Somerset Model for Intermediate Care

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NHS Somerset NHS Foundation Trust
NHS Somerset Clinical Commissioning Group
Yeovil Hospital Healthcare

What is Intermediate Care?

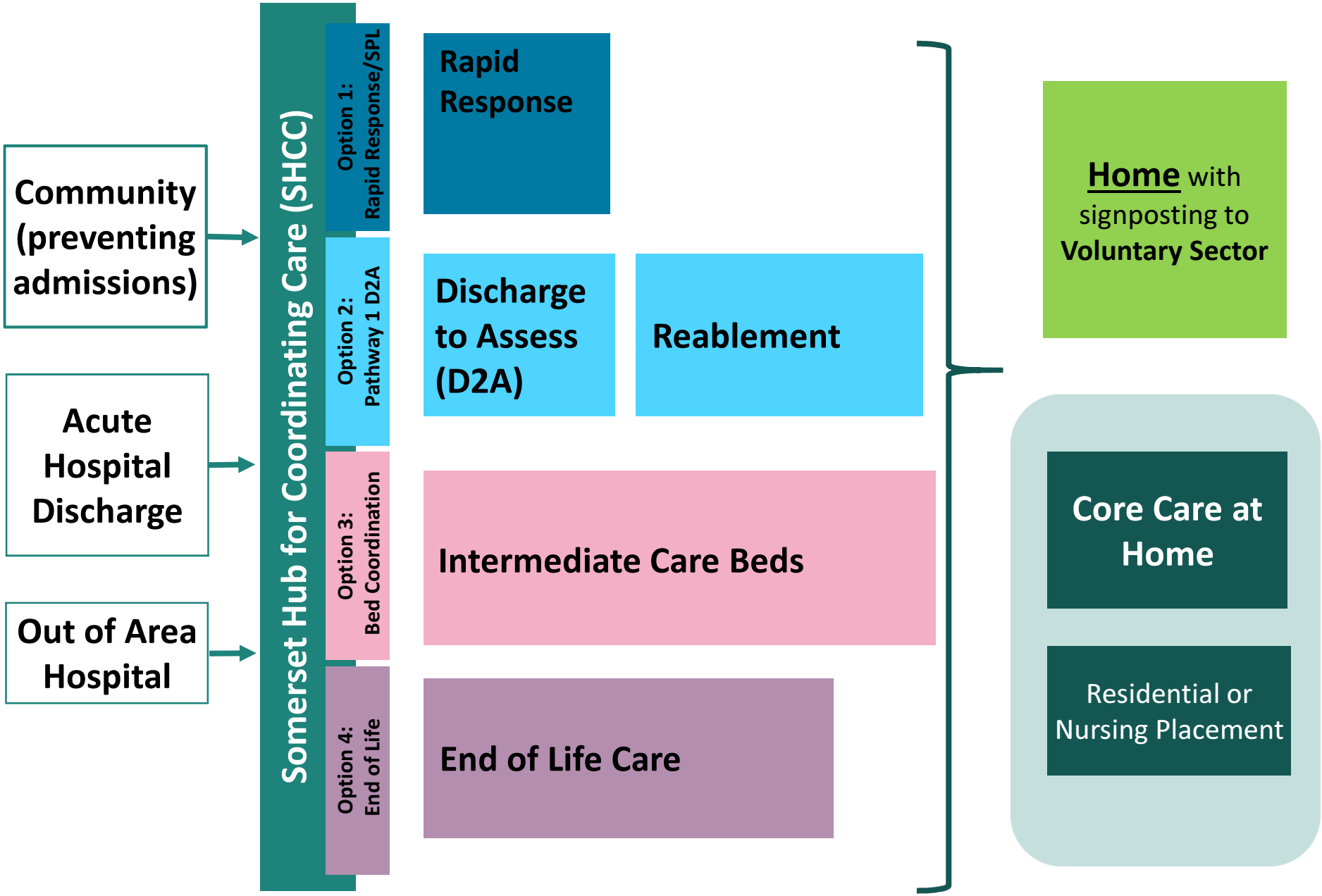
The term ‘intermediate care’ is used to describe **services in the community that provide short term period of stabilisation, assessment, and reablement with the view to maximising a person’s independence and, where possible, keep them at home.**

Intermediate care services can either:

- provide support to **people who are medically optimised following an acute episode of care**. This is referred to in this document as ‘supported discharge’; or
- provide support to **people in the community who are in danger of needing an acute episode of care** if an intermediate health or reablement intervention is not provided. This is referred to in this document as ‘diversion’, as it diverts people away from needing an acute hospital.

Intermediate care **also includes End of Life provision** for those people whose primary need is the short-term provision of care and comfort at the end of their lives.

The new Model for Intermediate Care in Somerset



Key features of the model

The current model for intermediate care was implemented as the system's response to Covid-19, following NHSE/I guidelines on hospital discharge.

