Learning Network: Intermediate Care Case Study

Care Provider Alliance and NHS England

One Croydon Alliance

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The One Croydon Alliance is piloting a ‘wraparound’ service to support people following a hospital discharge.

Background

One Croydon Alliance includes social care providers, the local authority, NHS services, Age UK, South London and Maudsley NHS Trust (SLAM) and the local GP Collaborative. One Croydon was formed in 2017 around a set of principles to support over 65s, preventing hospital admissions and supporting people living independently in the community. They have now expanded their focus to support all adults as an intermediate care frontrunner site.

They found that there were multiple teams, often working in silos, providing intermediate care.

They recognised the need to streamline services to ensure they were using the right workforce in the right way. They also realised that they were over-prescribing care. The discharge to assess arrangements were putting pressure on social care services – with many clients getting six weeks reablement, when other support would have been more appropriate.

Objectives

The objectives of the frontrunner project in Croydon are to:

- Simplify processes and SOPs and minimise steps to transfer of care
- Establish a true single point of access for hospital discharges and community step-ups
- Offer Discharge to Assess as default for all patients

- Deliver a truly integrated discharge team
- Introduce blended roles
- Define the workforce and skill mix required
- Decide where to treat patients to maximise outcomes (home vs hospital)
- Optimise provision of social care and reduce overprovision
- Define joint funding arrangements and budget
- Define clinical responsibility, oversight, and ownership for a truly integrated care offering
- Agree operational delivery by a single blended team with everyone managed under one collective
- Develop a permanent integrated health and social commissioning team
- Define data we need to record to support operations and performance reviews
- Define KPIs and operational information for all teams
- Improve IT systems and interoperability.

Actions

The One Croydon Alliance is developing an integrated team which will have a joint health and social care manager, together with new blended roles across the hospital and community services.

Within the hospital, they are establishing a **Transfer of Care Hub** which will be responsible for coordinating discharge from the acute setting to the Discharge to Assess settings. They are reviewing the tasks of hospital based social workers, and discharge coordinators and bring together this new role which will go live shortly. The hub does not wait for a referral. They start planning the transfer of care once the patient is admitted to hospital. They have oversight of all available capacity and when it is coming online. They have senior decision makers from both health and care. As the hub matures, the expectation is that they will become the hub for shared integrated data which will support demand and capacity planning.

The Wraparound service provides health and care support for up to seven days after discharge. Many people were being over-prescribed rehab and were not using the support, so this service was introduced to provide focused, short-term support.

Recovery care: Croydon has brought together all of their therapy and rehab services including their falls, physio and therapy services. They have streamlined their assessments and processes, and the aim is to reduce waiting times.

Centres of Excellence: Croydon Councils operates some large care homes. They are reviewing how to develop these into centres of excellence to include more rehab and reablement beds. They are also planning to locate their recovering team at the homes, and create a bedded facility for short term support after hospital discharge.

Joint budget: One Croyon is establishing two key joint budgets across the NHS and social care. One will be for the Transfer of Care Hub and one for the wraparound and recovery service. These budgets will enable the teams to recruit and work together.

Data and IT systems: One Croydon is integrating its IT systems so that social care, local authority and NHS acute systems can connect with each other through the use of APIs. They are also working with the data analysts team to standardize recording across teams with the aim of understanding demand, use of workforce time – including on new assessments, admin and meeting attendance. Having reliable data is critical and will require time with the data team.

Primary Care Networks: the PCNs have weekly meetings which includes a social worker, PIC, and nursing staff to prevent unnecessary hospital admisions. They also have a team in A&E which can refer to the recording team to prevent unnecessary hospital admissions.

Wraparound service

The wraparound service provides full holistic support to patients for up to seven days following discharge from hospital into the community. The aim is to get them back to their baseline before admission to hospital.

The service includes a daily multi-disciplinary team (MDT) meeting consisting of the community pharmacist, therapists, nurse, reablement officers, community geriatrician and care agency.

Each patient is discussed at the MDT on a daily basis. If the care agency raises any concerns, then can discuss this with the other members of the MDT. This gives staff the confident to know how to move forward or to bring in expert support – such as help from the geriatrician.

They have built close relationships with the hospital teams to ensure access to relevant information on discharge to the community. They have also engaged their wider voluntary sector such as Age UK.

