Learning Network: Intermediate Care Case Study

Care Provider Alliance and NHS England

Community Recovery Services - Warwickshire

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Warwickshire is one of the intermediate care 'frontrunner' sites. They have developed a Community Recovery Service to support the 'home first' delivery and vision.

Background

Like most areas, Warwickshire faces higher demands for support for older people to return home from hospital, increasing demand for domiciliary care services and pressure on acute hospital beds. There is increased demand, growing costs, and pressure on both health and care services.

Warwickshire is one of the six national 'discharge front-runners' which are exploring new long-term initiatives to free up hospital beds. The one-year pilot went live on 24th April 2023 with additional funding from NHS England to implement the programme.

Locally the programme is called the Community Recovery Service (CRS) and they have gone through a rapid phase of mobilisation and are continually learning and adapting as the pilot progresses.

The service strives to increase partnership working between social care, the NHS and care providers. It is committed to the 'home first' delivery and vision, in line the national discharge to assess ethos. Engagement has been a key focus in developing an integrated commissioning and delivery arrangement for hospital discharge, establishing new ways of working to transform health and social care services to meet people's needs.

Objectives

The vision for the service is:

> “Our vision is that Warwickshire people in an acute Hospital, who need further support to recover, will have access to effective therapeutic intermediate care services within 24 hours of no longer meeting criteria to reside.”

Through the delivery of a new Community Recovery Service, Warwickshire aims to:

1) Reduce hospital length of stay and bed days lost.
   - Decreasing the number of people staying in hospital who should be at home.
2) Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission.
   - Increasing people’s functional outcomes.
3) Decrease the need for long-term care.
   - By decreasing demand and acuity.
   - Decreasing long-term care costs.

Service model

The CRS delivers intermediate care, involving up to a maximum of six weeks of free care – dependent on individual patient’s needs – after a stay in hospital. Carers and therapists work towards assessing and reducing care, and increasing patients’ independence.

The hospital will determine the patients exit pathway and refer to the appropriate service. Referrals into the CRS are accepted on a trusted assessment basis. Hospitals only need to decide if the care calls are singles or doubles rather than prescribing the amount of care.

The CRS accepts patients with any condition; inclusive to all those leaving hospital to their own home who may have a new or increased care need, or a short-term recovery and rehabilitation need.

The aim is for care to commence within 24 hours of the referral being received.

All patients using the CRS initially go home with four care calls. Within two hours of the individual returning home an assessment is completed by the care agency to understand someone's individual needs and formulate a care plan.

Care agencies have full autonomy and are expected to actively seek to reduce care. This is supported by therapy staff if needed, who may also advise carers to reduce care. All cases can be discussed at weekly multi-disciplinary team meetings.

All patients can access therapy, with referrals being screened in order to determine patient need. Following the Therapists initial assessment, they share goals with the homecare provider to support with. Goals are person-centred and set with the patient.

The CRS provides regular assessment with the aim of reducing care as appropriate; acknowledging this will not be possible for all patients. Patients may exit the pathway at any time - returning to their previous level of independence or previous care package, or a new level of need is established and a long-term care package is requested.

An escalation log/contact list has been created alongside Warwickshire's Standard Operating Procedure to support staff in resolving any issues identified during the pathway.

Structures

Pathway one services are for patients going home from Hospital with new or increased needs. Warwickshire previously had nine services within this pathway, which they have consolidated into three:

- **Community Recovery Service** is for anyone with a new or increased care need or a recovery rehabilitation need. It was created to offer wider support for recovery for all following discharge. A new model for fast-track end of life delivery is also being explored through the CRS programme.
- **Reablement Service** remains, but with a criteria for patients needing that support who are more likely to return to independence and have no long-term care needs. Phase 2 of Warwickshire's activity will involve reviewing the reablement offer and how this works with the CRS.
- **Community Response Team** remains, which is a nursing-based team focused around admission avoidance.

The Community Recovery Service has commissioned 7 care providers and established a service criteria and standard operating procedure (SOP). The SOP has been instrumental in establishing integrated working practices which are now, after six months, becoming business as usual.

They have focused on improving integrated working with a multi-disciplinary team (MDT) including social workers, therapists and social care providers across health and social care. The MDT meets three times a week – once for each locality (North Warwickshire, South Warwickshire and Rugby). The MDT discusses all patients on their caseload and troubleshoots any challenges such as blocked flow or capacity within the system.

Integration and engagement have been fundamental to building relationships and supporting cultural change. This has been encouraged and developed through a range of methods, including: therapy-provider engagement meetings; establishing CRS Champions; holding away days; joint patient visits; enhanced communication

methods; a monthly CRS Newsletter for updates; shared training sessions; and regular stakeholder meetings.

Actions

Working with care providers

Warwickshire County Council ran an expression of interest exercise with the existing domiciliary care market and were able to select 7 providers to work with that are paid using a pre purchased block model which includes time for initial assessments. This mitigates capacity issues as they have set hours which they deliver. If they reduce the care calls – and therefore the costs - for one client, those hours go back into their capacity which is available to support other patients being discharged home. This enables Warwickshire to target the use of capacity within the domiciliary care market.

