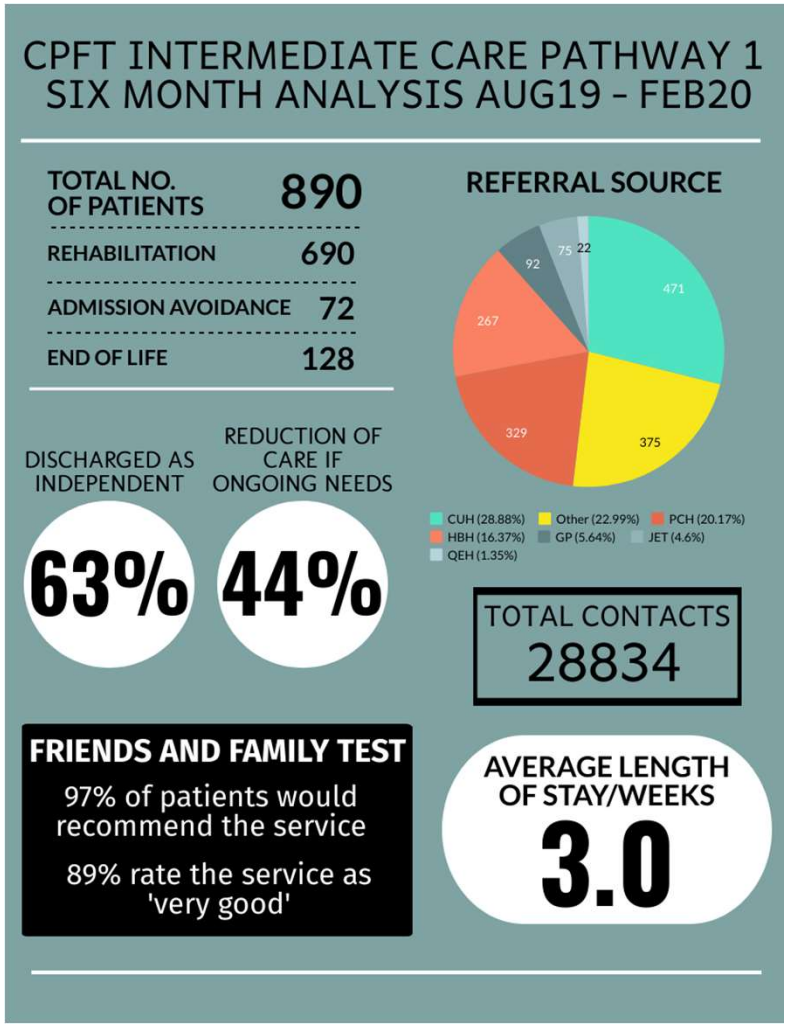
Pathway 1 contacts per care episode by type