Whilst a number of the pathways and operating principles where already in place in Somerset's Home First service, the revised model ensured that:

- **all supported discharge decision making is removed from the hospital wards** and instead made by a multidisciplinary team within a discharge lounge.
- **responsibility for managing the supported discharge pathways is separated from the acute discharge function** and instead managed out in the community.
- A **central Somerset Hub for Coordinating Care is set up** to provide a single point for coordinating and managing capacity across all the intermediate care options.
- All community beds, including Home First Pathway beds, community hospital beds and interim beds, act as **one bed base** and are coordinated and monitored from one place.
- The **previous Home First reablement pathway (Pathway 1) is converted to a discharge to assess model**, introducing a period of assessment to determine ongoing reablement or support needs.

Preparing Intermediate Care for winter

Services were expanded for winter 2021 and service transformation work continued.

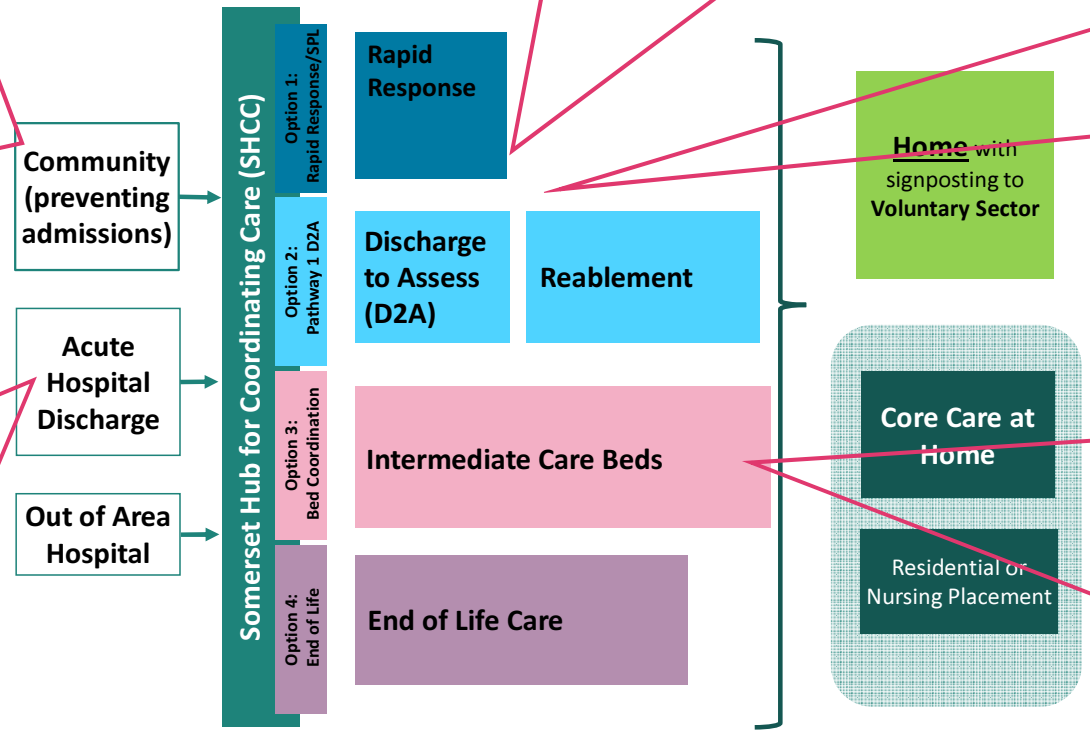
Opening up intermediate care pathways to referrals that prevent admission.

Focus areas SWAST and Front door

Increased capacity on our home pathways (Rapid Response and D2A Home) to optimise the opportunity for recovery at home.

Rapid Response and D2A working across both discharge and diversion.

Improving reablement practice



Focussed work on decision making and reducing barriers to getting people home.

Improving practice in pathway beds and Community Hospitals.

