Enhanced Integrated Hospital Discharge Team and Community Care Project

Evaluation Report
March 2012
Enhanced IHDT and Community Care Project
Evaluation Report and Recommendations for 2012/13

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EXECUTIVE SUMMARY

The Enhanced IDT (Intermediate Discharge Team) and Community Care Project was established in November 2011 with the intention of building on existing partnership work to:

- Implement the recommendations of several mid Mersey QIPP programmes in a co-ordinated way to deliver better outcomes for patients/service users;
- Respond to the challenge posed by the Whiston Hospital Tripartite Formal Agreement (TFA). In particular, contributing to workstream 2, the redesign of services which deliver efficiencies, utilise released capacity and strengthen clinical engagement and collaboration across the system;
- Manage anticipated winter pressures in the health and social care system;
- Begin to develop a longer term sustainable model of more effectively integrated health and social care services, breaking down some of the barriers which would seem to hinder good performance and positive outcomes for service users and carers.

In terms of long term financial sustainability, at the commencement of the Project, all partners were aware that to maintain successful elements of the Project would require some reordering or re prioritisation of resource allocation. The Project was also aware of funding commitments contained in the Department of Health letter, (Gateway Number: 15434) dated 13th June 2011 which identified a doubling of reablement funding in 2012/13. Many aspects of the Project would be suitable for consideration for this increased funding.

In considering this evaluation it is important to note that the Project has been fully operational for slightly over three months and therefore there will continue to be work to refine and develop the methodology. Another key point is that the focus of the project has been on the patients that the Integrated Discharge Team would normally work with at Whiston hospital. This represents approximately 20% of the patients in the hospital at any one time. While the group that is subject to this evaluation will of course have an impact on overall performance in relation to a number of key indicators such as length of stay and waiting times, the Project can only make a contribution towards this and any analysis of the success of the Project must have a clear understanding of this.

The Enhanced IDT and Community Care Project was established to achieve the following benefits:

a) A reduced number of ‘medically fit’ patients occupying Whiston hospital beds, (from 40 to 10 beds)
b) A ward equivalent freed-up at Whiston Hospital
c) Contributing to measurable improvement in the 18 week target
d) Patients would have the most appropriate management
e) Fewer delays in patient discharge
f) Improved capacity to tackle the additional winter pressures
g) Better integration of primary, secondary and social care
h) Reduction in direct transfers to long term residential and nursing care
### Table 1: Total Numbers of Medically Fit Patients in Acute Beds

<table>
<thead>
<tr>
<th>Weeks</th>
<th>No of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2012</td>
<td>0</td>
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<tr>
<td>11/01/2012</td>
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<td>15/02/2012</td>
<td>60</td>
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<td>22/02/2012</td>
<td>70</td>
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</tbody>
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### Table 2: Numbers of Medically Fit Patients in Acute Beds by Local Authority Area

<table>
<thead>
<tr>
<th>Weeks</th>
<th>No of People</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>08/02/2012</td>
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<tr>
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<td>22/02/2012</td>
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</tr>
<tr>
<td>29/02/2012</td>
<td>69.5</td>
</tr>
</tbody>
</table>
ACHIEVEMENT OF OUTCOMES A, B and C

- The number of ‘medically fit’ patients occupying Whiston Hospital beds has reduced from 40 to 5 beds, exceeding Project objectives
- Capacity equivalent to a ward has therefore been freed-up at Whiston Hospital
- The Project has contributed to the potential for improvement in the 18 week target

ACHIEVEMENT OF OUTCOMES D, E and F

- This Project has achieved better patient management.
- Patients have received more timely care, in an appropriate setting, particularly with assessment and discharge.
- They have more appropriate interventions through the work of the CCCP and other initiatives.
- Those patients who are medically fit for discharge have been placed in settings more appropriate to their needs.
- There has been a 17% Reduction in delayed discharges
- There has been a 5 day reduction in the average time between a section 2 notification and actual discharge
- There has been a significant increase in the number of assessments completed

ACHIEVEMENT OF OUTCOME G

- This Project, through the use of robust Project Management methodologies, clearly defined Project scope, deliverables and benefits realisation has supported the improved integration of primary, secondary and social care

ACHIEVEMENT OF OUTCOME H

Reduction in direct transfers to long term care.

- This project only covered a period of three months. Admissions to residential and nursing care is subject to seasonal variances and tends to be higher throughout the winter months, which is the period covered by this evaluation.
- Robust trends and performance data will need to be identified over a longer time period.
In conclusion the Enhanced IDT Project achieved and exceeded its objectives and has fostered improved working relations between primary, secondary and social care in a relatively short time period by adopting a task focused and proactive approach.

The key conclusions from the project are:

- The number of people declared medically fit and occupying acute beds has reduced from 40 to an average of 5 people per week (mostly Liverpool residents who did not take part in this Project.)

- This will support the Acute Trust in implementing the TFA and achieving improvements in its 18 week targets, and in freeing up the equivalent of one ward in Whiston. It responds positively and pro-actively to the actions within Workstream 2 of the Whiston TFA.