Pathway 1 data – Referrals and contacts mapped by Primary Care Network



Pathway 1 service use data



Pathway 2 – Inpatient Care and Rehab

The Lord Byrons , Brookfield Hospital, Cambridge – 36 beds.*

Intermediate Care Unit, City Care Centre, Peterborough - 34 beds.*

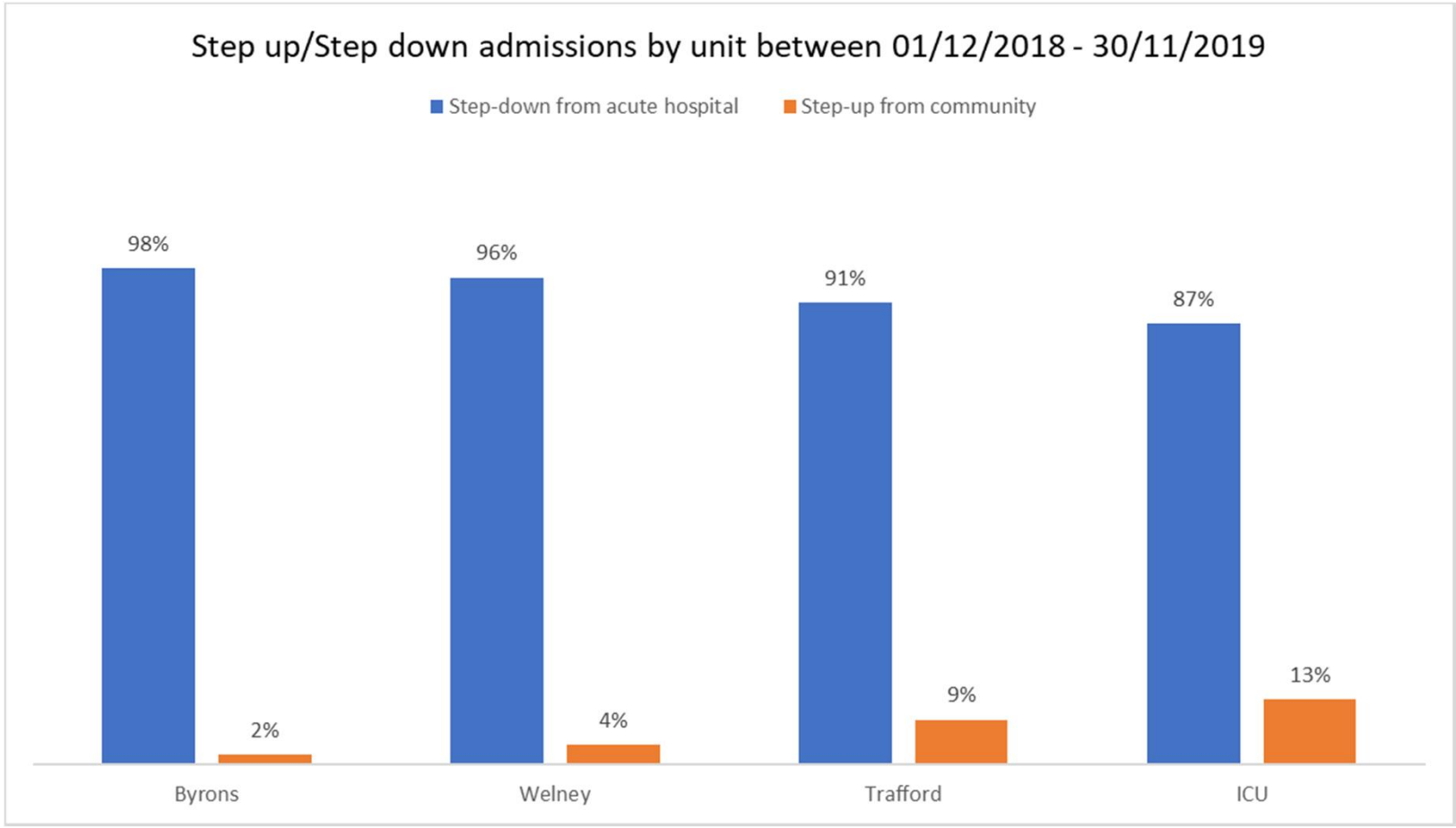
Welney Ward, Princess of Wales Hospital, Ely - 16 beds.**