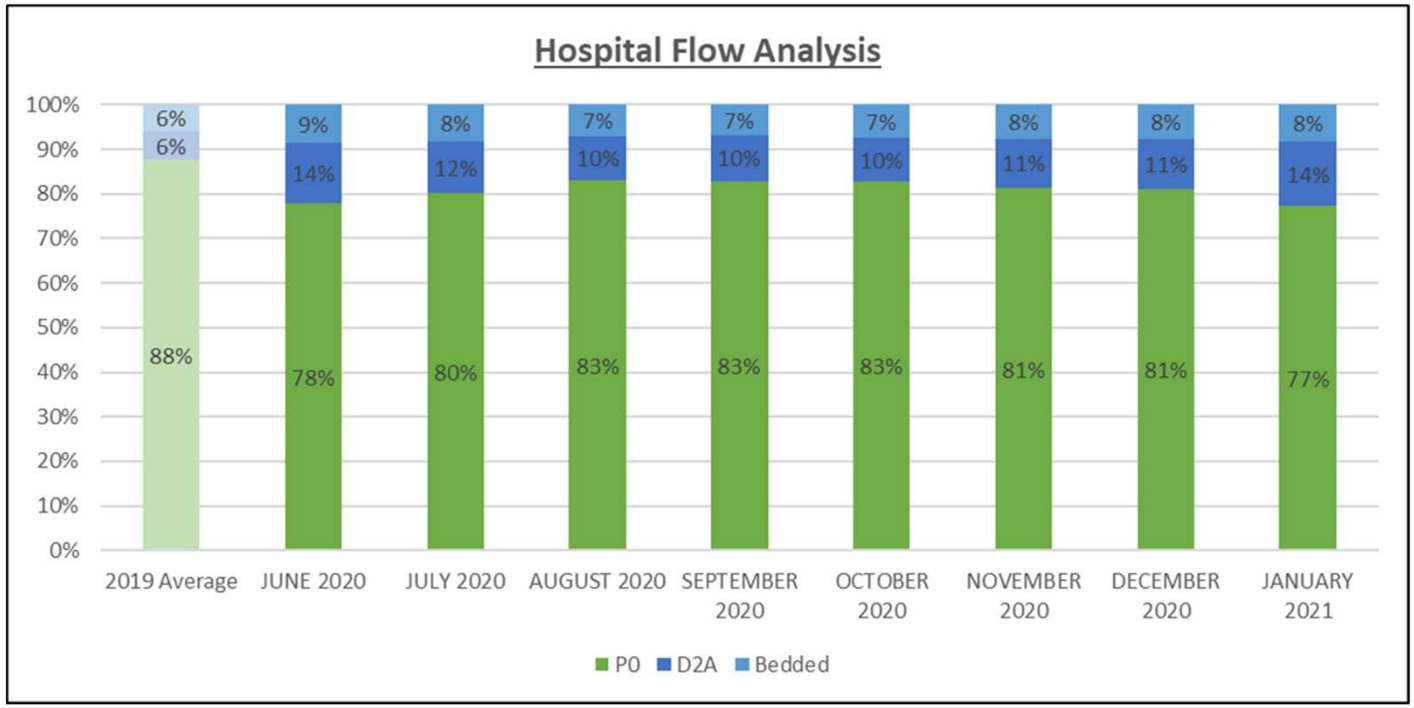
Focussing on discharging people as soon as they are safe to return home

Adding more P3 slow rehab beds

Daily snapshots of demand and capacity moving towards a live flow dashboard

Demand for Intermediate Care as a percentage of all discharges increased by approx. 20% during the pandemic.

Between Jun20 and Jan21 this higher demand meant that approx. an **additional 607 people** were discharged to intermediate care compared with the same period in 2019/20, at an average of **76 more people per month.**



Despite this, the Somerset System remains one of the best performers nationally for discharging home from hospital, if you combine P0 with D2A numbers.

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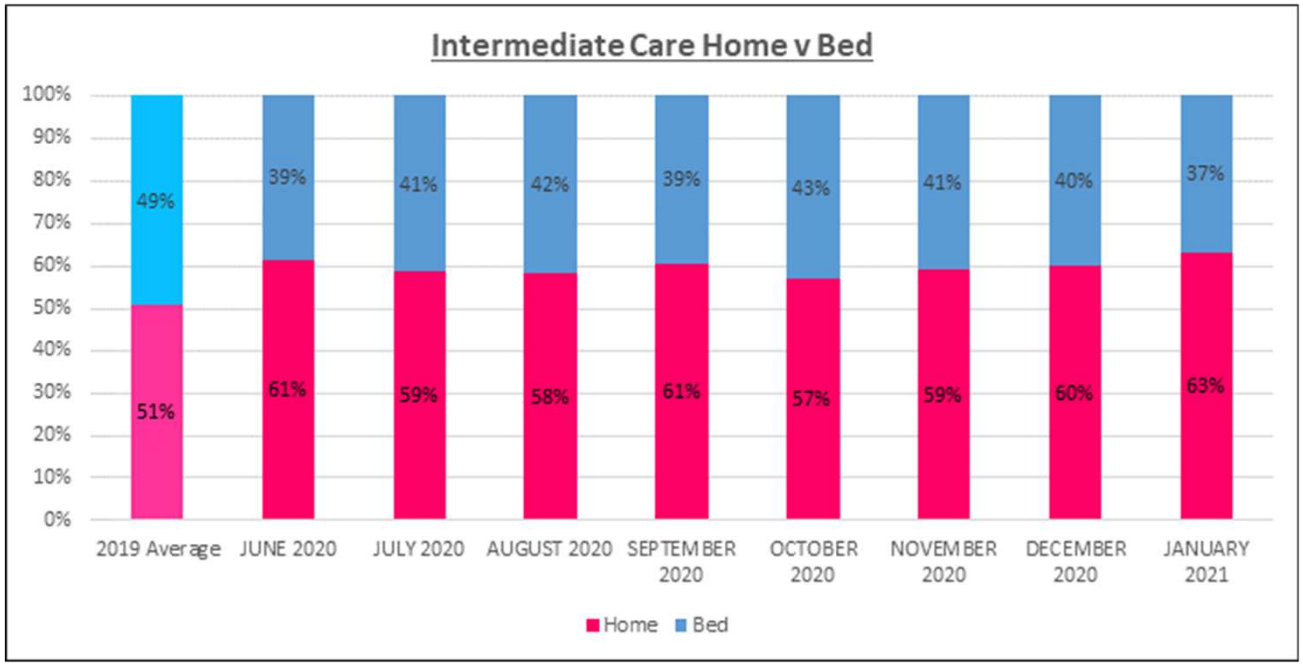
Despite the increased demand, the percentage of these people going to beds has decreased

In 2019, on average 49% of all supported discharges went to a bedded facility. Between Jun20 and Jan21 this **average reduced to 40%.** This is in spite the additional interim beds at use in the system.