- The project has achieved a 17% reduction in delayed discharges

- The number and speed of assessments completed by the IDT over the course of the project has increased substantially. The number of assessments undertaken by the IDT has increased by 140%, medically fit patients are assessed and discharged sooner to placements which are more suited to their needs so there has been an improvement in service user outcomes.

- Substantial savings across the Health and Social Care sector are likely to have been achieved
1. INTRODUCTION

The Enhanced IDT (Intermediate Discharge Team) and Community Care Project was established in November 2011 with the intention on building on existing partnership work to:

- Implement the recommendations of several mid Mersey QIPP programmes in a co-ordinated way to deliver better outcomes for patients/service users;

- Respond to the challenge posed by the Whiston Hospital Tripartite Formal Agreement (TFA). In particular, contributing to workstream 2, the redesign of services which deliver efficiencies, utilise released capacity and strengthen clinical engagement and collaboration across the system;

- Manage anticipated winter pressures in the health and social care system;

- Extend the definition of Intermediate Care in order that it focused on all older people requiring support at times of transition in their lives rather than focusing on those with reablement potential.

- Begin to develop a longer term sustainable model of more effectively integrated health and social care services, breaking down some of the barriers which would seem to hinder good performance and positive outcomes for service users and carers.

The partnership approach was developed around the model utilised to develop the Integrated Discharge Team at Whiston hospital. This was led by St Helens Council with the active participation and engagement of all key partners including St Helens Health Clinical Commissioning Group (who agreed to represent United League and Halton and Knowsley CCGs), Bridgewater Community Healthcare NHS Trust, Halton Council, Knowsley Council, NHS Merseyside, St Helens and Knowsley Teaching Hospitals NHS Trust.

In November 2011 NHS Merseyside invited bids to help the health and social care economy manage anticipated winter pressures. The original project brief which had already been developed and which is attached as Appendix 1, was refined to meet the format required of the bidding process.

During November 2011 the development of the bid was enhanced by a series of weekly developmental meetings, which engaged both Community and Acute Trust Clinicians. This helped to ensure that the model that was developed in a relatively short period of time, was patient centred and would support effective care.

The Project Team delivering on the enhanced IDT and Community Care Project has in the timescales allowed, adopted a clear programme management approach to implement activity in a co-ordinated way. The approach taken was established with key benefits and performance indicators in mind at all stages and the initial anticipated benefits and performance indicators are outlined in Section 2 of this report.

From its early stages the Project Team has been mindful of the need to co-ordinate discharge related activity with activity that promotes admission avoidance and some elements of the project have begun to achieve this, such as the Clinical Connection Point, whilst other proposals have been further developed e.g. support to care homes utilising the Project Team.
The Team has also always maintained a commitment to robust evaluation of its methodology and the outcomes delivered. This report represents the initial evaluation of the first three months of the Project's operation.
In terms of long term financial sustainability, at the commencement of the Project, all partners were aware that to maintain successful elements of the Project would require some reordering or re prioritising of resource allocation. The Project was also aware of funding commitments contained in the Department of Health letter, (Gateway Number: 15434) dated 13th June 2011, which identified a doubling of reablement funding in 2012/13. Many aspects of the Project would be suitable for consideration for this increased funding.

In considering this evaluation it is important to note that the Project has been fully operational for slightly over three months and therefore there will continue to be work to refine and develop the methodology. Another key point is that the focus of the project has been on the patients that the Integrated Discharge Team would normally work with at Whiston hospital. This represents approximately 20% of the patients in the hospital at any one time. While the group that is subject to this evaluation will of course have an impact on overall performance in relation to a number of key indicators such as length of stay and waiting times, the Project can only make a contribution towards this and any analysis of the success of the Project must have a clear understanding of this.
2. BENEFITS AND KEY PERFORMANCE INDICATORS

The Enhanced IDT and Community Care Project was established to achieve the following benefits:

i) A reduced number of ‘medically fit’ patients occupying Whiston hospital beds, (from 40 to 10 beds)
j) A ward equivalent freed-up at Whiston Hospital
k) Contributing to measurable improvement in the 18 week target
l) Patients would have the most appropriate management
m) Fewer delays in patient discharge
n) Improved capacity to tackle the additional winter pressures
o) Better integration of primary, secondary and social care
p) Reduction in direct transfers to long term residential and nursing care

The Key Performance Indicators used to inform the outcomes of the project were:

- Total number of admissions, reason for admission and length of stay into Nursing/Residential Homes - by LA
- Total number of admissions into Duffy reason for admission and length of stay
- Total number of admissions into Newton, reason for admission and length of stay - by LA
- Reduction in the number of direct transfers to Long Term Care
- Total number of Non Elective admissions
- Referral to Treat target for Elective Patients

In addition the proactive approach with very regular meetings of senior staff from all agencies and a programme managed task focussed approach would deliver qualitative benefits in partnership working and ensure joined up and consistent leadership of the system at a time of change and pressure on resources.
3. OUTCOMES

   a) A reduced number of medically fit patients occupying acute hospital beds, from 40 to 10.

The November 2011 baseline number of patients who were declared medically fit in Whiston hospital, but who were still occupying an Acute bed was 40. This was calculated from an audit of patients led by the Trust. During past winters this figure had increased to up to 60/70 people. The project’s objective was to ensure that patients were discharged to the most appropriate setting quickly, safely and effectively after being declared medically fit.

