Review of Intermediate Care Service (ICS) – final report including recommendations

1. Introduction

The Intermediate Care Service (ICS) in Walsall is the single largest integrated service within the local health and social care system and accounts for the highest amount of expenditure from the Better Care Fund (BCF). The ICS is fundamental to the timely discharge of adult (18+) patients from hospital and also facilitates the assessment of people during a period of intermediate care. It also enables people to return to the care home or extra care scheme where they live and facilitates the re-start of long term care and support package(s) in the community.

Since the integration of ICS in 2017 a number of different commissioning arrangements have been implemented and this final report will evaluate other options that should be considered e.g. developments to the current ICS pathways. Following a significant investment by Walsall Healthcare Trust (WHT) facilitated by the Walsall Together plan the expansion of hospital avoidance capacity has demonstrably increased the number of people who are 'stepped up' into ICS. There is also ongoing capital project which will result in a revised approach to crisis response. As such, it is anticipated that the new Emergency Department at Walsall Manor Hospital will be operational in September 2022 and the local Rapid Response service now operates until Midnight on weekdays. The above developments will take place in the wider context of fundamental changes to crisis response timescales mandated by the Department of Health and Social Care (DHSC).

A comprehensive review of the Intermediate Care Service (ICS) has been undertaken over a four month period with the continued support of key stakeholders within the ICS using a business analysis approach which included conversations with post holders across the ICS. A list of the associated task and finish groups with associated themes e.g. workforce is contained as an appendix (2) to this report. It was originally intended that the review would be framed by an evaluation of progress against the original business case and this analysis formed a key part of the midway report. The final report considers the ICS in line with associated national guidance and the future requirements of the service particularly in a post pandemic operating environment. The report outlines associated recommendations and details the associated enablers and timescales for completion (Appendix 3). If agreed, these recommendations will be formalised within an underpinning Service Level Agreement (SLA) and progress monitored by commissioners following the development of an associated transition plan.

The review has also considered the impact of the Covid pandemic period upon ICS staff morale, welfare and in some cases physical health. As such, we must also actively consider the impact of Covid in the future including people in the community who have delayed accessing health and social care due to the associated risk and also the impact of reduced immunity across the local population including younger people which will invariably apply additional strain upon acute and primary care services as we move into Winter. It is likely that the period March 2020 – 31st March 2022 will have far reaching consequences for the health and wellbeing of the population of Walsall for many years to come.

2. Background

2.1. Recently re-issued 'Hospital discharge and community response guidance'[1] identified that '*the discharge to assess model has been implemented since March 2020 with an intention to support more people to be discharged to their own home. Health and social care systems are expected to build on this work during the first half of 2021-22 to embed discharge to assess across England as the default process for hospital discharge during the funded period*.'

As the suggested 'Discharge To Assess' model (see diagram below) naturally includes community response (e.g. hospital avoidance) it can be reasonably argued that funding and resourcing has not re-aligned based on changes to the overarching process and as such the local Intermediate Care Service (ICS) has absorbed additional work without the funding envelope inflating in line with the increasing 'customer' numbers (44% between 19/20 and 20/21) and also increasing complexity of need particularly in the community. As an example, the community therapy and physio function have been impacted by emerging themes such as long-Covid and the fact that more people are going home is more logistically challenging due to travel time etc. However, the number of Full Time Equivalent (FTE) staff is less than before the service became integrated in 2017 despite vastly increased workloads. As such, the transfer of resources did not include a number of WMBC employees including two Occupational Therapists and two Physiotherapists.