This shift towards home based reablement on discharge is largely due to an **increased volume going home with D2A**, with this pathway now taking on **average 42% more people home per month than Home First pathway 1.**

Note: Before March 2020 the Home First figures would have reported a different average % split for 2019 (69% home / 31% Bed). This is because community hospitals were not included in the total bed count.

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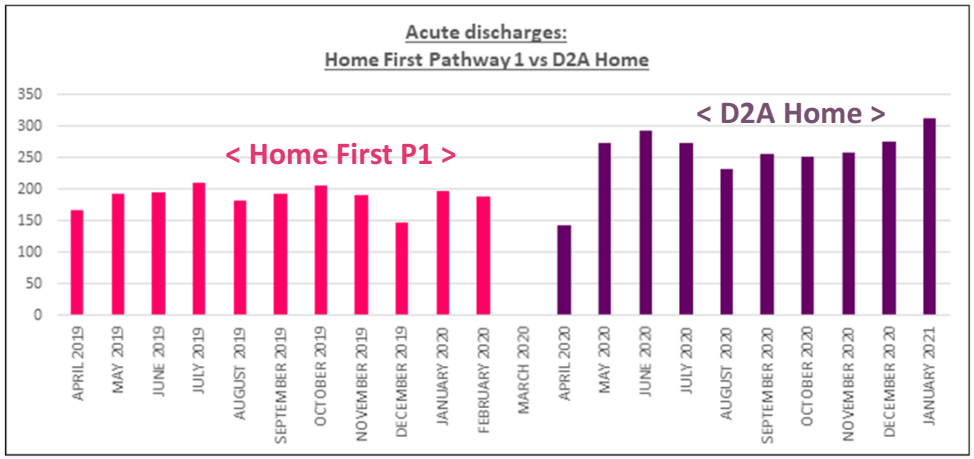
D2A has enabled an increase to Home First Pathway 1 with 42% more people going home each month

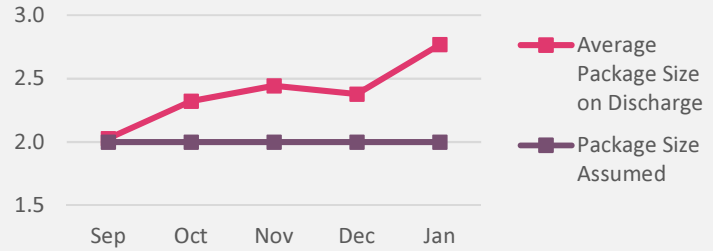
Between Jun20 and Jan21 this increase equates to an **additional 631 people going out on Pathway 1 D2A** compared to the same time last year.



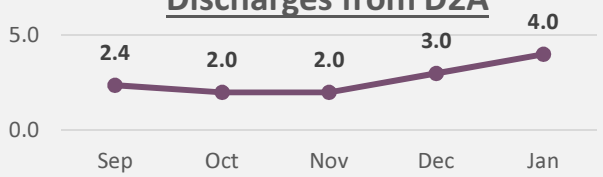
This increase was reflected in the **average caseload which rose from approx. 150 in Nov20 to approx. 200** people in Jan21.

D2A Daily Discharge Target

D2A's target expansion was to move from 13 discharges per day to 26 by mid Feb21. This has since been adjusted to 17 due to an average package size increase of 40%, from 2 visits per person to 2.8.