In the context of this project the term “medically fit” is in line with the SITREP national definition. This means that a patient is ready for transfer when:

a. A clinical decision has been made that patient is ready for transfer AND
b. A multi-disciplinary team decision has been made that patient is ready for transfer AND
  c. The patient is safe to discharge/transfer

It was acknowledged that there will sometimes be cases when a medically fit patient will occupy an acute bed. Therefore the target for the project was to reduce the number from an average of 40 at the time of the development of the project to an average of 10.

The project made strong progress against this target, and achieved the target during the second week of January, when 9 medically fit patients remained in an acute bed. Since the beginning of February the project continues to achieve this target and an average of only 5 medically fit people remain in acute beds.

<table>
<thead>
<tr>
<th>Table 1: Total Numbers of Medically Fit Patients in Acute Beds</th>
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<tbody>
<tr>
<td><strong>No of People</strong></td>
</tr>
<tr>
<td><strong>Estimated Baseline Winter 2010/11</strong></td>
</tr>
<tr>
<td><strong>Baseline Winter 2011/12</strong></td>
</tr>
<tr>
<td><strong>Actual Winter 2011/12 (All Areas)</strong></td>
</tr>
<tr>
<td><strong>Weeks</strong></td>
</tr>
<tr>
<td>04/01/12           11/01/12           18/01/12           25/01/12</td>
</tr>
<tr>
<td>01/02/12           08/02/12           15/02/12           22/02/12</td>
</tr>
<tr>
<td>29/02/12</td>
</tr>
</tbody>
</table>
The project was therefore successful in reducing the number of people declared medically fit occupying an acute bed, which was reduced from an average of 40 people in November 2011 to an average of 5 people since February 2012. Most of the remaining people are Liverpool residents. (Liverpool has the lowest number of admission rates in comparison with other areas but now accounts for nearly all of the acute beds occupied by the medically fit. Liverpool did not participate in this project). This has been achieved at a period of the year when the number of medically fit people occupying acute beds has previously risen to 60/70.

b) A ward equivalent freed-up at Whiston Hospital

The Project has achieved reductions in medically fit people occupying acute hospital beds from an average of 40 to 5. This is a reduction of 35 beds. The medically fit have been discharged to the community or to sub-acute beds and are therefore no longer in an acute setting. This has therefore achieved its target of freeing up of capacity equivalent to a ward at Whiston Hospital.

c) Contributing to an improvement in the 18 week target

The variables which impact upon the achievement of the 18-week target are numerous, and most fall outside of the scope of this project. This project has focused on the patients that the Integrated Discharge Team would normally work with at Whiston Hospital, which is on average around 20% of the total patient population.
However, a successful project outcome has been the significant reduction in the numbers of medically fit patients in acute beds – from 40 to 5. This has freed up capacity within the Acute Trust. Therefore, although this evaluation cannot comment on the overall current performance on achieving the 18 week target, as being outside the Project scope, it can however assert that the achievements of the Project in reducing the numbers of medically fit patients occupying acute beds will have freed up capacity and contributed to the performance management of this PI Indicator.

STHK has been able to achieve the 18-week standards in part due to the reduction in medical outliers in surgical beds. The data attached demonstrates performance in day cases and elective procedures for 2011/12 against 2010/11 and 2009/10. The number of procedures carried out between November and February 11/12 has risen by 25% since the previous year.

Table 3: Total Elective and Day Case Procedures Performed. (Source PAS)

<table>
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<th>09/10</th>
<th>10/11</th>
<th>11/12</th>
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<tr>
<td>Surgery</td>
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<td>6816</td>
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<td>2893</td>
<td>2972</td>
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</tr>
<tr>
<td>Total</td>
<td>9993</td>
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</table>

**ACHIEVEMENT OF OUTCOMES A, B and C**

- The number of ‘medically fit’ patients occupying Whiston Hospital beds has reduced from 40 to 5 beds, exceeding Project objectives
- Capacity equivalent to a ward has therefore been freed-up at Whiston Hospital
- The Project has contributed to the potential for improvement in the 18 week target

**d) Patients would have the most appropriate management**

A further objective of the project was to ensure that patients were managed in the most appropriate setting for their needs.

This was achieved in a number of ways;

- establishing a Community Clinical Connection Point
- ensuring that there are transitional beds in care homes within the community
- opening sub acute beds on the Duffy Ward at St Helens Hospital
- opening additional intermediate care beds at Newton Hospital

The impact of the additional beds is detailed below in point f) of this report.
The Community Clinical Connection Point (CCCP) is a pilot scheme, which has been developed to help reduce acute hospital admissions and provide care closer to home for the population of Halton and St Helens. Working collaboratively with the current Rapid Response Team, the CCCP allows inclusion of patients who previously failed to meet the criteria of “medically stable.” Through providing direct clinical contact between referrer and CCCP, timely decisions can be made to identify conditions which can be managed within the top tier of intermediate care services i.e. Newton Community Hospital or, more recently, short term intensive nursing support at home.

