# Darlington

# Intermediate Care Review (RIACT & Reablement)

Summary Report v3 - DRAFT

July 2017

# Contents

# SUMMARY REPORT

In this summary report we have set out the scope and methodology for the review we completed, along with the main observations, conclusions and recommendations based various discussions with members of staff and access to a number of documents.

The scope of the review included a number of services, namely the RIACT Service with its social care and health components, the in-house Reablement Service, the Reablement Service provided by external providers, Spot beds, Short Break Stay beds and Vane House Resource Centre.

# 1. Scope and methodology for the review of the RIACT and Reablement Services

GPA were engaged to undertake an independent evaluation of the performance and operation of Darlington's Responsive Integrated Assessment Care Team (RIACT) and the Reablement Service.

The RIACT team is jointly operated with staff from Darlington Council (DC) and County Durham and Darlington NHS Foundation Trust (CDDFT), to provide a single point of referral and triage within Darlington for intermediate care and reablement services, and the staff also provide support in a variety of locations. To define the scope of this review a table was devised to show the services and locations served or supported by staff from within RIACT and the Reablement Service. However, as a result of discussions onsite with local staff it became clear that

- Eastbourne Care Home:
    - It is understood that designated beds are funded by the CCG within this home and these are supported by RIACT health staff members.
    - In addition, DC commission spot beds and short break stay beds in this location. Social care staff do complete assessments with people during their admission but the DC therapy staff within RIACT do not provide any direct therapy support.
- Ventress Hall:
    - It is understood that designated beds are funded by the CCG within this home and RIACT health staff help facilitate discharge.
    - Although NHS RIACT staff did historically provide support for patients within Ventress Hall, it is understood that this was on a good-will basis since there was no contract for this work. Therefore, it is understood that the funding CCG have instructed CDDFT not to provide any further support.
    - Members of the Social Care therapy team within RIACT do support clients within Ventress with assessments to facilitate their discharge

home, but members of the in-house Reablement Service do not support these people in the care home.

  - In addition, DC commission spot beds and short break beds in this location. DC therapy staff within RIACT do undertake assessments of people in these beds to help facilitate discharge back to their homes.

- Richardson and Sedgefield Community Hospitals:

  - Both of these community hospitals are understood to be located outside DC's geographic boundaries. It is also understood that whilst CDDFT staff from within RIACT do provide some input to people in these two locations, the beds are actually funded by a CCG

  - Social care staff complete assessments of people in these locations but they do not provide direct input.

- Vane House Resource Centre:

  - The service in Vane House supports people from Darlington with sensory disabilities but neither CDDFT or DC staff from RIACT or the Reablement service support people in this location.

- Spot Beds

  - It is understood that whilst CDDFT RIACT staff may support people in some of these beds, the actual beds are funded from a pooled BCF budget.

  - Social care staff complete assessments of people in these locations but they do not provide direct input.

Therefore, the following table illustrates the amended scope of the review of the RIACT and Reablement Services

| Funding / Staffed | SERVICE DESCRIPTION | SERVICE SETTING | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Care homes | | Community Hospitals | | Vane House Resource Centre | Spot purchase beds cluster | Client's Home | | |
| | | Hundens Lane | Eastbourne | Ventress Hall | Richardson Community Hospital | Sedgefield Community Hospital | | | In-house Service | Private providers: Framework | Private providers: Off-framework |
| Joint | Triage | x | | | | | | | | | |
| Health | Rehabilitation | | | | | | | | | | |
| | Beds | | x | | | | | | | | |
| | Nursing team | | | | x | x | | | x | | |
| | Therapy team | | x | | | | | x | x | | |
| Social Care | Reablement | | | | | | | | | | |
| | Spot Beds | | x | x | | | | x | | | |
| | Short Break Stay Beds | | x | x | | | | x | | | |
| | Domiciliary team | | | | | | | | x | x | x |
| | Therapy team | | | x | | | | x | x | | |
| | Sensory impairment reablement | | | | | | x | | | | |

The review was to cover all aspects of the services, including processes, pathways, skills, culture and structures.

The review included access to background information and a number of discussions with key individuals from DC and CDDFT to explore a range of topics. This pre-visit information was to be provided at least 7 days prior to the planned visit to allow for adequate preparation and planning. The majority of these discussions, which took place on 10th, 11th and 12th January 2017, were focused on issues that had arisen from the pre-visit information and our knowledge of services across the country.