Weekend Average Daily Discharges from D2A



During this time weekend daily discharges rose from 2 to 4 per day

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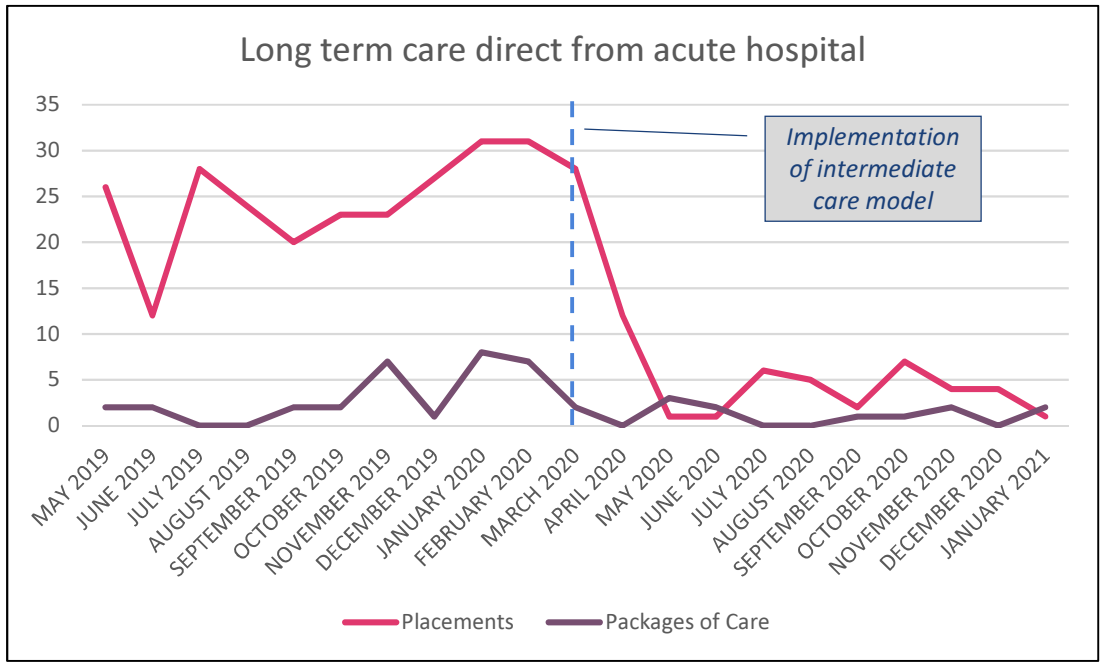
Since moving to the Intermediate Care model fewer people are being placed into long term care direct from hospital

Long term placements to residential and nursing homes direct from hospital have **reduced by 81% since May 2020**



Discharges into long term care now account for 1% of all discharges compared with 6% pre-March 2020.

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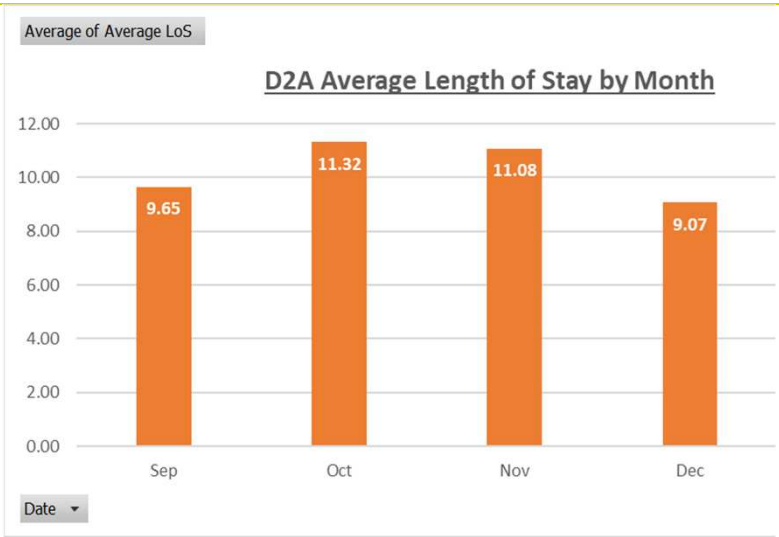
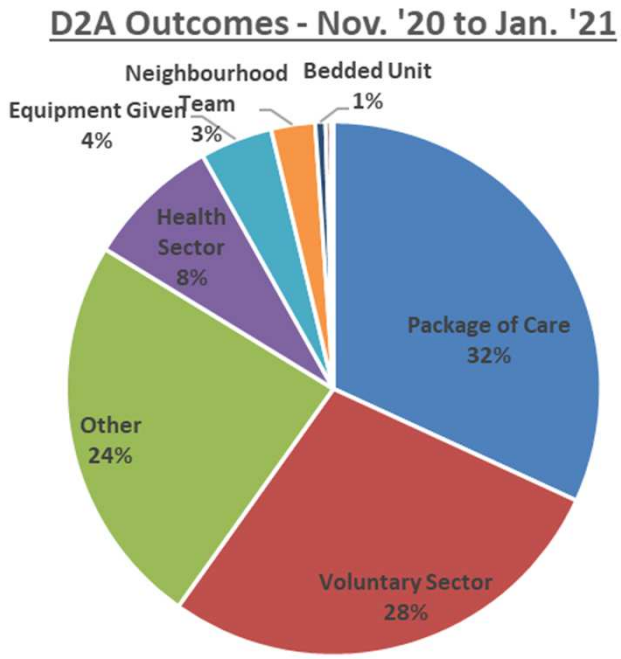
D2A length of stay is shorter than Home First Pathway 1 and approximately 1/3 go on to receive a package of care



The average length of stay on D2A for period Sept20 to Dec20 is **9.61 days.** This is significantly shorter than the **12.1 day** average length of stay on Home First pathway 1 in 2019.

This could be due to the introduction of the D2A part of the pathway allowing for shorter length of stay as more people are assessed and moved on. It could also be due to pressure to move people on and improve daily capacity.



- Approximately 1/3 of people on D2A go on to need a package of care.
- Of the remainder, the vast majority receive short term informal support at home.
- A small minority go on to need a bedded facility.