The CCCP was introduced following feedback from General Practitioners in order that they could speak directly to a clinician rather than having to follow what was perceived as an inefficient administrative referral process.

During the period 27th December 2011- 21st February 2012 136 calls were received by the CCCP. 79% of these calls were referrals from GPs (108/136). Calls were from a wide range of surgeries across Halton and St Helens. 39 people were admitted to Newton via the CCCP and the average length of stay for CCCP patients was 13.43 days. These people would have potentially gone straight to A&E if the CCCP were not in place. The remaining enquiries were directed on to other teams/ settings, including A&E in 7% of cases. During the same period only 3 people went to A&E following assessment by the CCCP.

Of admissions to Newton 59% of these people (23/39) were discharged to their own home. The full dataset in relation to the CCCP is at Appendix 2.

As part of the overall evaluation process and as evidence of effectiveness, Bridgewater collated feedback from both patients and referrers. The full feedback can be read at Appendix 3.

The key messages from the feedback were:

a) Patient Feedback
   - Overall the service has been scored “Excellent” or “Good” for the majority of indicators, at 86%.
   - Patients commented that their experience compared favourably to a wait in A&E.

b) Referrer Feedback
   - 86% of referrers (12/14) stated that they would have sent their patients to the Acute if the service had not been in place.

Case studies from the CCCP are detailed at Appendix 4.

Whilst the CCCP is in its infancy, and comments to date are overwhelmingly positive it is recognised that with future developments the CCCP service could continue to evolve from an embryonic stage to a truly effective hospital avoidance team if it is effectively integrated with other relevant initiatives.
e) Fewer delays in patient discharge

The data for the period November 2011- January 2012 indicates that the project has achieved a 17% reduction in delayed discharges of care. This builds on the IHDT’s achievements since its inception in June 2011.

The Community Care (Delayed Discharges) Act 2003 states that the NHS must alert social care (i.e. the IHDT) if they believe a person is likely to need community care services when they leave hospital. This is referred to as a “section 2 notification”. The average time between a section 2 being issued on the ward and the date of actual discharge has steadily declined since June 2011, and the establishment of the IHDT. However between 1st December 2011 and 31st January 2012 with the extra capacity in the team this ‘turnaround’ reduced further from an average of 9.3 days to 4.3 days (Halton, St Helens and Knowsley patients).

![Table 4: Average Days between s2 issued and date of discharge](image)

f) Improved capacity to tackle the additional winter pressures

The project implemented increased capacity in a number of areas;

- a. 5 Additional Social Workers working within the IHDT and an additional Occupational Therapist
- b. 29 additional beds (phased implementation) on the Duffy Ward at St Helens Hospital
- c. 17 additional Transitional Beds within the Community
- d. 6 additional Intermediate Care Beds in Newton

The project “enhanced” capacity in a number of areas in order to ensure that patients could be quickly, safely and effectively moved to more appropriate settings after being declared medically fit.

i) Additional Social Workers and Occupational Therapist

Additional Social Workers within the Integrated Hospital Discharge Team have not only significantly impacted on the number of social care assessments completed but have ensured that assessments are being picked up earlier and carried out in a much more timely manner.
The team have more than doubled the amount of assessments completed during the course of the project, from a total of 59 assessments in December 2011 to 143 in February 2012. Prior to the project complex assessments would have been referred to the community teams in each local authority. Having social workers within the team who can conduct complex assessments and plan complex discharges has greatly contributed to increasing the speed at which medically fit patients can be discharged from Acute beds. In winter 10/11 there were 29 delayed transfers of care (DTOC) and in winter 11/12 this had reduced to 24 DTOC. All partners have agreed that the additional qualified Social Workers have been fundamental to the success of the project and would recommend that they remain in post.

An Occupational Therapist was funded as part of the project in response to an hypothesis that some delays to discharges were caused by delays with assessments for aids and adaptations, including complex risk assessments for moving and handling. Within the lifetime of the project it was identified that the hospital therapy team required refresher training in moving and handling risk assessments. This training has now been delivered. Any impact that it has had on the hospital therapy teams skill base as well as capacity to manage the range of assessments necessary without having to rely on additional therapy input will require further testing. In addition, early indications show that there is likely to be a positive community impact with acute therapists undertaking manual handling assessments. Community therapists anticipate a reduction in referrals from the acute trust thus freeing them up to focus on community cases and preventative work.

**ii) The Duffy Ward at St Helens Hospital**

At the outset of the project all partners agreed that, once deemed medically fit, the most appropriate place for an individual to be discharged to is the community. However it was acknowledged that, as the project was being implemented during the winter pressure period, during the implementation of the Whiston TFA, and, as enhanced community arrangements needed to be established and embedded, that the Duffy Ward at St Helens Hospital would be opened, as a sub acute ward to offer additional capacity for a temporary period.
The Duffy ward was established as a Step Down provision – sub acute care that would support patients who required further ongoing clinical input. For example patients being discharged from an acute ward who:

- Though stable, require diagnostics or invasive procedures, but not intensive procedures requiring an acute level of care.
- Require active physician direction with frequent on site visits, professional nursing input and significant ancillary services.
- Were suitable for reablement but could not yet access reablement services due to being temporarily non weight bearing.