A key change is that care providers have been given full autonomy to assess and amend care packages. This change is welcomed by care providers who report feeling more valued and listened to. Providers receive support from therapists, the MDT and training.

Enhanced communication and collaboration between Therapists, Care Providers and the Council has been established. Engagement sessions took place between the therapists and the seven selected care providers to increase understanding of each other's roles and their shared challenges. Staff have access to key contacts lists for support, an escalation log, scenarios, links to individuals within the Council and MDT meetings. There is also a CRS domiciliary care reference group and plans to develop a learning network and provider ambassadors.

Information sharing is currently completed via email as the partners work across different IT systems. In the long-term, it is an ambition to work towards shared systems.

Therapy Workforce

Warwickshire has been assessing the capacity and demand for therapy staff to support workforce planning. The aim is to ensure they have the right staff in post to meet the needs of their current and future client base.

The recruitment focus has been on the band 4 unregistered workforce and the teams are involved in a behaviour change project in terms of delegating work.

Recruitment into new non-clinical roles such as Admin and Clinical Coordinators aims to increase Therapists clinical time/patient contact.

Process mapping has taken place in order to improve efficiency and streamline activities such as admin and coordinator processes.

Bi-weekly team meeting and away days have focused on maintaining engagement and providing updates and support during this time of rapid change.

Warwickshire has not moved therapists out of the acute setting as demand for therapy within this setting remains high. Instead, they are reviewing ways of working for therapy staff, including; recruiting to additional community posts; skill mixing; recruiting admin and clinical coordinator staff; hybrid working across the acute and community; reviewing data to better understand capacity and demand; and participating in a national workforce project led by NHS England to inform future workforce planning.

Therapists are working more closely with Care Providers than ever before, sharing patient goals and encouraging joint assessments; with therapists reporting a better insight into the challenges faced by care providers in the community.

Impact

Anecdotal feedback from care staff and managers is that they have greater job satisfaction and feel valued as a result of the Community Recovery Service (CRS).

Between April and October 2023:

- 1,150 packages of care had started on the Community Recovery Service.
- 53% of them started the service within three days of referral. Work is underway to improve this further.
- There has been an 80% increase in the number of patients using therapy services which is in line with the CRS objectives.
- 85% of all referrals are accepted by Therapy.
- Hospital discharge teams report feeling a reduction in waiting times. This is currently anecdotal, and they are awaiting data to support reporting.
- Data sets for exits and the impact on long-term care need is also being developed, but the majority of patients exit the CRS with some level of long-term care which is to be expected given caseload acuity.
- Patient and staff feedback is being collected. It indicates that patients welcome the service, with people mobilising quicker and improving their quality of life.

Warwickshire County Council is currently working on their data set to review the impact on long-term care needs, including onward referrals to other services, and therefore cost-benefit.

Case studies

Examples of patient exit routes from the CRS include:

- **Reduction in long-term care**: A patient came home from hospital with four care calls with in-bed care. Following support from the CRS, they are now walking with a frame and only require two care calls long-term.
- **Discharged independent:** A patient was discharged and for the first three weeks, they were primarily all care-in-bed. They had significant pain that was limiting, but over the six weeks of CRS support, they increased their ability, and they had no long-term care requirement afterwards.
- **Long-term care needs unchanged – but improved wellbeing:** Some patients do not physically improve and may enter and exit the CRS with four care calls, yet the service can still have impact. Care providers have reported improvements in client's well-being such as a person becoming more talkative and having a more positive outlook.

Next steps

Warwickshire is continuing to refine and develop its Community Recovery Service. This includes expanding the data set available to them, continuing workforce planning and behaviour change, and considering how they can integrate and collaborate even further. Specifics include:

- Expanding data & service analysis.
- Continue to expand the therapy workforce, increasing recruitment.
- Continue to expand therapy & provider training plans.
- Patient and stakeholder engagement/ feedback.
- Explore Community Response Team & Reablement offers.
- Re-design the Continued Healthcare Checklist (CHC) process.
- Trialling the use of CRS for CHC fast track patients
- Explore collaboration with voluntary and community sectors.
- Further improve collaborative working.
- Develop the offer for out of area referrals.

Lessons learned from Warwickshire

- **Communicate and engage with all stakeholders regularly.** Constantly review what can be improved.
- **Manage patients, family members and staff expectations.** Be clear about what can actually be achieved and ensure everyone across the pathway provides a consistent message – from hospital to community staff.
- **Build in patient engagement and coproduction from the start.** Codesign and integrated feedback from patients.
- **Find workarounds to integrate technology and data:** The Council, NHS, and care providers all use different systems so data sharing is challenging**.**
- **Support ongoing learning and development:** Warwickshire is evolving and adapting the needs of providers and therapists.
- **Be open to continuous review and learning:** For Warwickshire this work continues broadly across the system.
- **Understand capacity and demand for key roles** – such as therapy staff.
- **Understand the impact of new pathways on the wider care market and mitigate any risks**.

Further information and contacts

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