## 2. Limitations of the review

As outlined above, a schedule of information requirements was submitted for each of the component services and all pre-visit information was to be received at least 7 days prior to the planned visit dates. Unfortunately no background information was received from CDDFT until the onsite visit was underway, and then the data received was very limited in terms of its scope and depth. This hindered any ability to pre-plan in detail the exploratory sessions with CDDFT staff members.

It was planned and agreed that meetings with DC and CDDFT staff would take approximately 1 ½ days for each organisation. However, as a result of the non-availability of some staff due to operational imperatives, and the view by CDDFT that no further detail would be gained from meeting some of the proposed attendees, the meetings with CDDFT staff were contracted into less than ¾ of a day.

In both cases, data and information of case activity, etc. was not as detailed as requested or as comprehensive as seen in some other reviews we have undertaken. This is not uncommon, and DC were able to provide some anonymised activity data at client level for their services. However, no detailed anonymised activity data at client / patient level was received from CDDFT.

The limitations or absence of data and information from CDDFT means that the observations and recommendations for these components of the overall service are limited when compared with those for the components provided or commissioned by DC.

Finally, in common with reviews of other integrated services, it was not possible to track people between organisations to determine whether, and if so to what extent, participation appropriately prevented or reduced the need for support or care from other parts of the integrated service.

## 3. Main findings

In any review of this type it is clearly important to focus on those areas which require further investigation or action to improve operational performance, effectiveness and cost effectiveness, but it is also important to acknowledge that much is also good.

As can be seen from the RIACT central team, it appears to work well with a combination of social care and health staff working alongside each other to

appropriately manage the demands of the people of Darlington from a variety of settings. Based on discussions with staff from both organisations and descriptions of the working practices, this team is able to try and ensure that the most appropriate support or care is offered to individuals to meet their needs.

As outlined above, the depth of analysis possible for each service, and hence conclusions and recommendations, has been directly linked to the availability of information. The conclusions section within the full report contains a number of recommendations for each service but the more important items are summarised below.

## *3.1 Items common to all services*

Other than service specifications for the designated intermediate care / step-down beds at both Eastbourne and Ventress Care homes, we did not see specifications for any of the other services. These are essential because they set the purpose, focus and priorities for a service, how its fits into the wider picture of services, how it is to operate, the source for its referrals and response times. It should also set out the performance levels required if the service is to meet local demand and deliver the effective and cost effective services required.

We have not seen nor gained any sense of there being a comprehensive set of management and operating performance reports for any of the service that would enable managers at all levels to understand how the services are performing and to highlight areas for further investigation. These need to reflect what information is needed to operate the service, and include month and year to date information along with budgets / targets and outturn data where applicable.

Despite staff costs commonly representing over 95% of service costs, there does not appear to be any information available on the uses of paid time in terms of how much is actually in contact with clients / patients as opposed to travel, down time etc. The proportion of contact time is obviously important in reabling services because it will have a material impact on outcomes, effectiveness and cost effectiveness.

The absence of outcomes data for virtually every service has meant that it has been difficult to impossible, in some cases, to consider the extent to which individual services have been effective in reducing the need for ongoing support or care.

This review has been complex in that it includes services operated by both social care and health. However, it has not been possible to track people using subsequent longer-term services within social care or health to establish whether, and if so to what extent, their participation in reabling services has reduced their need for ongoing support and how long this may have lasted. This is needed to consider the extent to which a service is cost effective.

In addition to these common points the service specific items are as follows:

## *3.2 CDDFT's Team in RIACT*

The CDDFT section of the central RIACT function contains therapists, nurses, generic assistant practitioners, healthcare assistants and administration staff. It is understood that this team perform two functions within CDDFT, namely they provide an intermediate care service as well as the community nursing and therapy service.

In comparison with DC staff within the central RIACT function, those from CDDFT are understood to also support services and locations that fall outside of the scoped range of services for this review because they are the intermediate care and community health service team of CDDFT.

Through discussions and subsequent information received, we understand that although some intermediate care cases (e.g. domiciliary, spot beds and beds at Eastbourne) require a high level of support, with some domiciliary cases requiring up to 4 calls a day by a Health Care Assistant, compared with non-intermediate care cases who may 'only' require weekly input, at a caseload level the intermediate care cases account for only 1/16 th (6.3%) of the total caseload. However, this very small proportion account for approximately 50% of the contacts for the team.

## *3.3 Darlington Council's Therapy Team in RIACT*

Three Occupational Therapists from DC are members of the joint RIACT team at Hunden Lane, and it is understood that they work exclusively with people passing through the reablement service and that no other members of the DC Therapy team work with these people during any reablement phase.

