Development of Warrington's Intermediate Care Services: engagement summary

Contents

About this document

This document, and the consultation process it supports, is about intermediate care – intermediate care services provide support for a short time to people who are/have been unwell and need these services to recover and/or increase independence.

This document explains how Warrington Borough Council (in partnership with the Warrington Health and Social Care system) intends to develop community and bed based intermediate care services in the future by ensuring better provision in community-based services and by making sure that bed-based services are provided in a fit for purpose environment.

The development of community and bed based intermediate care services will continue to provide the best possible care and support for our residents whilst making our services sustainable for the future.

This document is part of a consultation pack which includes useful information about what people have already told us about intermediate care and how this has helped shape our thinking.

Why do we need to change intermediate care services?

In 2019, a document called the NHS Long-Term Plan was published. The Plan outlined clear expectations for an **'increase in the capacity and responsiveness of community and intermediate care services'**.

All areas of England were required to:

1) Deliver services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate
2) Deliver reablement care within two days of referral to those patients who are judged to need it

3) Provide more NHS community and intermediate health care packages to support timely crisis care (with the ambition of freeing up over one million hospital bed days nationally)
4) Deliver services through flexible teams working across primary care and local hospitals, developed to meet local needs, including GPs and specialty and associate specialist (SAS) doctors, allied health professionals (AHPs), district nurses, mental health nurses, therapists and reablement teams
5) Ensure access to extra recovery, reablement and rehabilitation support to wrap around core services and support people with the highest needs

The national commitment to enhance and improve intermediate care was underpinned by evidence that people in England can now expect to live for far longer than ever before – but these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life. Councils and the NHS can play a key role in helping older people specifically manage long-term conditions, making sure they receive the right kind of support to help them live as well as possible.

When the NHS Long-Term Plan priorities were announced, Warrington did not have the right services in place to meet the requirements. Existing intermediate care services had challenges around waiting times and recruitment. There was not the capacity in services to respond consistently to referrals within two hours.

A programme of work called **'Living Well with Frailty'** was established to help oversee improvements in care and support for people living with frailty in Warrington.

For intermediate care services those changes include:

1) A model of care that is integrated from the perspective of the person using the service and their families/carers (nurses, social workers, therapists etc. working closely together with primary care, community and hospital services and offering a seamless customer journey)
2) Processes (triage tools and assessment procedures) and pathways (steps taken with individuals by services) that are effective and efficient
3) A focus on home-based services to ensure that when appropriate, patients can receive the care/interventions required in their own home/community rather than in a bed-based setting to avoid an acute admission and ensure an acute length of stay is not extended
4) Bed-based care provided in a building(s) that is/are fit to deal with future demands.
5) A system that can support more people per day, more quickly
6) IT systems that can support integrated working and produce information that inform service development and commissioning

What have we done so far?

We started our work to develop better intermediate care services by listening to a range of views from people who use services, people who work in services, and people who work with services.

We also asked experts who work in estates, finance, IT, data analysis etc. for information.

We reviewed national guidance and looked at examples of good practice. We pulled all that information together to help inform our plans.

What people have told us to date?

You can find our full engagement report and a summary of our 'You Said We Did' on our website.

People who use intermediate care services (including reablement and bed-based care) had positive experiences of community and bed-based intermediate care services and they were keen to see good quality care provision continue.

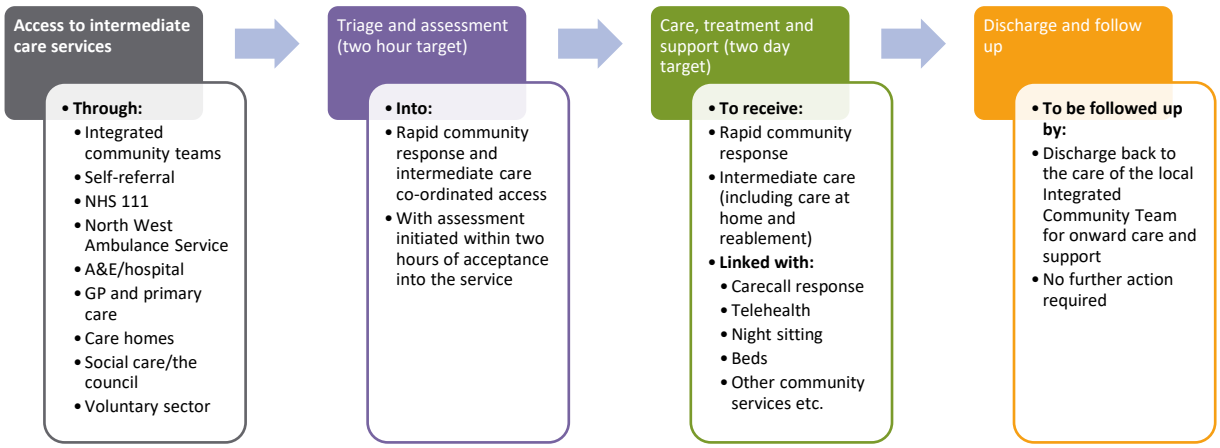
People who work in and with intermediate care services and the experts we spoke with highlighted opportunities for ensuring good quality care into the future.