The Duffy ward was established in accordance with the same governance procedures and standards as acute wards within the Trust, including agreed protocols for managing any incidents that occur. The Director of Nursing from NHS Merseyside approved the nursing and care model for the ward. GP cover for Duffy was provided by Aspect Care.

The Duffy ward provides sub acute care (Level 1) that differs from the existing bed based intermediate care services (Level 2) in St Helens, Halton and Knowsley. The difference of a Level 1 service is that it:

- Is provided in partnership with acute care (usually on site)
- Has a higher nursing ratio of qualified to unqualified staff (40:60)
- Is for patients with a moderate-high risk of readmission

Duffy Ward was opened in 2 phases, 12 beds were opened on 29th December 2011, and an additional 8 beds were opened on 8th January 2012, totalling 20 beds overall. Over the length of the project there were 1952 bed days available at Duffy. During the period 29th December 2011 to 29th February 2012, 76 people were admitted to Duffy utilising 1812 bed days. Between 29th December 2011 and 29th February 2012 Duffy patients were mainly St Helens residents 59%.

Table 6: Breakdown of Duffy patients by Local Authority (L.A).

<table>
<thead>
<tr>
<th>L.A.</th>
<th>St Helens</th>
<th>Knowsley</th>
<th>Liverpool</th>
<th>Halton</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>45</td>
<td>16</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Duffy was utilised by patients who did not require an acute bed or who were medically stable and were waiting for complex support to be arranged and commence in the community. Access to the ward was via the IHDT.

There were various reasons why patients were admitted to Duffy. The most common reasons were:
- Awaiting a family choice of care home
- Complex case management
- Complex care packages
- “Other”

The category “other” covers individuals on Duffy because:
- they refused services offered but it was unsafe to discharge them
- there were issues with their property

20 people ‘Stepped Down’ to Duffy were awaiting a complex care package. This was primarily due to the commencement of new domiciliary care contracts in St Helens on 1st December 2011. Retender for these contracts commenced in January 2011 and
was well underway before this project was conceived. Whether the timing of this had an impact on Duffy admission required further analysis. It is however felt that very few people should be admitted to sub acute beds for this reason in future.

A common reason was that the patient was awaiting a particular preferred care home that was not able to accommodate them at time of discharge. Commissioning teams continue to monitor trends in relation to the most in demand Care Homes in the borough both in terms of category of care home and location/ desirability etc. The Project has adopted several strategies to deal with the home of choice issue however due to the Choice Directive no single strategy will ever be able to resolve this issue.

Another reason for admittance to Duffy is for complex case management. These cases are where individuals require a number of assessments, which can include; mental capacity assessments and best interests decisions, psychiatric assessment. Continuing Healthcare assessments or there are safeguarding issues under investigation.

The average length of stay on the Duffy Ward is 10.5 days. Therefore if Duffy Ward had not opened this would have increased the average length of stay at Whiston. For example in February 2012 the average length of stay at Whiston was 3.96 days. If all patients that stayed on Duffy for 10.5 days had stayed in an acute bed for exactly the same period of time, the impact on overall length of stay at Whiston would be that it would have increased to 4.01. In reality it may be that someone who was on Duffy for 10 days may have stayed in an acute bed for 7 of these days prior to discharge and therefore we cannot state the exact impact that the non-existence of Duffy would have had on overall length of stay.

There are also a number of people who were transferred to Duffy as they declined any other alternative to enable the Integrated Hospital Discharge Team to discharge them safely. Prior to the opening of Duffy ward these patients would have remained on an acute ward. Two case examples of such patients are detailed at Appendix 5.

30 patients were transferred to Duffy from an Intermediate Care bed in Seddon Suite. These were patients who had reached their rehabilitative potential and no longer required intermediate care but still had complex care issues that required addressing before they were discharged home. By transferring these patients to a setting that best suited their needs this enabled the IDT to maintain flow from Whiston to Seddon thereby freeing up acute beds and ensuring the most appropriate service for patients.

The Duffy ward has therefore contributed to the flow of patients between acute beds and intermediate care beds. It has provided a temporary bed based sub acute setting for patients who are medically fit but due to various reasons could not be safely discharged directly to the community. A Case Study example is detailed at Appendix 6.

iii) Transitional beds within the community

Transitional beds within the community were purchased for cases that did not have clinical complexity. They were procured from a range of care homes to offer 24 hour support for individuals, including personal care, activities of daily living and accommodation. Transitional beds were available from 28th November 2011 in St Helens, Halton and Knowsley. The purpose of the beds was to offer the patient a step down provision in a community setting if the discharge to their own home should be delayed for any reason or they were awaiting their home of choice. The provision was free for up to 6 weeks; this was an incentive for the individual and their families to accept this interim solution and move out of an acute bed whilst they did not
require complex clinical interventions, as the transitional beds were not subject to any fairer charging.

One example of the use of a transitional bed was with regard to Mrs L; prior to discharge from the acute setting there was a major water leak in her home rendering it an unsafe discharge destination. As this lady did not require any complex clinical intervention then it was agreed that a transitional placement would meet her needs and allow the family time to make the necessary repairs.