Trafford Ward, North Cambs Hospital, Wisbech - 16 Beds.**

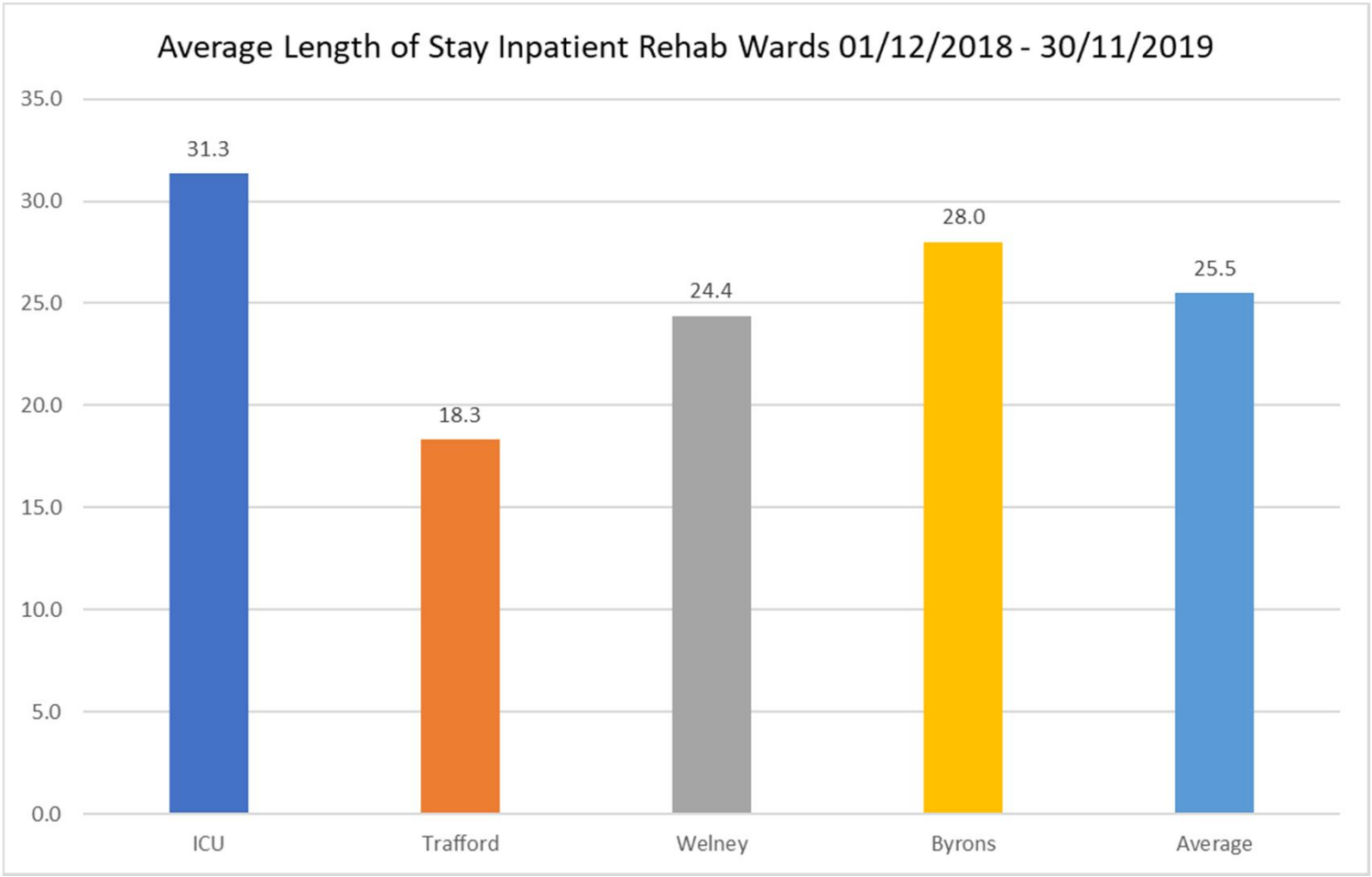
Patients on the ESD pathway for stroke*

Patients at the end of life who require care**

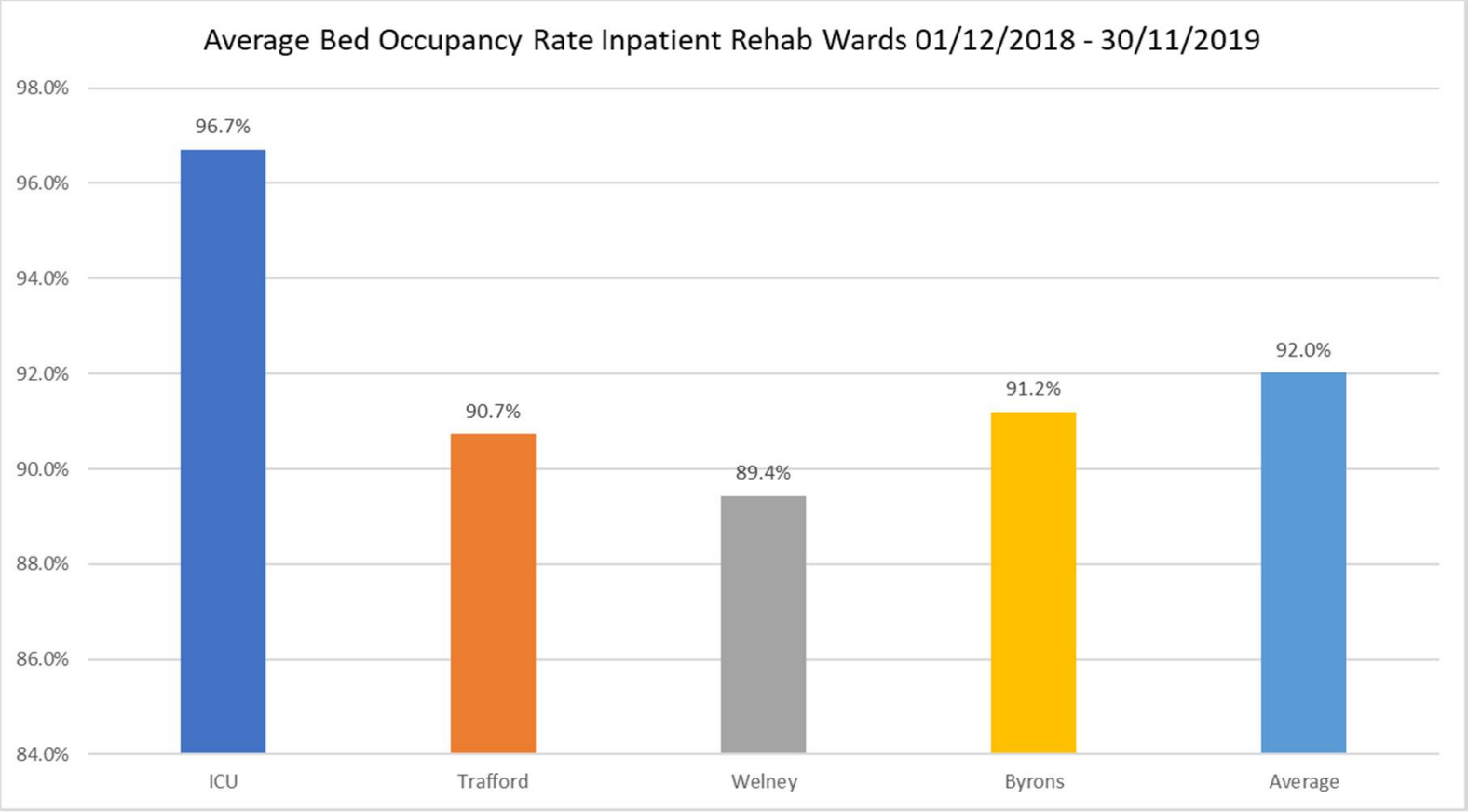
Pathway 2 data – Step Up/Step Down



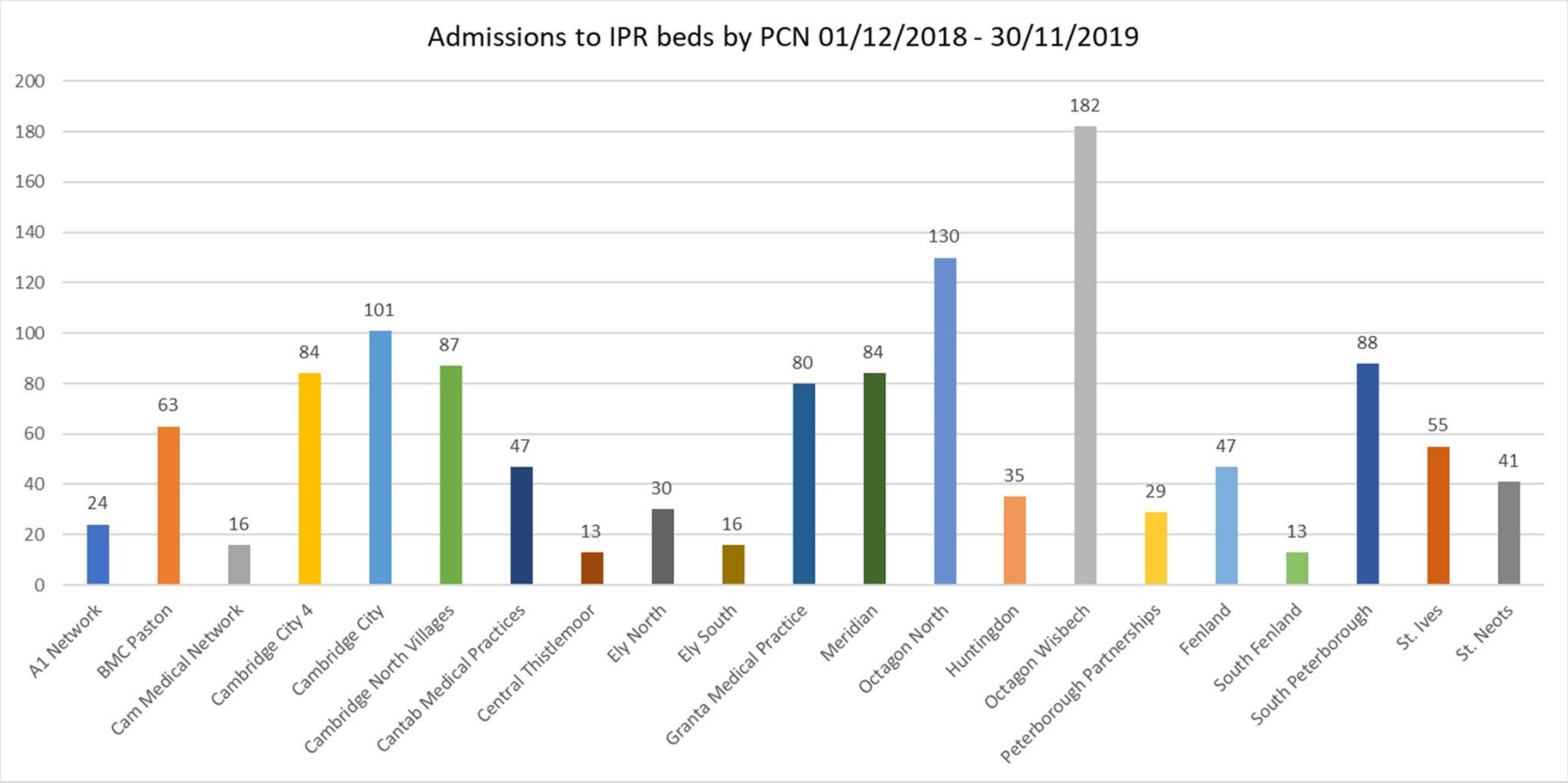
Pathway 2 data – Length of Stay



Pathway 2 data – Bed Occupancy



Pathway 2 data – Admissions mapped by Primary Care Network



Pathway 3

- Patients that have likely long term health care needs and require ongoing health care in a residential setting.
- Pilot started in Feb 2017 for patients to be screened whilst in hospital as to whether their need was primarily health or social care. Patient then discharged under the care of and funded by the assigned organisation for 28 days. During this time the patient was assessed by a Specialist Nurse and Social Worker by means of a Checklist and then a Discharge Support Tool to agree the long term needs of the patient and which organisation will finance the ongoing care.
- Fast Tracks also completed by DPSN for patients in acutes.
- Due to this being a pilot, agency staff were primarily sourced. Problems with recruiting and retaining staff was a recurring problem making it difficult to achieve 80% completion and verification within 28 days.
- Paper written and then submitted to CCG in August 2019 regarding developing a permanent Service Model. Now agreed that CCG will provide this role from April 2020.