Some of the key themes from stakeholders included:

- Processes and practices need to be improved to make working together easier and to ensure that good quality care, treatment and support can be provided more efficiently
- IT systems need to enable sharing of information across disciplines
- Buildings providing bed-based care need to be fit for purpose

What do we need to do to deliver improvements?

To meet the expectations in the NHS Long-Term Plan, Warrington has developed a new model for the future arrangement of intermediate care services.



Services working closely together with clear pathways for patients all the way through and a focus on support at home.

To help explain what our future model aims to deliver, we have described nine core improvements that we have designed the model around:

1) Home first

Design criteria: Do everything we reasonably can to keep a person at home or in the community

Design commitment: We will deliver an intermediate care service that can help people stay safely and happily in their own home whenever possible

2) Strengths based

Design criteria: Provide services that meet the needs of individuals and carers focusing on maximising independence and leveraging strengths

Design commitment: We will ensure that our intermediate care service has staff with the right skills to enable people to live as independently as they can

3) Step up and step down care

Design criteria: Ensure that we provide services that can support before people go into hospital as well as when they leave hospital

Design commitment: We will develop our intermediate care service with a focus on supporting people to stay at home as an alternative to admission to hospital (where this is appropriate). We will also support people to leave hospital where intermediate care is appropriate before going home

4) Pathways led

Design criteria: Organise intermediate care with clear and consistent pathways and an efficient and effective route for referrals

Design commitment: We will provide an intermediate care service that is based on evidence of need and that operates with as few steps as possible between referral and the right point of care delivery

5) Maintain quality

Design criteria: Build on the good work already underway in existing services

Design commitment: We will ensure that our intermediate care service continues to deliver the elements of existing services that are already proven to be effective

6) Integrated approach

Design criteria: Deliver a truly integrated system, allowing health and social care providers to effectively support people in a wrap-around manner with shared skillsets and shared access to information

Design commitment: We will provide our intermediate care service with effective, person centred care as our mission. Staff and managers will work across the service according to skills (not employer) and they will have access to the various sources of health and social care information to ensure safe service delivery. They will deliver an offer that is coordinated and integrated from the perspective of the user

7) No wrong door

Design criteria: Provide services that are proactive and ensure new ways of working to support reduced ‘hand offs’ in patient care

Design commitment: We will use more opportunities to work differently where it enables better quality of care and smoother transitions for the patient between care settings e.g. wider use of Trusted Assessor approach

8) Fit for purpose buildings

Design criteria: Provide bed-based care in buildings that are suitable for the future

Design commitment: We will provide bed-based care in buildings that support good clinical practice and safe, high quality care delivery

9) Co-location

Design criteria: Locate services together where this makes sense

Design commitment: We will limit barriers to effective and efficient working caused by the separate location of services and will look to co-locate services wherever possible

What do we need to change?

To deliver the ambitions of our new model and the expectations in the NHS Long-Term Plan, across community and bed based intermediate care services, we are going need to make some changes to our services that we would like your views on.

Community services

We can deliver many of the improvements required in the community elements of the new model in intermediate care through our existing plans and without any changes to frontline services, for example:

- We have already enhanced our community service capacity to help us meet the two hour target for referrals
- We have also significantly increased our community carer support workforce to help us meet the two day target in reablement
- We are developing care pathways to support more effective and efficient assessment, treatment, and care delivery
- We are providing a service that can support with more focus on 'step up' care, i.e. supporting people to stay at home instead of going to hospital where that is appropriate as well as 'step down' i.e. helping people leave hospital
- We are working to better align our IT systems for our intermediate care services so that staff can have access to more shared information
- We have co-located Rapid Community Response and the Primary Care Home Visiting services with our community intermediate care services to support joint working and an integrated approach
- We have initiated team training that includes awareness raising about holistic and strengths-based working in the context of frailty
- We have improved team processes for referrals to reablement and therapy support

The community element of intermediate care is a vital part of a whole system model that can improve wellbeing. The Association of Directors of Adult Social Services summarise the importance as follows:

> ‘People have the best outcomes when they are helped to avoid having to go to hospital or return home from hospital safely and without delay, with support targeted on their needs. The evidence is clear that home is the most appropriate place for resolving crises and recovery for nearly all people being discharged from hospital…We need to extend best practice and re-orientate services and funding to help more people to get home when that is the most appropriate place for them – and to stay at home’[1].