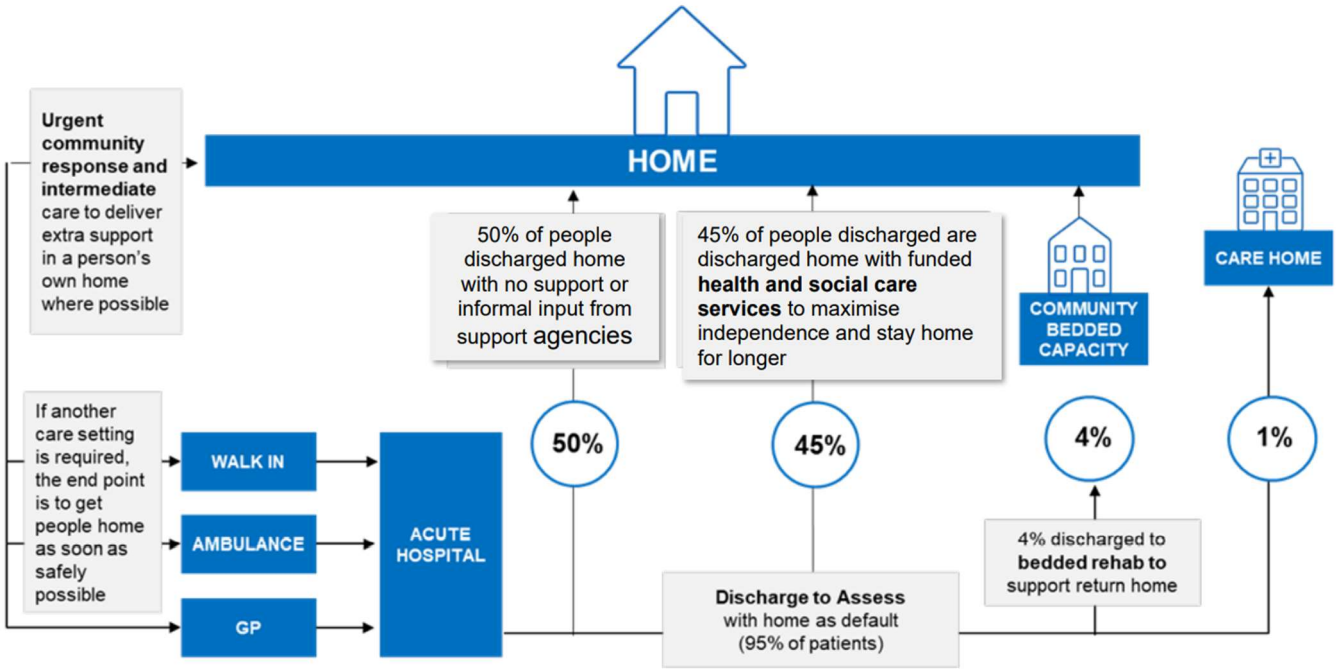

Table A: Discharge to assess process (Hospital Discharge and Community Support: Policy and Operating Model)

2.2. The ICS is a complicated and time intensive service which requires full time focussed leadership including strategic development e.g. horizon scanning, planning and workforce development. As previously evidenced, there has also been a significant increase in the numbers of individuals who have accessed the service including crisis response e.g. hospital avoidance. The ICS management team have performed admirably particularly during the peak Covid pandemic period but the service structure and associated roles and responsibilities must deliver an effective ICS both in the present and for the challenges

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/999443/hospital-discharge-and-community-support-policy-and-operating-model.pdf

ahead as numbers of people accessing the service and complexity of need inevitably increase.

2.3. The majority of adults who access the ICS are over 65 years old and are likely to be living with a degree of frailty. Walsall Healthcare Trust's current 'Frailty Service Outline' (known as FSO) states that within '*Walsall CCG [as was], an estimated 7,223 people are estimated to be living with moderate or severe frailty. However, only 26% of GMS eligible patients aged over 65 have been screened for frailty (12,467/47,771 (2017-2018 data)). Estimated figures suggest that as a consequence of this, around 50% of patients living in the locality with moderate or severe frailty are currently unidentified*' and '*About 5-10% of all emergency department (ED) attendees and 30% of patients in Acute Medical Units (AMU) are older people with frailty*. Following the Covid pandemic period WHT will need to re-commence a dedicated focus on mitigating pyjama paralysis[2]. An associated initiative began in Walsall in 2019 with the ultimate aim of '*patients dressing in their day clothes while in hospital rather than pyjamas or gowns. This aimed to enhance normalisation, dignity, autonomy and in many instances shortening their stay*.'

2.4. Although a monthly ICS monitoring meeting has been active for a number of years the structure of the meeting has actively been reviewed. As such, this group is in the process of developing agreed terms of reference as well as standing agenda items which will include budget monitoring. It was also noted by the group that performance indicators have not been a standard agenda item on an ongoing basis and this will be prioritised going forward.

