Item No. 13

Meeting Date **Wednesday 7th February 2018**

Glasgow City Integration Joint Board Finance and Audit Committee

Report By:	**Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services**
Contact:	**Stephen Fitzpatrick**
Tel:	**0141 276 5596**

INTERMEDIATE CARE AUDIT

Purpose of Report:	To inform IJB Finance and Audit Committee of the findings and improvement actions emerging from the recent audit of intermediate care services.

Background/Engagement:	Not applicable.

Recommendations:	The IJB Finance and Audit Committee is asked to: a) note the findings of this report.

Relevance to Integration Joint Board Strategic Plan:

Intermediate Care is a core component of the shift in the balance of care proposed by the IJB Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	This report has particular relevance in relation to outcomes 2, 3, 4, 7 and 9.

Personnel:	No issues.

Carers:	Success in supporting more people to return home from intermediate care will impact on some caring roles.

Provider Organisations:	This report identifies some areas for improvement for independent sector providers of intermediate care.

Equalities:	No issues.

Financial:	No issues.

Legal:	No issues.

Economic Impact:	Not applicable.

Sustainability:	Not applicable.

Sustainable Procurement and Article 19:	Not applicable.

Risk Implications:	This report identifies areas for improvement, but no urgent or immediate risk issues.

Implications for Glasgow City Council:	No specific issues.

Implications for NHS Greater Glasgow & Clyde:	No specific issues.

1. Background

1.1 Glasgow HSCP currently purchases 90 intermediate care places from 6 independent sector care homes across the city. The function of this service is to create a stable non-Acute environment where individuals being discharged from hospital with enduring complex care needs can have their long-term social care assessments undertaken. The majority of intermediate care resource is focused on this ‘step down’ cohort, although at any given time up to 5 of the 90 beds can be used for ‘step up’ intermediate care, designed to avert avoidable admissions to hospital. It is important to note that this is a distinctive and bespoke service

commissioned by the HSCP and does not include the former continuing care beds transferred to HSCP management by the Health Board during 2017.

1.2 Intermediate Care was initially funded from the Reshaping Care Change Fund as a test of change to establish whether it could generate an evidence base that it was capable of meeting its two key strategic objectives, both of which relate to shifting the balance of care. These were to reduce the number of frail older people delayed awaiting discharge from hospital in Glasgow; and, reducing the number of frail older people being placed in long term care following a hospital admission. Since its introduction in December 2014 the evidence has been conclusive that intermediate care has delivered significant improvement on both these measures, to the extent that its funding has now been mainstreamed and it is regarded as a core element of the older people's health and care system in the city.

1.3 Because of its strategic importance to the overall older people's system agreement was reached to undertake a practice audit of the service during 2017, with any learning used to inform further service improvements.

2. Intermediate Care Audit

2.1 The scope of the audit was to assess the outcomes for a significant sample of people discharged from hospital to intermediate care; the processes for individuals in intermediate care; how the processes aid decisions about future care; and, how decisions are made for those who lack capacity to make their own decisions at the point of hospital discharge with particular reference to the use of 13za.

2.2 The methodology for the audit work comprised a retrospective file screening exercise for all admissions to Intermediate Care in February and March 2017; tracking the outcomes for this group until August / September 2017 (6 months later); a full practitioner lead file reading for a sub sample; visits to all of the Intermediate Care Units; observation all multi-disciplinary team meetings (MDTs); discussions with lead staff; review of a sample of Intermediate Care Unit recording; and, a small focus group of OT and physio staff working in Intermediate care units.

2.3 The audit considered 129 admissions from hospital to intermediate care in February and March 2017, a statistically reliable sample. The average age of individuals accessing the service was 85 years and more than 75% were female. Six service users in this sample were aged 95 years or older.