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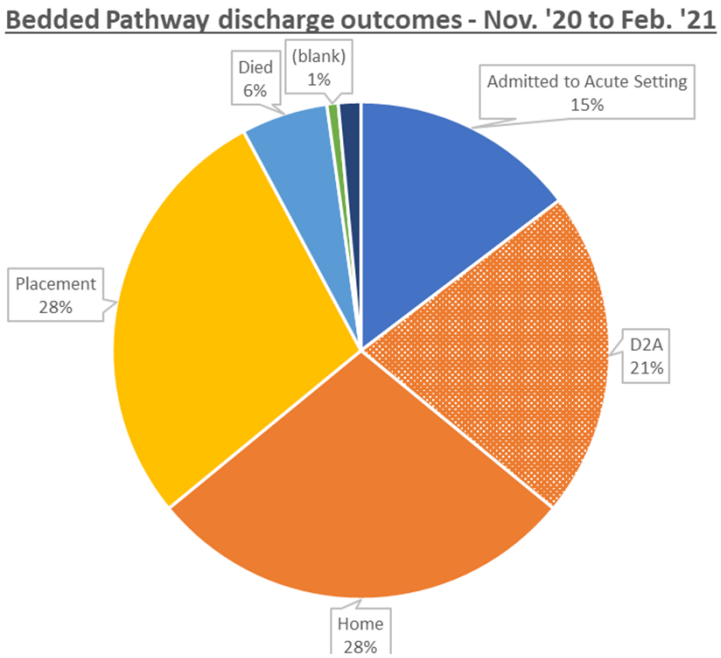
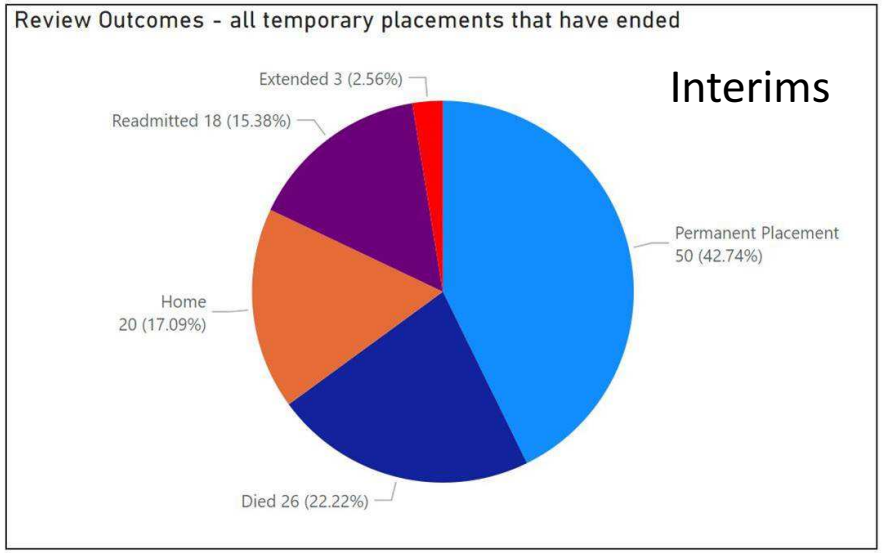
Outcomes from Bedded Pathways



- Approximately 50% of people go home from the bedded pathways, with 21% being supported by D2A to continue reablement at home
- If D2A use on discharge was increased, those going home with no support would go home sooner
- 28% discharged to placements



People in interims are:

- Significantly more likely to go into long term placement
- Only 1 in 5 go home compared with 1 in 2 in other bedded facilities