We are passionate about improving our community offer. We want to provide more dynamic ways of helping people quickly and with a more diverse range of supports e.g. supporting access to diagnostics in the community, providing reablement for a few days (rather than over several weeks) if that’s all that’s needed. By working closely with other services e.g. the Frailty Assessment Unit and Hospital Geriatricians we aim to improve the experience of recovery at home.

Bed-based care

Where an individual needs to be cared for in an intermediate care bed we want to make sure that we continue to provide an excellent quality of care.

We cannot deliver the improvements required in some of the bed-based elements of the new model in intermediate care without making changes to frontline services. The future requirements in some of our buildings requires us to think differently.

We currently provide 35 beds in Padgate House (an additional 23 intermediate care beds are commissioned in separate units in Warrington from private sector providers).

Padgate House is a relatively old building. Whilst CQC rate the standard of care delivered in Padgate House as ‘good’ and our patients feed back to us that they are highly satisfied, Padgate House as a building is not fit for purpose for future intermediate care provision.

We have assessed the building and identified several challenges, including:

- The inability to provide en-suite bathrooms for patients
- Insufficient parking for staff and visitors
- Corridors and doorways are too narrow for modern equipment
- Heating system in need of replacement, no air conditioning
- Inadequate therapy rooms
- Inadequate storage space
- Lack of space for visiting
- Lack of potential to accommodate extra beds or extra office space to enable co-location of other beds or additional staff
- Part of a spilt site arrangement with other bed based intermediate care providers (which generates challenges for staff who must travel to provide support to patients in bed-based care)

The council needs to consider the future of Padgate House, considering these challenges. There are three main options that have so far been identified:

Option 1: Maintain the current arrangement

Option 2: Build a new intermediate care facility

[1] file/LGA-ADASS%20Statement%20on%20Community%20Care%20and%20Health%20Discharge%20new.pdf

Option 3: Re-provide the beds from Padgate House through existing provision

The council has not decided on any of the above options and would welcome your views as part of undertaking further analysis. To help you consider these options we have provided some information below.

Option	Benefits identified so far	Constraints identified so far
Option 1: Maintain the current arrangement		• The council does not consider it financially viable for bed-based services to remain at Padgate House long-term. • The physical constraints of the building prohibit renovations to meet standards for the future
Option 2: Build a new intermediate care facility	• A new facility would enable the development of a building that is fit for purpose • It could potentially be scaled to not only re-provide the beds at Padgate House but potentially co-locate all our intermediate care beds together on one site. Our preliminary modelling work suggests that we may need a total of up to 60 intermediate care beds for the future (subject to optimal working in other aspects of service) • A new site could potentially provide space for some community services co-location too. • A potential land site has been identified (Bewsey Old School). Bewsey Old School is in proximity to the hospital which would enable transfers of patients requiring step down care from hospital. Proposed development site of Bewsey Old School. • A desk top exercise suggests that the site could accommodate the total number of intermediate care beds required for Warrington on one site, with the improvements required in terms of space and design	• Bewsey Old School is the only potentially suitable site available for such a development in Warrington • Requires a full technical feasibility study • Will require significant additional capital investment • Will be subject to planning and assurance processes • If approved will take time to complete

Option	Benefits identified so far	Constraints identified so far
Option 3: Re-provide the beds at Padgate House through existing provision	• Only facilities that can provide a fit for purpose building space would be considered • We would not have to wait for a full new building project to be completed. If approved, could potentially be implemented more quickly than Option 2 (subject to sourcing the right provision) • Would not require the same capital investment that a new build will require	• Requires a feasibility assessment on any potential existing sites • Re-providing the beds from Padgate House into capacity within existing provision would continue the use of three sites for intermediate care delivery into the Warrington patch which would further fragment service delivery **Note:** it could be that an existing provision is identified that can accommodate all our required Intermediate Care beds in one fit for purpose, existing provision. If this were to be the case then the same benefits of co-location could be realised as in Option 2 except potentially the co-location of community staff • May still be subject to any relevant planning should any renovations be required etc. and assurance processes • If approved will require a negotiation process with the relevant existing provider(s) in Warrington

Take part in the consultation

We would like to hear your views on the things we have described in this engagement summary, both the future model and the options for bed-based care.

Visit warrington.gov.uk/IMC to complete the survey. You can also view the full pre-engagement report.

Thank you for taking the time to review this summary. If you have any queries, please email the intermediate care service team at ICreview@warrington.gov.uk