In St Helens these beds were block purchased to ensure availability for the winter period, and were being implemented for the first time as part of plans to increase choice of intermediate care services. In Halton and Knowsley beds were spot purchased, as some transitional beds were in operation in these areas prior to the project.

St Helens

13 beds were commissioned in St Helens (1365 bed days available); 1 Nursing EMI, 2 Nursing, 3 Residential, 3 Residential EMI, 2 Residential Respite and 2 Nursing Respite. Occupancy levels up to and including week commencing 30th Jan were as follows:
- Nursing EMI 82%
- Nursing 32%
- Residential 69%
- Residential EMI 28%
- Respite 3%

20 people have accessed transitional beds in St Helens over the course of the project and the average length of stay in St Helens is 4 weeks.

The most in-demand transitional bed is nursing EMI, possibly linked to the growing prevalence of dementia within the population.

There was an underutilisation of the respite beds compared to the other provision available. Therefore the project board took the decision on 26th January that the respite beds should be converted into transitional beds as there was more demand for this.

Halton

In Halton 9 individuals were placed in a transitional bed during this project period. The average length of stay was 3.5 weeks.

Knowsley

Knowsley did not separately monitor beds purchased through the Enhanced IDT and Community Care Project. During the period of the project 36 people were placed in transitional beds in Knowsley. The average length of stay was 2 weeks. (approximately 504 bed days utilised).

iv) Additional intermediate care beds at Newton Hospital

Newton Community Hospital provides 23 intermediate care beds. Capacity was enhanced to open 6 additional beds from 29th December 2011. During the pilot period there were 98 admissions into Newton. 45% of admissions were from the IDT and 43% of admissions were from the CCCP. The other 12% were from other community sources. The step up: step down ratio is 55:45.
The majority of patients (91%) were St Helens residents. The others were from neighbouring boroughs. The average length of stay for Newton is 19.7 days. The weekly cost of a bed at Newton Community Hospital based on the funding for the project is £592.59 per week. The number of step up patients has increased during the length of this project in comparison with previous years. For example in January and February 2011 24 patients were admitted to Newton Community hospital from the community and in the same months in 2012 this number had risen to 36 (a rise of 50%). Without the extra resource at Newton the impact may have been that the 54 step up patients may have attended AED at a significantly higher cost and/or placed extra demand on primary care resources. 39 of these patients were admitted through the CCCP. As stated earlier on page 8, 86% of referrers using the CCCP stated that they would have directed their Patients into AED without that provision.

The full dataset in relation to Newton is at Appendix 7.

v) Other Community Initiatives

Equipment

Some of the local authority funding was used to purchase equipment. During the project period only a minimal amount of this funding was utilised. This included costs to equip Newton and Duffy. Therefore this funding was re-aligned to ensure that the additional Newton beds could remain open for duration of the project.

It was acknowledged that the St Helens and Halton Community Equipment Service had received some funding from Reablement monies and therefore already had some additional stock during the winter period.

It was also found that by employing an additional staff member in the St Helens Improvement Agency this allowed additional 2 person jobs to be undertaken. For example, on some occasions it was said that a person required a profiling bed. However when assessed it was determined that what was actually needed was the persons existing bed to be lifted downstairs, which the Home Improvement Agency (HIA) were able to facilitate promptly. The manager of the HIA is fully engaged with the IHDT. There is a 2 day target for interventions including grab rails, intercoms etc. This has a positive impact on safe and timely discharges.

Domiciliary Care Hours

St Helens were the only borough which proposed utilising additional domiciliary care hours. In fact these additional domiciliary care hours were not utilised.

This was partly because St Helens domiciliary care contracts were retendered and new contracts started at the same time at the project. These contracts had been awarded following a retendering process that had commenced 9 months earlier. The new contracts impose a requirement for domiciliary care providers to put packages in place within 48 hours and therefore further testing needs to be undertaken to determine whether any additional domiciliary care hours are required.

Capacity for Moving and Handling Risk Assessments

Two occupational therapists were employed within St Helens Council to provide additional capacity for complex risk assessments. A business case is now being taken forward within St Helens Council, Halton Council and the Merseyside NHS Cluster to look at reviewing current contractual arrangements and providing in house resources for these assessments. This will be monitored and progressed through the
St Helens and Halton Equipment Service Executive Board. At the end of Feb 2012, 29 moving and handling assessments have been completed with 60 interventions.

**Clinical Input to Residential and Nursing Homes**

Clinical input to residential and nursing homes was not tested as part of the project. Proposals have been put forward and are being considered by the Project Team.

<table>
<thead>
<tr>
<th>ACHIEVEMENT OF OUTCOMES D, E and F</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <em>This Project has achieved better patient management.</em></td>
</tr>
<tr>
<td>• <em>Patients have received more timely care, in an appropriate setting, particularly with assessment and discharge.</em></td>
</tr>
<tr>
<td>• <em>They have more appropriate interventions through the work of the CCCP and other initiatives.</em></td>
</tr>
<tr>
<td>• <em>Those patients who are medically fit for discharge have been placed in settings more appropriate to their needs.</em></td>
</tr>
<tr>
<td>• <em>There has been a 17% Reduction in delayed discharges</em></td>
</tr>
<tr>
<td>• <em>There has been a 5 day reduction in the average time between a section 2 notification and actual discharge</em></td>
</tr>
<tr>
<td>• <em>There has been a significant increase in the number of assessments completed</em></td>
</tr>
</tbody>
</table>

**g) Better integration of primary, secondary and social care**

The Project team met on a weekly basis until January 2012, and a fortnightly basis thereafter. All organisations have for the most part been represented at all meetings. This has allowed very positive working relationships to develop and has ensured that issues have been escalated quickly and appropriately.