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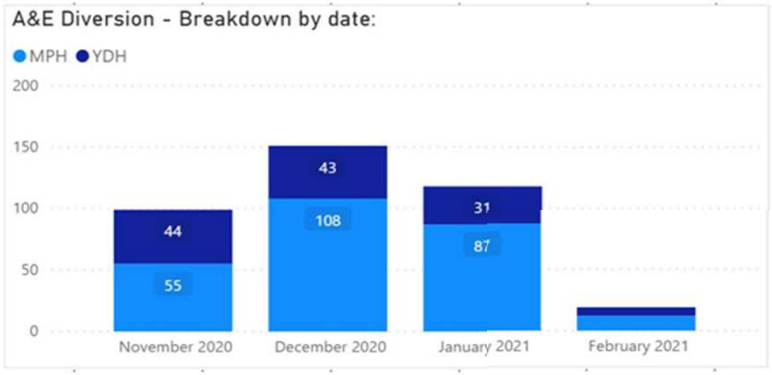
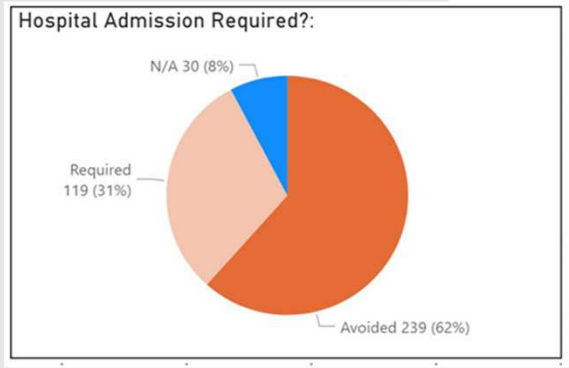
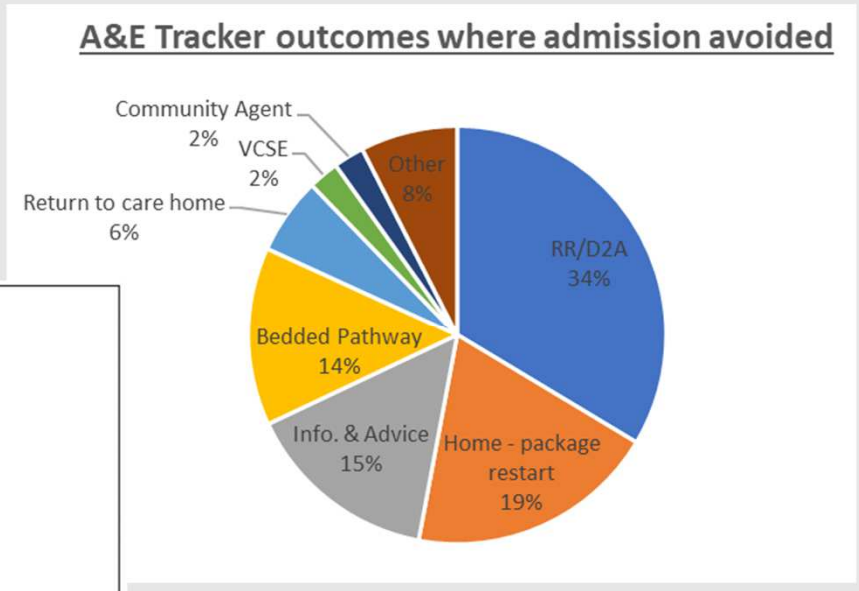
62% of Adult Social Care contacts at the front door resulted in admission avoidance

Since November 2020 ASC staff have been recording details of interventions in A&E at both YDH and MPH including details of whether they were able to prevent an admission to hospital. Since November a total of 388 contacts have been recorded.



Of these contacts, **62% resulted in admission avoidance**, with **74% of these being returned home** or their usual place of residence. Just under half of these received support from Rapid Response or D2A.





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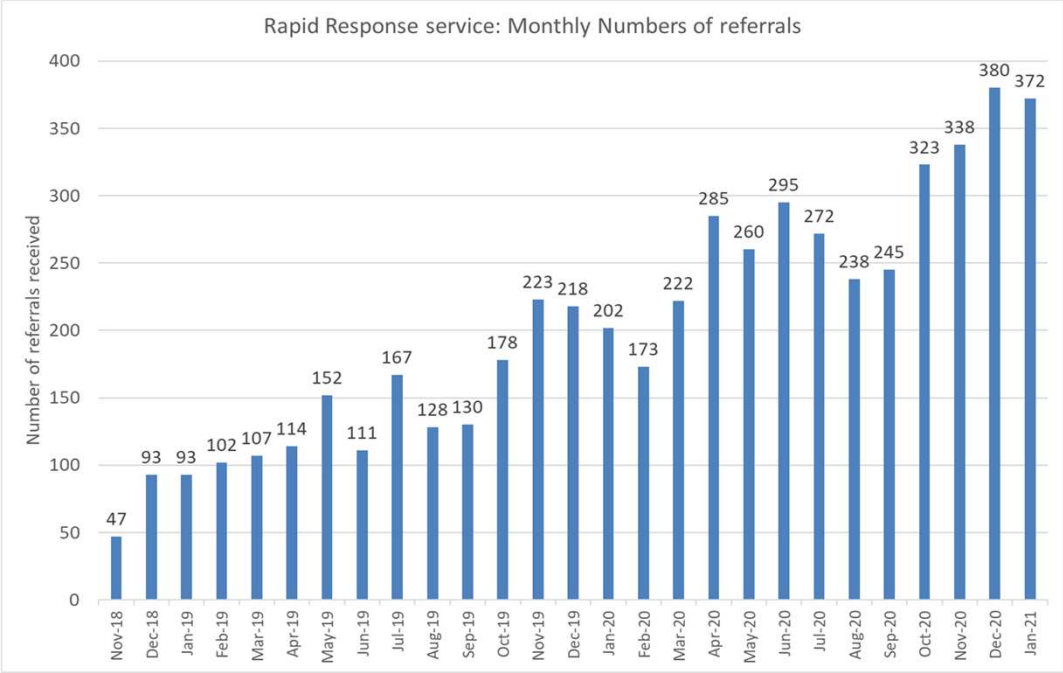
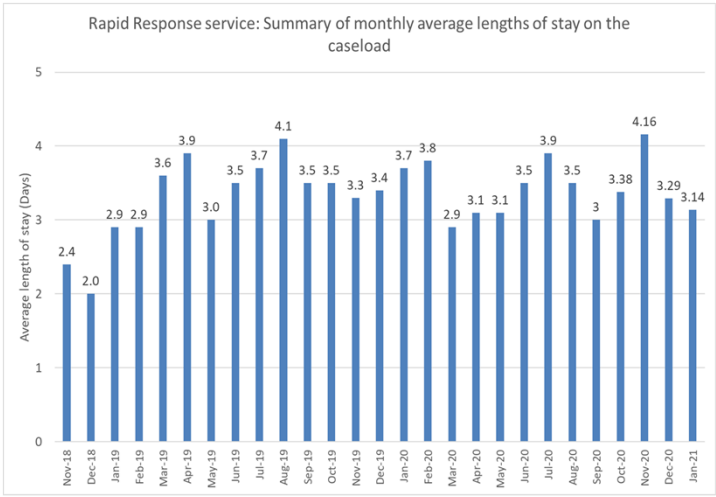
Rapid Response monthly average referrals are 79% higher in 20/21 than in 19/20