2.4 44 service users (34% of the sample) returned home. At follow up 6 months later in August/ September 2017:

- 29 (66%) remained home
- (9%) died at home
- 1 (2%) returned to hospital
- 8 (18%) were admitted to nursing /other 24 hour care permanently
- 2 (5%) were placed in residential care permanently

2.5 85 service users did not go home. At 6 month follow up:

- 73 remained in 24 hour care (with 4 experiencing a change in category of care)
- 1 returned home
- 9 died
- 2 returned to hospital

2.6 The general frailty level of the cohort accessing intermediate care is confirmed by the fact that around 10% (13 of 129 service users) had died within 6 months. At the same time, readmission rates to hospital were low (3 of 129 service users).

3. Key Audit Findings

3.1 A key general finding noted by the audit lead was the structural and cultural change achieved in services for older people that has allowed for success in hospital discharge and in returning people to live in their own homes. This was based on a comparison with previous auditing of older people's services during 2010/11 and represents a significant and positive finding.

3.2 The audit found that the outcomes for people admitted to Intermediate Care are dependent on a number of things

- The nature of the needs of the individuals admitted
- The processes that optimise the use of the multi-disciplinary resources that are available
- The competence and effectiveness of the Intermediate Care team within the unit
- The use of the multidisciplinary team's input to inform assessment to conclude that the person can go home
- The capacity of the unit to allow other agencies the space and access to fulfil their roles
- The quality of the "return home" plans and the time and ability to effect the required plans
- The working culture of the multidisciplinary team
- The mechanisms to approve funding for long term care

3.3 It concluded that the potential role of the MDT in intermediate care to optimise care plans for return home has not been fully realised across the city, particularly given the collective knowledge attending professionals have of individual service users. More consistently rigorous and structured chairing of MDTs were identified as key to achieving this.

3.4 Improved adherence to the intermediate care service specification is required to ensure the optimum number of people return home and that return home plans are sustainable. This means intermediate care units having the specified staff and

resources in place, but also relates to practice, behaviour and culture within the units. There is great variability in the six units across the city with significant room for development in all units.

3.5 There is a need to improve the quality of multi-disciplinary assessment of some service users. Some assessments did not take proper account of the views of the available OT and physio staff, particularly their professional expertise in assisting people to return home.

3.6 Some service users do not receive the most appropriate service and intervention from the intermediate care unit. This can be due to lack of appropriate planning and information sharing or lack of appropriate staffing or space resources in the unit.

3.7 Workers noted that service users and families were being advised in hospital that they required a nursing home placement and that this represented a backward step after previous improvements in relation to this practice.

3.8 Improvements are required in screening to ensure that only those with some possibility of rehabilitation are admitted to intermediate care. The service was significantly disrupted by the admission of only a small number individuals who required end of life care. Caring for such individuals can disrupt the intermediate care task for the remaining populations, whilst it is difficult to provide this care appropriately in such busy units.

3.9 File reading identified very few inappropriate admissions to long-term care as an outcome of intermediate care assessment, however, at the borderline there could be very little difference in the needs profiles of those that went home and those that did not. This reinforced a finding that the service does not consistently fully explore options and choice for all service users and their families.

4. Detailed findings from file reading exercise

4.1 The audit undertook a more in depth review through file reading of around 20% of the sample (26 of 129 cases) ultimately placed in long-term care following their assessment in intermediate care.

4.2 Further evidence of the frailty of the intermediate care population was that 5 of 26 service users had had 3 or more hospital admissions in the preceding year.

4.3 Carer support (24 of 26) and assistive technology (20 of 26) were widely in use for this group prior to hospital admission.

4.4 There remains small numbers of assessments which do not explicitly report when service users oppose care admission, however, the prevalence of this is much reduced in comparison to earlier work in 2010/2011.

4.5 The prevalence of individuals opposing their move to long-term care is very significantly reduced. It appears for many that the spell in intermediate care allays

their worst fears about admission to a 24 hour service. However, in 21 of 26 cases it remains the professional and family views which are most weighted in the decision making about future care.

4.6 The 26 cases presented for file reading were not significantly different in characteristic from some of the higher risk individuals who went home from intermediate care. They also were less high risk than some of the individuals currently continuing to be supported in the community.