The aim is to ensure that the care agency is 'doing *with* the person – not *to* the person', in order to get them back to being at home again and doing things and supporting themselves.

Model

The objective of the wraparound service is to increase residents' independence and reduce over-provision of immediate intermediate and ongoing care, and to reduce re-admissions.

The hospital-based therapists carry out the initial assessment and discharge to assess referral. The hospital has a triage team in place to ensure all the information is available on the referral so that they can brokerage the package of care.

The welfare check within about 20 hours after discharge is carried out by the Council's health and wellbeing assessor *and* the care agency. They work together with the patient to set goals.

The assessment is then reviewed by the MDT (including therapists, pharamacists etc) to ensure that it has been completed to a high standard and to consider any other issues that need to be included.

Recovery care is then provided by the LIFE team – One Croydon's reablement and rehabilitation provision which manages all hospital discharges in the community.

Goals and managing expectations

Goals that are set in the hospital are reviewed and revisited at home to make sure these are achievable within the home environment. These can be changed depending on time frames and patients and family members' cooperation. Positive risks are welcome and risk assessments are constantly updated.

The senor reablement officer goes out when the patient is discharged. They see them mobilising within their setting and assess whether then need to be referred on to any other service (e.g. OT or physio) or if the care package can actually be reduced. The assessors also consider the mental health and wellbeing of the main carers, family, friends and neighbours. They also need to not over-promise what can be achieved.

All team members – including hospital staff, therapists, care workers and assessors – are reminded that this is a reablement not an ongoing service. They reinforce this message with patients and family members in order to manage expectations.

Case study: ‘Harold’

Harold, an 84-year-old man who had spent 10 days in hospital with acute pancreatitis was transferred to One Croyon’s wraparound service. He had multiple health conditions and not all of these – including his history of esophageal cancer - were included on the original Discharge to Assessment referral.

Harold was discharged home under the care of his wife who did not want a visit from the service on the first day. She did, however, then contact the service who were able to visit on the day, identify the need for pads, and provide those on the same day.

The following day, the reablement seniors carried out a full assessment, identified the need for equipment and delivered this on the same day. This rapid turnaround was critical to the success of the service as it enabled the care workers to move the patient more successfully and safely immediately.

Unfortunately in Harold’s case, his health deteriorated but because of the multi-disciplinary team arrangements the care staff were able to speak to the rapid response team and he was quickly assessed and readmitted to hospital. He was discharged ten days later.

As the equipment was already in place, the team was able to support him immediately and within six days he was independent with his personal care. The team continued to visit him once per day to support with exercise. When he was able to move indoors, the visits were reduced to three days per week until he was mobile outdoors.

In total, he accessed the service for 14 days following discharge. After this he was independent with no ongoing need for a care package.

Benefits/ Outcomes

- **The outdoor mobility work eased Harrold's anxiety** – this improved his mood significantly
- Harold’s wife had struggled with Harold’s sudden immobility and illness but was **able to better manage with the Wraparound input**
- **Harold achieved all of his goals**:
    - To regain independence in all aspects of personal care
    - To regain independence with outdoor mobility using a stick
    - To improve strength and balance in upper/lower body

- **Wraparound and daily MDT made it easier to identify need for emergency pads were assesses and deliver by A&E LIAISON**
- Harold was able to remain at home despite being palliative.

This example also identified issues for improvement including:

- D2A referral sometimes misses key information
- Key information is sometimes missed by triage team
- There are sometimes delays in medication blister pack delivery from ICN+ pharmacy
- Some people are potentially discharged too quickly in the first instance.

Lessons learned

- The hospital and local authority teams need to **work with care agencies to set KPIs and deliver services** from the outset. Involve them at the start of any process.
- Rapid access to equipment is essential to successful reablement. It increases the patient's confidence, and enables care staff to commence reablement rapidly.
- Other aspects of the client's life should be considered such as family dynamics (positive and negative), other comorbidities.
- Mental health of clients and their main carer should be considered. These will affect the outcome of an individual's reablement and whether they return into the hospital cycle.
- **A hybrid model** is required including the use of internal reablement service with the hospital as well as the external care agency.
- **Access to comprehensive data to provide 'one version of the truth'** is challenging as health and care used different system. Croydon is using front runner funding to invest in a connected data system across health and social care.

Further information

One Croydon Alliance