3. Staffing resource

The enclosed staffing structure (see Appendix 1) was provided as part of the review and a dedicated task and finish session explored the structure in detail and the wide ranging discussion provided the business analysis below.

3.1. Service Director

This role has previously been undertaken by Director level post holders within the Council and Trust. Presently, it is not clear who the current holder of the 'Service Director' role is and what the associated remit involves. As such, this situation needs to be reviewed and if this role is continued then a specification of the roles and responsibilities will be required.

3.2. Service Manager

The review has established that a number of the management team job titles do not correlate and the upper part of the structure. As such, the structure on paper is not consistent with the day to day operational management of the service. It is also the case that the service manager role is to a degree split between two individuals and neither of these individuals are able to fully focus on ICS as there are other time intensive aspects to their portfolio(s).

The reality of the operational management of ICS on a day to day basis has been that WHT's Deputy Director of Operations and Operational Manager, ICS manage the front door activity within the acute setting including hospital avoidance and a WMBC Group Manager and Team Manager, ICS essentially manage the flow through the ICS pathways. It is not sustainable to continue forward on this basis and whilst it understandable that the service requires an element of flexibility a clear structure with defined job roles and responsibilities is required.

[2] https://www.cqc.org.uk/sites/default/files/Walsall_Healthcare_NHS_Trust_Evidence_appendix_published_25_July_2019.pdf

3.3 Overall structure

Whilst there is evidence of oversight around the decision making re: staffing assignments there is potential for these decisions to be made in isolation and therefore without strategic oversight of the wider needs of the service including future planning. Furthermore, the staffing assignment that was envisaged within the original business plan has not developed in line with both increasing demand and complexity of the day to day activity i.e. due to increased acuity within the community as a result of a reduction in care home admissions prompted by 'Home First'. Therefore, roles and responsibilities need to demonstrably be commensurate with associated job grades including required qualifications and/or experience. As such, a robust workforce plan would ensure that professional oversight (including supervision, peer challenge and reflection time) takes place as standard thereby ensuring the quality of practice. This measure would also help the ICS prepare for future CQC local health and social care system inspections, peer reviews and other quality assurance measures.

A consolidated workforce plan is likely to recommend three Heads of Service (HoS) operating under the Head of Intermediate Care (Service Manager in the current structure). These four post holders would then form the senior management team with an expectation that each HoS would undertake professional development to the point that they could deputise for the Head of Intermediate Care and also cover for a HoS during periods of leave and other absences. As previously recommended the workforce plan must also ensure sufficient Registered Mental Nurse (RMN) capacity and cover arrangements e.g. leave.

4. Strengths and Opportunities (ICS)

Strengths

4.1 The first 'High Impact Change Model'[3] overarching principle is '*Commitment and focus to support people to remain in their homes or usual place of residence, when they are having a health or social care crisis, preventing admission to hospital or long-term care where possible AND then supporting them to maintain or regain skills, confidence and independence*.' The ICS in Walsall has made good progress (75% of people through ICS go home as a general rule) against this principle which is to be celebrated.

4.2 The review has also identified that there are generally good working relationships across ICS which has been identified during task and finish meetings and the monthly monitoring meeting which is attended by key people currently employed by the NHS and Council. These working relationships enable joint working to resolve complex situations. It is anticipated that the recommendations in this report will continue to strengthen integrated working relationships.

4.3 Walsall Together in its capacity of integrated care provider actively encourages and provides traction to service developments which actively promote robust integrated working. As such, the aim of this report will be to outline the recommendations (including enablers) which would deliver full integrated (or MDT working) such as a shared electronic record for ICS and the local health and social care system.

Opportunities

4.2. There is a clear opportunity to develop existing and future practice within ICS with a longer term focus around striving for best in class locally. Hospital discharge and community service guidance provides a clear framework around how community and voluntary organisations can actively support the Intermediate Care Service and wider health and social care system e.g. individuals who are discharged home without care and support needs (known as Pathway 0).

[3] https://local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

The review has also identified that there must be dedicated focus on the development of independent sector provider relationships to the point that they become equal partners e.g. their regular participation in MDT meetings and presence at discharge hubs. Commissioners have begun to meet with provider's on an individual basis and thereby understand their challenges and issues present at an individual provider level and also deal with issues before they escalate.