4.7 The file readers noted that all but 2 of the assessments gave adequate justification of the decision to admit to 24 hour services. However, they identified 12 instances where the outstanding practice issue was the lack of choice or options provided to the service user or their family. In some of these instances the family were persuaded into a care home admission without evidence that the alternatives were detailed to them.

4.8 The use of 13za was scrutinised as part of the file reading exercise. This is the mechanism by which individuals lacking capacity can be legally moved in the absence of formal guardianship powers. The audit found that of the just under 20% of the sample (24 of 129) moved from hospital to intermediate care in the 2 month period in question, less than a third (n7) moved without evidence of the use of this process. In the remaining 17, the use of 13za was appropriate and well recorded. This represents a significant improvement from previous audits.

4.9 The audit indicated less robust practice in using 13za for moves from intermediate care to permanent care locations. The audit did not provide assurance that the substantive moves, often to long term care, were appropriate and met the requisite tests. Procedures did not offer guidance on the appropriate authority to make further moves after 13za had been used and local custom and practice developed as a pragmatic alternative.

5. Conclusions

5.1 Encouragingly the audit found there has been significant cultural and system change in relation to the use of long term care. It found that some people who would previously have gone directly to Nursing Care from hospital are instead now going home, in line with HSCP policy. It also found that some staff are building skills in the best practice associated with successful return home.

5.2 However, more challengingly, intermediate care is not optimum in any of the units and is widely variable. Needs assessments are not always fully representative of the expert views available in the MDT and do not always fully explore the potential options for a return home.

5.3 Technology and care at home resources mean that there is a borderline group of service users who might go home with significant support or go into a care setting. The audit concludes we must ensure we are fully supporting and promoting the option of return home, both by promoting informed individual choice and also

through best practice in our processes and systems. Again these are currently highly variable.

5.4 It is notable that there are a number of variables which affect the rate of return home. Staff absence, deterioration in unit performance or staffing, team work and working relationships and the nature of presenting service users can very quickly lead to decline in performance. This suggests that intermediate care will always require a strong management focus.

5.5 There is still significant evidence that family wishes are very heavily weighted in all decision making, with lesser attention on the primary service user.

5.6 Some of the risks we tolerate with people living in the community remain higher than the risk we routinely tolerate to return people home from intermediate care.

5.7 We routinely use 13za to help individuals without capacity to benefit from a move from hospital to intermediate care. This is now well recorded and appropriate. However, we failed to apply the same rigour to the onward permanent move from intermediate care.

6. Audit recommendations and basis for improvement action plan

6.1 The audit report made a number of recommendations that are now being translated into a number of key improvement actions by HSCP teams:

a) The service should consider what steps can reasonably be taken to standardise Social Work practice in relation to intermediate care across the city. This should include assurance that all social workers understand the rigours required of them in terms of teamwork, assessment and timescales whenever they have a service user in Intermediate Care.

b) The service should consider if this could be best achieved by limiting the number of workers working with the Intermediate Care units to dedicated staff where possible. (Note: this is being actioned through the introduction of dedicated intermediate care teams in each of the three localities).

c) The team leaders who are chairing Intermediate Care MDTs should work together to develop shared standards and could usefully observe each other's practice. This should include rigorous monitoring of timescales to ensure throughput in the intermediate care units.

d) Managers involved in authorising admission to 24 hour services or signing off social work assessments should satisfy themselves that service users have benefited from full consideration of all options.

e) The service should continue to invest time in the forums that have helped to develop teamwork and culture. In particular, it is essential to involve Intermediate Care Unit staff that provide the service.

f) The service should consider developing work on specification of the types of service user characteristics or conditions that we cannot support at home.

g) The service should consider whether it is feasible to integrate carers support workers into the MDT.

h) The required work should be undertaken to ensure that health professionals who are involved in discharging patients from hospital are reminded that it is inappropriate to pre-empt the assessment outcome particularly by advising patients and relatives that they will require nursing care.

i) The service should consider joint work with the providers of intermediate care to ensure that the essential aspects of the intermediate care service specification are being delivered. The contract management team responsible for intermediate care should consider standardising their approach to monitoring these units. All should be vigilant about actions on the part of the provider that work against the desired outcome of returning people home. This could include fostering dependence, failure to work to the agreed care plan or a desire to fill long term places.