A case study example of how these improved relations have worked is included at Appendix 8.

<table>
<thead>
<tr>
<th>ACHIEVEMENT OF OUTCOME G</th>
</tr>
</thead>
<tbody>
<tr>
<td>• <em>This Project, through the use of robust Project Management methodologies, clearly defined Project scope, deliverables and benefits realisation has supported the improved integration of primary, secondary and social care</em></td>
</tr>
</tbody>
</table>
h) Reduction in direct transfers to long term care

Data in relation to direct transfers to long-term care is collated by the Advancing Quality Alliance (AQuA) and is reported in the quality and efficiency scorecard for frail elderly.

The latest published report (16th March 2012) covers the period January 2011-December 2011. The results for the proportion of people aged 65+ discharged directly to residential care are as follows;

- St Helens 1.1% (rated green)
- Halton 2.1% (rated amber)
- Knowsley 1.4% (rated green)

These percentages have decreased since the last scorecard was published in December 2011; this is very positive and demonstrates that the local authorities above have been performing well in this area prior to the commencement of this project.

The Health Episode Statistics (HES) used by AQuA state the number of acute patients who were discharged direct to a nursing or residential home during the duration of the project. However, HES does not distinguish between whether the move is permanent or short term. Therefore the next time that AQuA reports the HES data (June 2012 covering the period April 11 – March 2012) it may not truly reflect the volume of patients discharged direct to permanent residential or nursing care due to the higher volume of patients being discharged direct to transitional placements within care homes in winter 11/12 than previous winters.

ACHIEVEMENT OF OUTCOMES H

Reduction in direct transfers to long term care.

- This project only covered a period of three months. Admissions to residential and nursing care is subject to seasonal variances and tends to be higher throughout the winter months, which is the period covered by this evaluation.

- Robust trends and performance data will need to be identified over a longer time period.
4 CONCLUSIONS

In conclusion the Enhanced IDT Project achieved and exceeded its objectives and has fostered improved working relations between primary, secondary and social care in a relatively short time period by adopting a task focused and proactive approach.

The key conclusions from the project are:

- The number of people declared medically fit and occupying acute beds has reduced from 40 to an average of 5 people per week (mostly Liverpool residents who did not take part in this Project.)
- This will support the Acute Trust in implementing the TFA and achieving improvements in its 18 week targets, and in freeing up the equivalent of one ward in Whiston. It responds positively and pro-actively to the actions within Workstream 2 of the Whiston TFA.
- The project has achieved a 17% reduction in delayed discharges
- The number and speed of assessments completed by the IHDT over the course of the project has increased substantially. The number of assessments undertaken by the IHDT has increased by 140%, medically fit patients are assessed and discharged sooner to placements which are more suited to their needs so there has been an improvement in service user outcomes.
- Substantial savings across the Health and Social Care sector are likely to have been achieved due to this integrated whole system approach to hospital discharge
5. RECOMMENDATIONS

For 2012/13, the project would recommend continuation of the following areas:

1. **Enhanced IDT**
   Having additional Social Workers in the IDT has allowed 140% more assessments to be completed for patients and IDT have been made aware of the patients at an earlier stage. This has also improved outcomes for service users and ensured that they can transfer to settings more appropriate to their needs. The business case approved was for 5 additional qualified staff members;

   **Recommendation**

   *To continue to fund qualified social workers in the Integrated Discharge team for a further twelve months.*

2. **Transitional Beds**

   Transitional Beds have enabled people to be discharged from hospital whilst they are waiting for something to be arranged to enable them to go home.

   Each local authority has managed the use of transitional beds in different ways.

   **Recommendation**

   *It is recommended that funding is made available to each local authority for a further twelve months in order that they can continue to offer transitional beds in ways that best suits their local commissioning needs.*

3. **Retain the Community Clinical Connection Point**

   This report has demonstrated the success to date of the CCCP in diverting admissions to the acute into intermediate care and in facilitating joint assessments. Over the 3 months of the Project, there were 39 people who may have otherwise been admitted to an acute bed. This represents potentially 156 people over 12 months. As the cost of a bed in Newton Community Hospital, or intensive community nursing at home is less expensive than the cost of an Acute bed, then this is felt to be cost effective option with improved patient outcomes. It is therefore recommended that the CCCP is retained, The CCCP also diverts people from all beds and represents a step forward in integrating initiatives focusing on admission avoidance with those focusing on an effective discharge.