4.3. Having reviewed current Pathway 2 and 3 arrangements it is clear that the current arrangements are limited. The current offer of 14 beds across two nursing homes does not provide a sufficient range of options for patients who cannot return to their own home upon discharge. This is evidenced by the high proportion of individuals who are placed into bedded provision on a spot purchase basis and the ratio of block to spot placement has varied significantly during the past 12 months. Initial conversations with procurement colleagues have indicated that hybrid commissioning arrangements (e.g. retainer fees rather than 100% funding for unoccupied beds) could be developed. This will be further considered in the recommendations section of the report.

4.4. There is a clear opportunity to improve the efficiency of the service including the independent sector through promotion and incentivising the use of technology. An example is technology enabled care (TEC) which elsewhere enables independent sector providers to monitor care delivery and thereby measure outcomes through their PCs. The CQC have developed their inspection regime to accommodate the use of electronic care monitoring (ECM) systems and a number of the contracted domiciliary care providers use ECM systems but the potential of this functionality (e.g. remote system access for the provider and/or commissioner) is not currently being maximised by ICS and commissioners.

4.5. The complexity of the service results in the operating model also being complex. The reporting requirements that a SLA will outline have also evolved including the requirement for individual level outcome reporting which is expected to be mandated early in 2023. These future requirements present an opportunity which is being explored through a data, systems and performance sub-group and we also need to be aware of the likelihood that Integrated Care System level inspections are regularly undertaken by the regulator, Care Quality Commission (CQC).

5. Weaknesses and threats (ICS)

<u>Weaknesses</u>

5.1. The ICS is a hugely complicated and time intensive service which requires full time focussed leadership which includes horizon scanning, planning and workforce development. Although the management team have performed admirably particularly during the Covid pandemic period it has become apparent that a 'Head of Intermediate Care' role with a 100% focus on ICS must be implemented as a matter of urgency. This issue will form a recommendation.

5.2. Following the integration of the ICS in 2017 the staffing resource within the service has not transferred as anticipated. For example, the number of FTE staff within the therapy function remains depleted despite increasing demand and unforeseen pressures caused by Covid and also the termination of the falls prevention service. Any significant staffing assignment decisions cannot be made in isolation and must be jointly made by the ICS management team going forward with regular updates to the ICS monitoring meeting.

5.3. It is also evident that multiple factors have impacted upon ICS' ability to establish MDT working as custom and practice in line with the High Impact Change Model's exemplary standard. At this time there are pockets of effective multi-disciplinary working but this is not the default position. This situation is not isolated to ICS as the review has established that

this situation exists across the wider health and social care system including MDT working between the ICS front door (i.e. ICS Nurses and managers) and wider NHS colleagues e.g. Frail Elderly Service (FES). It is also the case that Walsall people are regularly admitted into 'out of Borough' hospitals e.g. New Cross or Good Hope Hospital. These alternative hospitals have different ways of working which do not necessarily align to the local operating model.

Threats

5.4. There continues to be a threat which is linked to the wider job market (which is currently buoyant) as we exit the Covid pandemic period and sectors like retail and entertainment completely re-open for business and thereby begin to advertise for employees. All of these sectors are conscious of this competition for employment and we are now seeing examples of monetary and other types of incentive. During Covid the Department of Health and Social Care (DHSC) paused their national campaign to promote working in adult social care and although that is being re-started it will take time to have a meaningful impact. Independent sector care home providers have also started to introduce high value '*golden hellos*' to Registered Nurses (RMNs and RNs) which represents a threat to WHT and thereby ICS in terms of the recruitment and retention of Nurse's.

5.5. A move towards full integration and therefore consistency of working practice will be challenging as Council and NHS staff currently work very differently in terms of flexible working. The ICS will need to strike a balance between flexible arrangements and meeting business needs. Furthermore, there is a requirement to move towards full 7 day working and this will inevitably lead to a complex management of change process with the associated risk of staff turnover.