j) We should seek to clarify with all social workers in intermediate care units that information sharing with housing options staff for the purpose of promoting care plans is legitimate.

k) We should, as a matter of urgency, ensure staff are aware of the 13za requirements for moving individuals into permanent care, or permanent return home.

l) At the point of authorising admission to 24 hour service the relevant service manager should ensure that there has been due process for any service user lacking capacity.

m) The functioning of intermediate care units and their MDTs should be subject to further audit activity in the next 12 months.

6.2 The improvement action plan remains a work in progress. The current iteration is attached for information as Appendix 1.

7. Recommendations

7.1 IJB Finance and Audit Committee are asked to:

a) note the findings of this report.

APPENDIX 1 – DRAFT ACTION PLAN

Area	Action	Lead	Timescales	Update	Comment
Admission	Review criteria and engage with all stakeholders to ensure a better understanding of the focus of intermediate care (including providers, families and service users)	Intermediate Care Group	April 2018		
Admission	Review written information provided to service users and families to help manage expectations	Intermediate Care Group	April 2018		
Admission	Review information given to service users and families by acute staff that may influence their intermediate care experience. Evidence that this had improved but appears that consultants are again suggesting long term care which has not been assessed by a social care / community team.	Intermediate Care Group	April 2018		

Area	Action	Lead	Timescales	Update	Comment
Admission	Management of capacity – variation in how this is managed across Localities and the opportunity to identify a standardised approach.	Intermediate Care Group	September 2018		
Admission	Limitations of admissions per day or weekends and public holidays – commissioning to review this as it can have a major bearing on throughput whilst recognising the need for safe admissions.	Commissioning . Intermediate Care Group	September 2018		
Admission	Understanding the use of 27a for step down or Complex Care – Review as part of introduction of Edison replacement	Edison Replacement Group / Intermediate Care Group	April 2018		
Admission	Improve discharge information through immediate discharge letter, prescription information from acute and handover to intermediate care	Intermediate Care Group / Acute	September 2018		
Admission	Review transport options for transfer to intermediate care to reduce delays and improve timeliness of arrival at intermediate care	Intermediate Care Group	April 2018		

Area	Action	Lead	Timescales	Update	Comment
Effective Use of Resources	Review of the role of community rehabilitation staff and their potential to improve throughput, including reliance on SNA completion by social work	Intermediate Care Group	September 2018		
Effective Use of Resources	Review of the use of continence nurse – 2.5 days of time into intermediate care and feedback is that this resource could be better used with opportunities for assessment, support and training for providers, families and others.	Intermediate Care Group	September 2018		
Effective Use of Resources	Social Work resource within intermediate care – benefits of dedicated workforce that cross covers absence but is fully informed around clients' progress and status. The resource is also available throughout the week to progress agreed actions and to support the provider and other stakeholders.	Intermediate Care Group	April 2018		

Area	Action	Lead	Timescales	Update	Comment
Effective Use of Resources	General Practice – review in more detail what the issues are around medical cover through the issues log from GPs, work that Ann Burns is progressing around readmissions and identifying some of the critical incidents. Access to GP and timeliness of response are noted in feedback as well as GPs having specific issues / expectations around how they are utilised.	Intermediate Care Group	September 2018		
Effective Use of Resources	Holding of beds following readmission to acute – there is a variance across Localities as to how this is managed. There is an opportunity to develop a system wide approach to this.	Intermediate Care Group	April 2018		
Effective Use of Resources	Throughput following discharge – there are some contractual agreements around turnover of beds following death / discharge. Other elements such as cleaning and repair could be reviewed	Commissioning / Intermediate Care Group	September 2018		