   **Recommendation**

   *To continue to fund the Community Clinical Commissioning Point for a further twelve months.*

4. **Bed Based Care Provision**

   Any decision to withdraw funding for bed based provision will need to be carefully considered to ensure that viable alternatives are in place which would see that the needs of patients and service users are appropriately met.
It would also be necessary to ensure that any decisions do not impact on the Health and Social Care system in the relevant boroughs and impose significant pressures.

It is therefore proposed to continue the funding of the bed based provision at both Duffy Ward and Newton Ward, with full funding for an initial three months. At the end of one month a decision will be made about the future of Duffy ward. This would allow for consideration of bed based provision at Duffy Ward, Newton Community Hospital and also Seddon Suite, to be considered as part of the Urgent Care Review presently being led by St Helens Health with other partners. Maintenance of the present bed based population in this way will ensure for further more detailed evaluation and consideration of the issues as part of a fuller system wide review. The review would also consider clarifying the roles of different bed based provision and ensuring that relevant specifications are fit for purpose.

**Recommendation**

*To continue with present funding for bed based services at Duffy Ward for an initial three months with a decision being made about future funding at the end of month one.*

*To continue to fund the additional intermediate care beds at Newton Hospital pending the review of Urgent Care.*

*To ensure that all decisions in relation to bed-based provision are made in advance with clear transitional plans put in place to mitigate risks to individual service users/patients and the system.*

*To agree that the project continues to evaluate the impact of the beds and that this contributes to the wider review of urgent care services which St Helens Health and other relevant clinical commissioning groups are undertaking over the next two to three months.*

**Table 7: Estimated Costs of Continuation in Accordance with Recommendations**

<table>
<thead>
<tr>
<th>Areas</th>
<th>Annualised Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 x Social Workers IHDT</td>
<td>£200,000</td>
</tr>
<tr>
<td>10 X Transitional Beds</td>
<td>£260,000</td>
</tr>
<tr>
<td>Clinical Connection Point</td>
<td>£204,000</td>
</tr>
<tr>
<td>TOTAL COMMUNITY (Full Year)</td>
<td>£664,000</td>
</tr>
<tr>
<td>Additional Intermediate Care (Newton) and Sub Acute Beds (Duffy) (3 months full cost)</td>
<td>£492,000</td>
</tr>
<tr>
<td>TOTAL BED BASED (6 months)</td>
<td>£492,000</td>
</tr>
</tbody>
</table>

*This is an estimated cost and actual costs will need to be calculated when deriving the transition plans for these settings.*
5. **Areas that the evaluation demonstrates should not continue at this stage**

   a  **Block purchased Respite Care Beds**

   There appears to be sufficient capacity within social care residential and nursing sector for respite beds. This funding is therefore felt to be no longer needed.

   b  **Additional Aids and Adaptations**

   The existing resources and stock of aids and adaptations are sufficient to meet the discharge and hospital avoidance needs of vulnerable people. Therefore the project recommends that this funding is no longer needed.

   c  **Additional Occupational Therapy Staff**

   A Business case is being progressed to improve the commissioning and delivery of complex assessments for aids and adaptations. The Project therefore recommends that this funding is no longer needed. Saving of

   d  **Additional Domiciliary Care hours**

   The new St Helens contracts for domiciliary care include provision that domiciliary care agencies will pick up packages of care within 48 hours. Although this will require ongoing monitoring to ensure that the domiciliary care providers are able to deliver on this, at this stage the Project recommends that this funding is no longer needed.

**Recommendation**

*That funding for the elements of the project outlined in point 5 be immediately discontinued.*

6. It is proposed that in relation to all of the initiatives identified above, that where continued funding is recommended, that these should be prioritised for first call on additional reablement funding in St Helens (separate discussions will need to be had with Halton and Knowsley Local Authorities). Details of the additional reablement funding are contained in the Department of Health letter Gateway No. 15434 dated 13th June 2011 an in the NHS Operating Framework.

**Recommendation**

*Elements of the Project recommended for continuation are in the first instance funded via additional reablement funding being made available to local Health and Social Care economies.*
6. FURTHER DEVELOPMENTS

There are a number of other projects, initiatives and reviews that would link to and impact on the further success and continued improvement of the project. These include projects focussed on diverting admissions and preventing readmissions.

Examples of the areas that are being developed and explored further by the Project Group and associated initiatives are:

- Care Homes project in Halton and St Helens
- Frequent Attenders Project
- Integrated Nursing Redesign Project
- Clinical input to the St Helens Council Intelligence and Outcomes Unit. Monitoring activity in care homes that comes under nursing element of funding.
- Prevention through technology—telehealth/telecare/enhancing response service
7. Appendices

Summary of Appendices

Appendix 1  St Helens original case to implement the project (preceding business case)
Appendix 2  Community Clinical Commissioning Point dataset
Appendix 3  CCCP Service User and Referrer Feedback
Appendix 4  Community Clinical Connection Point Case Studies
Appendix 5  Duffy Patients who declined alternatives
Appendix 6  Duffy Case Study
Appendix 7  Newton data
Appendix 8  Case Study on Improved Working Relationships
Appendices

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Appendix 2- Community Clinical Commissioning Point dataset

Appendix 3 – CCCP Service User and Referrer Feedback

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Appendix 7 – Newton data

Appendix 8 – Case Study on Improved Working Relationships