5.6. The key role that independent sector provider's play in the delivery of the ICS is under threat from a nationwide issue relating to carer shortages due to job fatigue, a vibrant wider job market and a number of other factors. This shortage of carers could be further exacerbated by a DHSC requirement for all carers to be fully vaccinated against Covid-19 from 11th November 2021. A local shortage of carers has already reduced the number of people who are discharged home and this situation has the potential to continue into the Winter period and thereby further erode the Home First ethos which has been developed and maintained within the ICS and at Walsall Manor hospital. Furthermore, a greater reliance upon the use of bedded provision will invariably result in a significant overspend against the ICS budget as care home placements are generally more costly than reablement in the community or DH2A packages of care and support.

6. Commissioned services (ICS) – current and future arrangements

6.1. The review has identified that the commissioned services which ICS is able to access needs to be re-evaluated in the light of changes to the hospital discharge and community response guidance, the impact of Covid and following close consideration of wider good practice.

It is anticipated that the development of commissioning arrangements will lead to alternative arrangements taking effect during the 2022/23 financial year in line with High Impact Change Model principle 8 '*Focus on what works using research, emerging and established evidence and lessons learned*'. This will allow sufficient lead for tender development and reflects the fact that there is likely to be a difficult Winter ahead. However, the associated planning including benchmarking and reviewing of good practice etc. has already begun and a multi-disciplinary working group for tender development will commence in September 2021.

6.2. Pathway 0 (Discharged without care and support needs)

No current commissioned service but the potential around a pilot (funded through BCF) as proof of concept will form part of the ICS transition plan. The associated guidance indicates that each health and social care system offer should include the community/voluntary sector.

6.3. Pathway 1 (Reablement in the community and Discharge Home To Assess (DH2A)

This is currently delivered through a combination of contracted providers and spot purchased packages due to increasing numbers of people being discharged home. Time and task continues to be the default position which can partly be attributed to the standard rate (see table below) being payable on a per package basis. The comparatively low independent sector hourly rate (see Table B below) combined with high staff turnover rate for carers will not stimulate an operating environment where providers feel able to adequately invest in recruitment and retention (including contracted hours for carers) including training and development. Associated provider investment would develop the associated roles to establish reablement caring as a vocation. It must also be considered that bordering Authorities and systems are engaging in commissioning activity which impacts upon local capacity e.g. Staffordshire County Council have recently let a high value contract for reablement across the County. As such, our bordering Authorities are actively tendering for reablement and hospital avoidance work which impacts upon the recruitment and retention of contracted Walsall providers in terms of local carers particularly if care staff can receive a higher hourly rate "in another patch".

There is also development work to do in terms of the culture across the service so that independent sector providers are viewed as equal partners e.g. present at the discharge hub (Swindon), access to the Council's care management system (East Sussex) or independent sector staff acting as trusted assessors in the community (Swindon and Somerset). This change would require both a culture shift and investment in order to deliver a training and development offer across the ICS. Procurement advice is pending in regard to the notice period for existing reablement in the community contracts as this could affect the necessary change more quickly.

Pathway 1	Hourly rate for
Authority	Reablement/DH2A
Birmingham	£16.28
Dudley	£17.00
Sandwell	£15.16*
Staffordshire	£17.36
Walsall	**£15.57**
Wolverhampton	£17.22 - £17.44
*Sandwell is predominately in house reablement	

Table B: Hourly reablement rate (bordering LA's)

Average number of P1 referrals per week (FY 2021)	
Pathway 1	Discharges
Community reablement	37
Non-weight bearing (NWB)	3
Discharge Home To Assess	25
Total	65

Table C: Average number of P1 discharges p.w. (FY 2021/22 to date)

As we can see in table C above the 'Average number of P1 referrals per week' has been around 43% (28) of individuals did not have reablement potential and/or required a period of recovery following discharge during FY 2021/22 to date. As such, it could be reasonably argued that there are two pathways within Pathway 1: these being recovery (including non-weight bearing) generally known as 'Discharge Home To Assess' (DH2A) followed by reablement.

In the short term it will be necessary to tender for two providers who can demonstrate that they can both cover the entire Borough including the difficult to reach areas and also recruit and retain carers. Following completion of the tender exercise (which will be scored in line with an agreed criteria) the successful provider's will begin to provider additional reablement in the community as soon as possible. Despite a significant increase in Pathway 1 referrals the budget for Pathway 1 reduced from £1,903,888 in 19/20 to £1,626,768 in 20/21 and will remain at this level for 21/22 despite the hourly P1 rate increasing following the annual fee review process. The Pathway 1 budget was £750,000 overspent for 20/21 financial year.