Area	Action	Lead	Timescales	Update	Comment
	through commissioning to ensure these are as efficient as possible.				
Effective Use of Resources	Contingency planning for outbreaks or other factors that may influence capacity – commissioning may for example be able to focus on plans around Norovirus or other outbreaks and also to improve prevention and speed of response to ensure capacity back on line at the earliest opportunity.	Commissioning / Intermediate Care Group	September 2018		
Effective Use of Resources	Transport – there is a dedicated intermediate care transport service provided through the British Red Cross at present. This should be reviewed as part of the new tender process to ensure it is being used effectively or to identify improvements.	Intermediate Care Group / Transport Tender lead	July 2018		
Effective Use of Resources	Review of engagement with Carers and exploiting opportunities from carer services to support family / friends.	Carer Services / Intermediate Care Group	September 2018		

Area	Action	Lead	Timescales	Update	Comment
Effective Use of Resources	Review approaches to family to understand opportunities to influence where this is noted as a reason for delay.	Intermediate Care Group	April 2018		
Effective Use of Resources	Review options around housing including supported housing where this is at times a significant delay due to lack of availability (sometimes still being built) or where existing housing no longer an option.	Intermediate Care Group	September 2018		
Effective Use of Resources	Engage with providers to better understand their role and influence on throughput / quality and to understand their expectations, training requirements, support needs. Recognition that this is a different way of working for many and that there is a sense that the provider is critical to success of intermediate care.	Commissioning / Intermediate Care Group	September 2018		

Area	Action	Lead	Timescale	Update	Comment
Monitoring to Support Practice and Performance	Effective use of the Tracker system to map each client's journey through intermediate care	Intermediate Care Group	April 2018		
Monitoring to Support Practice and Performance	Development of Carefirst 6 based collection to allow for direct entry to support • Timeliness • Accuracy • Reduce double entry • Reduce multiple systems • Reduce risk of error in data transfer • Improve communication • Use as a driver to progress actions	Intermediate Care Group	December 2018		
Monitoring to Support Practice and Performance	Infrastructure to support meetings and data collection including: • Appropriate room – with desks / presentation equipment • Connectivity – Wifi / 4G • Access to information • Appropriate attendance	Intermediate Care Group	April 2018		
Monitoring to Support Practice and Performance	Meeting approaches and actions to support throughput / quality and progress including • Role of chair – Team Leader level or delegated worker	Intermediate Care Group	June 2018		

Area	Action	Lead	Timescale	Update	Comment
	• Appropriate members in the group who contribute to the meeting • Preparedness of attendees to report on progress / actions and ensuring they are well informed about the client • Immediate updates and coding to understand progress or any reasons for delays – expectation that lack of progress will be challenged • Progress of actions as a priority to support throughput • Training to stakeholders to increase awareness and influence their commitment to intermediate care • Use of single systems city wide • Reduction of multiple information logs / systems				
Monitoring to Support Practice and Performance	Reduce known reasons for delays through a better understanding of why things have not progressed around the noted areas of; • Family • Outstanding actions from staff	Intermediate Care Group / Locality Teams	June 2018		

Area	Action	Lead	Timescale	Update	Comment
	• Aids / Adaptations / Equipment • Funding • Place availability – including - interim placement or use of charging policy				
Monitoring to Support Practice and Performance	Revise targets and effectively communicate these to all stakeholders including: • A review of the target for home as an outcome • The balance of nursing and residential care provision • Readmissions from intermediate care • Readmissions following discharge home • Home care provision / support – including telecare • Days delayed from Estimated date of Discharge	Intermediate Care Group	April 2018		
Monitoring to Support Practice and Performance	Use of IoRN (Indicator of Relative Need) – to review how this is used city wide to support decision making	Locality Management Teams	September 2018		

Area	Action	Lead	Timescale	Update	Comment
Monitoring to Support Practice and Performance	Anticipatory Care Planning – to review how these are established and developed and used through escalation in the event of illness and also in discharge / handover	Locality Management Teams	September 2018		
Monitoring to Support Practice and Performance	Readmissions – build on the analysis by Ann Burns to identify opportunities to reduce specific reasons for re-admission (potentially avoidable) including feeding into wider quality discussions, GP involvement and anticipatory care planning	Intermediate Care Group	September 2018		