From Acute Hospital to independence: A patient story

- 89-year-old lady admitted to acute hospital after a fall. Fractured humerus, a history of falls, confusion and urinary incontinence.
- Referred then assessed for Pathway 2. Rehabilitation needs identified: management of meals, mobility, toileting and night time needs.
- Admitted to Health Interim placement. Intermediate Care intervention included full continence assessment and a therapy programme aimed at improving function, muscle strength and mobility with the goal of achieving a level that would enable a return home.
- Referral to Assistive Technology. Liaison with Red Cross for befriending services and assistance with shopping.
- Patient discharged from Health Interim Bed to Pathway 1 with care and therapy support.
- Medication management at home implemented to enable independence with medication.
- Continuing therapy and support to progress with management of personal care and mobility.
- Provision and fitting of equipment to enhance independence with toileting and meals.
- Fracture clinic review: patient was able to weight bear on the injured limb and was given further exercises and functional tasks to improve range of movement and use of the limb.
- Falls assessment completed and referral to falls service for therapy intervention aimed at reducing the risk of further falls and injuries.
- Effective Multi-Disciplinary Team working has led to the patient being discharged fully independent, able to mobilise indoors and outdoors (with appropriate walking aid) and having achieved a good quality of life.

Patient Flow – CPFT Operations Hub

The CPFT Operations hub provides oversight and improves patient flow in Pathway 1 and 2 by:

- Overseeing all Pathway 2 referrals and uploading to Systm1. These are then visible to the IPR Wards and can be followed up. The Operations Hub will chase and escalate when patient flow is difficult.
- Convening daily discharge planning calls in Pathway 2 – IPR wards, social care and operations hub team discuss patient pathways at an individual patient level.
- Validating Delayed Transfers of Care (DToC) in Pathways 1 and 2, and following up with external organisations (Social Services/CHC) to create Pathway 1 and 2 capacity.
- Monitoring Long Length of Stay (LLoS) for Pathway 1 and 2 and collating data for reporting purposes.

Next Steps

- Streamlining Health Interim admissions process to reduce patients' Length of Stay.
- Build up a model to capture demand and estimate capacity for pathway 1 with a view to improving reporting capabilities.
- Mixed analysis of inappropriate referrals in Pathways 2 in order to reduce the proportion of inappropriate referrals and improve adherence to service access criteria.