6.4. Pathway 2 (Rehabilitation in bedded setting)

The current bedded offer of 14 Pathway 2 beds across two nursing homes has provided consistent capacity of dedicated block beds but does not deliver the good practice model of

rehabilitative care e.g. access to a kitchen, flight of stairs and specialist rehab equipment ideally on a unitised basis; Reablement Key Workers undertaking exercise classes rather than a dedicated team at the care home. However, at this juncture and approaching the Winter period a pragmatic approach is required. As such, permission has been requested to extend the current contract for these 14 beds until 31st March 2022. In the interim, commissioners will actively work (including regular meetings) with the providers to implement an admission criteria e.g. agreed arrival time windows for new placements. It is anticipated that 18 x Pathway 2 beds will be required in the future with the potential for alternative commissioned services e.g. shared lives and extra care could be piloted during FY 2022/23.

6.5. Pathway 3 (complex including DST in bedded setting)

There is a high proportion of individuals who are placed into bedded provision on a spot purchase basis. Although the associated average rate for spot placements has reduced during the current financial year (predominately due to an abundance of supply in the local market) continuing to spot purchase for Pathway 3 placements is not sustainable and does not deliver the best outcomes for individuals. A more formalised commissioned arrangement including service specification, eligibility criteria and assessment tool to establish a rate for very complex care and support needs is recommended. The average rate for nursing complex is in excess of £1k per week but this has reduced during the current financial year probably as a result of significant capacity (vacant beds) in local care homes following the Covid pandemic period. However, due to increasing staffing costs (e.g. staff leaving due to mandatory vaccination) it is likely these rates will increase as we move into the Winter period.

6.6. Pathway 2 & 3 combined (bedded provision)

The budget for Pathway 2 & 3 in 2021/22 is £1,636,000 of which £578,500 was committed to fund the 14 block Pathway 2 beds. This leaves a remaining £1,057,500 for spot purchased Pathway 3 beds and any required Pathway 2 spot purchases. This amount would purchase around 6 beds per week (or an average of 28 active placements per week) based on an average length of stay of 28 days at a bed rate of £900.00 per week. The general rule of thumb for P2 and P3 discharges has been two P2 and ten P3 per week although this has been impacted in recent weeks by a reduction in Pathway 1 discharges due to a shortage of capacity in the domiciliary care market. The P2 & P3 budget overspend in 20/21 was £2,948,580 predominately due to the length of stay being impacted during the Covid pandemic period and an unknown number of bedded placements required due to requests from family and/or representatives as a result of the associated Covid risk in the community.

Spot Plmts (p.w.)	Average active spot plmts (p.w.)	P2 beds (Block)	Average total beds	Average Length of Stay	P2 block spend (without in year increase)	Per annum	Total (P2 & P3) beds	21/22 Budget (P2 & P3)	Overspend
12	48	14	62	4 weeks	£578,500.00	£1,914,580.80	£2,493,080.80	£1,636,000.00	-£857,080.80
11	44	14	58	4 weeks	£578,500.00	£1,755,032.40	£2,333,532.40	£1,636,000.00	-£697,532.40
10	40	14	54	4 weeks	£578,500.00	£1,595,484.00	£2,173,984.00	£1,636,000.00	-£537,984.00
9	36	14	50	4 weeks	£578,500.00	£1,435,935.60	£2,014,435.60	£1,636,000.00	-£378,435.60
8	32	14	46	4 weeks	£578,500.00	£1,276,387.20	£1,854,887.20	£1,636,000.00	-£218,887.20

Table D: Spot purchased placement and combined P2 & P3 projected spend model

The predicted overspend against ICS budget for bedded provision is recorded on the ICS risk and issues log and rated as high risk and updates will be provided monthly to the ICS monitoring group and then the JCC. The overspend must also be viewed in the wider context of the adult social market presently (e.g. widespread recruitment and retention issues) and as we move into the Winter when it is likely these issues will become even more profound.