Average length of stay on Rapid Response has remained consistent across 2019 and 2020.



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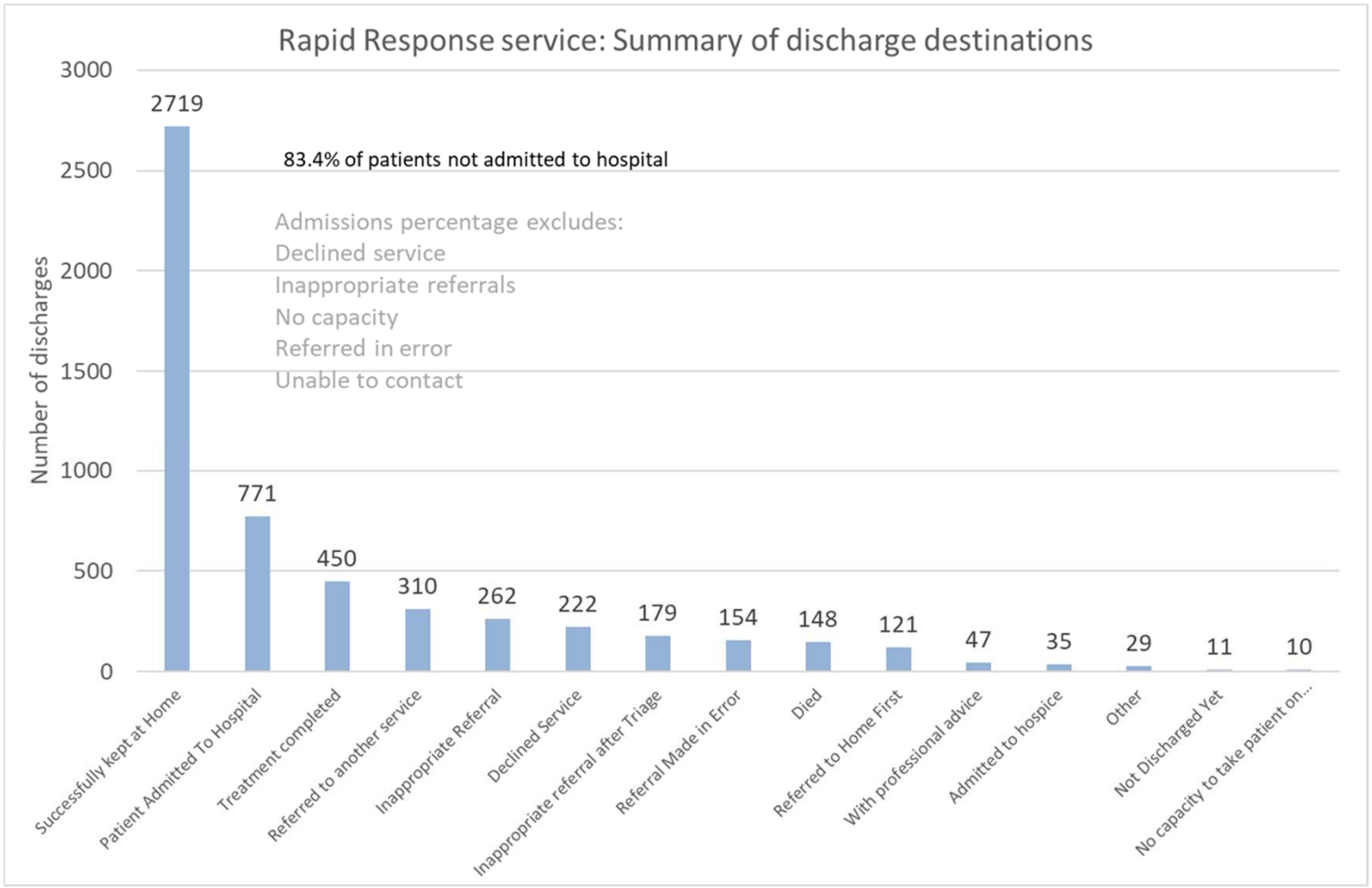
Over 83% of people in Rapid Response have been supported to stay at home



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