7. Recommendations – to be monitored through a ICS transition plan (Appendix 3)

7.1. Workforce resilience

7.1.1 It is recommended the service provider, namely WHT is required to ensure that there is a dedicated 'Head of Intermediate Care' in post with no other roles or responsibilities within their portfolio. If WHT is not able to agree to this requirement then it is recommended that the service provider would need to actively recruit to a 'Head of Intermediate Care' post or equivalent – **this post is currently funded on the basis that it is a standalone role.** The establishment of a Head of Intermediate Care role would enable the post holder the time to focus on strategic and operational oversight including sufficient time (including planning) with the management team to provide a concentrated focus on the delivery of a high performing Intermediate Care Service for the people of Walsall.

7.1.2 The review has identified that the current staffing structure will need to be adjusted to meet the increased demand including the increasing proportion of people returning home to the community with complex needs. It is commonly accepted that the workforce is an organisations biggest asset and workforce development is currently one of NHS England and NHS Improvements key areas of focus in regard to Discharge to Assess across the Country. As such, this review recommends that a robust workforce plan actively considers the ICS team's health and wellbeing (including the potential impact of management of change) and also their continuing professional development from 22/23 onwards.

The review has also identified that there is no training budget for ICS and this situation needs to be remedied in the short term to enable professional development across the service and thereby promote staff retention at a time that Intermediate Care Services are actively being developed in other systems and remuneration levels are being adjusted accordingly. This review would be informed by an evaluation of predicted demand (provided by business analysts) and also due consideration of the impact of changes to the revised operating model e.g. the location of the assessment for Pathway 1 - the initial assessment is currently undertaken in the hospital.

It is recommended that the fully considered workforce proposal will include consistency of job title(s) and also define roles and responsibilities including stipulations around which roles require which professional qualifications and/or experience. The workforce planning exercise will also develop a management of change process with a view to adopting 7 day working across the service and also develop a timeline for evaluating the potential around parity of conditions e.g. flexible in line with business needs. It is further recommended that the proposed ICS staff structure and workforce plan is presented to the ICS monitoring group in the first instance for discussion and approval before being presented at Walsall Together SMT for consideration and ratification by 31st March 2022 unless the Head of Intermediate Care post has to be advertised in which case the timeline would be adjusted accordingly.

Recommendation 1: 'Head of Intermediate Care' role to be formalised as an integrated role to be implemented or advertised by 1st April 2022.

Recommendation 2: Development of proposed integrated staff structure and costed workforce plan (including professional development) by 31st March 2022 or 30th September 2022

7.2. Financial resilience

7.2.1 The review has identified that the ICS budget has been overspent for the previous two financial years (19/20 & 20/21). Whilst FY 20/21 was significantly impacted by the Covid pandemic period there is consensus that the ICS must operate within the financial envelope that it has available. However, this envelope must be informed by predicted demand and ideally with due consideration of the local cost of care for the independent sector which is

currently being impacted upon by multiple complex issues. As such, it is recommended that the budget setting process is more reflective of predicted demand and market conditions and better connected to ICS budget management oversight and mitigation.

7.2.2 There are significant numbers of complex care and support packages which require a period of recovery before assessment. As such, there is a clear need to commission block beds rather than spot purchase particularly as the length of stay is generally longer than the average. This commissioning arrangement would need to be creative rather than a standard block where beds are fully funded irrespective of occupancy. As these beds would regularly be used for DSTs (pending Continuing HealthCare assessments) placements weekly demand is difficult to predict and it is a similar story for complex care including delirium which is linked to a deterioration in physical health and therefore requires a period of recovery. Following conversations with data analysis colleagues it was established that the ICS dashboard is in the process of being re-designed. It is therefore recommended that the new iteration of the dashboard will enable reporting upon recovery period(s) and this will thereby enhance performance reporting and further inform the development of risk share arrangements with CCG partners.

Recommendation 3: The adjustment of the budget setting process including risk share agreement in line with predicted demand

Recommendation 4: The establishment of a recovery pathway with associated budget line

7.3 Operational resilience

7.3.1 Pathway 1

It is intended that a short term block arrangement totalling 700 hours will commence in September 2021 for an initial 12 week (up to 24 weeks) period. This contract will be delivered by two providers in order to facilitate Borough wide coverage. It is also intended that one of these providers will test a more outcome based model in line a reablement ethos in order to shape the future Pathway 1 commissioned service. There will also be expression of interest issued to contracted reablement in the community providers for a block contract over the Winter 21/22 period up to the value of £50k.

There must be a distinction drawn between reablement in the community and DH2A in terms of the initial assessment and brokerage process and therefore the information distributed to the care provider as the tasks, goals or outcomes will be different.

The average number of referrals for the first 8 weeks of FY 21/22 was 65 per week of which 28 required a period of recovery including Non-weight Bearing and delirium. The 21/22 budget for Pathway 1 funds around 2000 hours per week which equates to around 129 care and support packages based on 14 hours per package, per week. In order to maintain spend on P1 in line with the budget the average length of stay would need to be around 14 days for reablement in the community and DH2A (including recovery). It is recommended that the budget setting process for 22/23 is based on analysis of the first quarter of 21/22 including step up (admission avoidance) referrals which will inevitably increase and step down (from P2). This budget would also be separated into two separate budget lines: recovery and reablement and with due consideration of the local cost of domiciliary care and support.

7.3.2 Pathway 2 (rehabilitation beds)

It is intended that the current block contract for 14 x Pathway 2 (currently known as transitional beds) contract will be extended until 31st March 2022. This review has identified that 18 x P2 beds is the indicative number of P2 beds required as there has been regular spot purchasing of rehabilitation beds (i.e. outside of the block beds) during the past two financial years.

7.3.3. Pathway 3 (complex beds including DSTs)

Based on analysis of demand for the first quarter of 21/22 and a continued reduction in Pathway 3 placements the required budget for 32 active P3 placements per week is estimated to be £1,854,887.20 (see Table D above).

It is intended that 6 x P3 beds will be commissioned on a time limited basis through Winter Pressures funding up to the value of £98k over 16 weeks. This would provide useful market testing information which would be used to inform the subsequent tender process for commissioned Pathway 3 options from 1st April 2022 onwards. It is proposed that the Pathway 3 beds are tendered for on a hybrid block basis (retainer fee of £50 per night) rather that 100% payment for a vacant bed. An assessment tool will be used to determine the rate for very complex needs as opposed to current process where the provider in effect sets the rate.

7.3.4. Pathway 2 & 3 combined (bedded provision)

It is recommended that the required number of Pathway 2 & 3 beds is 50 in total. It is anticipated that these beds would be split by 18 x Pathway 2 beds and 32 x Pathway 3 beds. This would represent a significant increase of 13 beds to the 37 total beds which are currently budgeted for. Using the same method (£800 p.w. x 50 beds x 52.14 weeks) to calculate the budget based on 50 beds the 21/22 budget would have been set at c.£2m. As such, it is recommended that the budget setting process needs to be re-evaluated and thereby linked to predicted demand with due consideration of the local cost of care including complex care.

Multi-disciplinary Team (MDT) working

7.3.5. The review has identified that consistent MDT working has not been achieved to date and the major blocker to this is the fact that there is not a shared record which is accessible by every function within the ICS. Along with full integration of the different systems that are used across the local healthcare providers (e.g. Medway, Total Mobile, Rio) it is intended that the shared system will also interface with the electronic systems used by reablement providers (to actively evaluate and measure outcomes) in the medium term.

As the ICS (including the independent sector) are not working in isolation all aspects of the wraparound support across health and social care including primary care must be delivered in line with the 'High Impact Change Model' principle of 'Right care, right time, right place' e.g. Walsall's Rapid Response is now operating until Midnight on week days. The review has established that the local Community Nursing team is operating at around 75% of capacity due to vacancies and the physiotherapy function within ICS is managing a caseload that has been unmanageable for a prolonged period of time. For physiotherapy it is likely that this will a re-setting of the operating model which sets a maximum caseload in line with KPI targets around visits and case management. In the medium term the SLA will provide a framework for a key professional being identified for each individual and this professional actively leading the respective MDT process.

It is intended that a comprehensive MDT process for ICS is outlined within the SLA and the monitoring of the associated MDT practice will be actively monitored through key performance indicator measurement overseen by the ICS monitoring group.

Recommendation 5: Outcome based commissioned pilots during 21/22 to shape future longer term commissioned services to be implemented in 22/23 financial year

Recommendation 6: Implementation of 'exemplary' MDT practice across ICS by 1st October 2022