All referrals to RIACT are assessed as to whether their primary need is of a social care or health nature, resulting in the appropriate team undertaking an assessment with the person.

Unless considered urgent, it is understood that if the referral relates to a person in an acute bed, designated bed in Eastbourne or Ventress, or a spot bed then the target response time for an assessment is the next day, otherwise the target is within 7 days, which seems lengthy.

It is understood that the members of this team principally undertake assessments for equipment and aids to daily living, whilst adaptations are dealt with by the long-term team. It was understood that if the subsequent service is to be provided by the in-house team then the OT can complete this assessment but if it is to be completed by an external provider then it must be completed by a Social Worker or Community Assessment Officer.

It was also understood that the attendance of the OT staff at the twice weekly review meeting of reablement cases with the in-house team and external providers allows them to give advice on individual cases and pick-up any general themes that are emerging that may require further training or guidance. However, we did not gain any sense from the various discussions or the information provided that this team provides any material hands-on therapy input with clients as they complete their reablement phase.

In many services elsewhere, assessments for and the supply of routine aids to daily living / community equipment are undertaken by trained members of the reablement team (trusted assessors as recognised by the College of OT) rather than using the relatively expensive OT resource. This allows the trained therapists to focus on complex equipment and aids, and helping to support those clients with more complex reablement and therapy needs.

## *3.4 Reablement Service: in-house*

Experience elsewhere shows that if support plans are based on an assessment of a person's needs whilst they are in hospital or any location other than the one they are to be reabled in, then they will have limited relevance. The reablement support plan and schedule of tasks need to reflect the person's abilities within the environment they live. Therefore, consideration should be given to trialling the completion of scored functional assessments in the client's home and using these to guide the reablement work.

The only available information on outcomes was based on a manual exercise completed for this review and although the caseload was materially different to that reported by the care management systems, it indicated that only 29% of people left the service having regained their independence. If correct, this level is very low, if not the lowest, seen in services elsewhere: many are achieving 50% to 60%. It is also complicated by the fact that we understand a needs based criteria is not applied on entry to the services. Therefore, in the absence of reablement, some of these people (the comparatively very low level of 29% leaving having regained independence) may not have 'qualified' for an ongoing service, and so their participation may not have prevented ongoing demand anyway.

The high rate of discharge within the early weeks, a material number of cases with gaps in the continuity of their support over their time with the service, and the fact that over 60% of cases experienced either one or more weeks of 15 minute calls a day, or weeks during which the average duration of their calls were 20 minutes or less raises concerns about the extent to which a reabling approach has been adopted.

Based on hours recorded over a 7 month period, it is estimated that contact time with clients was only 24% of paid hours. This is one of the lowest levels seen in services reviewed to date. If the service were to improve its utilisation rate to 50%, and even if it virtually double its contact time with each client passing through in its efforts to improve performance, it could accommodate more cases and potentially remove or at least reduce the need for Darlington to engage with external providers for this service.

## *3.5 Reablement Service: external providers*

It is understood that at times of inadequate capacity with the in-house service, cases are placed with external providers who are either on a framework agreement or, in the absence of capacity, off-framework. Although we are aware of a requirement on them to work in a reabling way, their staff are not trained or skilled in reablement and

they mix working with reablement and maintenance homecare clients. Evidence from elsewhere indicates that they are highly unlikely to be operating in a reabling way.

This is accompanied by a high rate of discharge in the early weeks and absence of any data to evidence effectiveness. Anecdotally it was felt that most people placed with these providers go on to long-term support packages with the same provider.

Unsurprisingly, the average cost per case for those placed with external providers is significantly lower than the cost of the in-house service despite what appears to be a higher average number of hours per case. However, the absence of any information on outcomes means that this, and any implications, need to be considered carefully. Greater clarity is needed on performance and either a reduced reliance on external providers to provide reablement or a requirement and ability to ensure that they deliver a reabling service.

### *3.6 Spot Beds*

Based on experiences elsewhere, and from our own experience of managing care homes, we remain concerned that they are rarely an appropriate setting for the delivery of a reabling service. Their layout, facilities, staff training and competencies and even business model are not compatible with this approach. Further, the fact that beds are taken in a variety of care homes means that only a few will have received any credible volume of cases for them to have gained any real experience of working with people with this different type of need.

Given the year on year increase in demand for spot beds, the average occupancy for the current year has been 11 cases per month, with an average length of stay of 18 days. Therefore, consideration should be given to the appropriateness and opportunities to commission a block of core beds in one location. This should improve outcomes and potentially reduce costs. If it were possible to engage with a new provider or additional capacity in an existing provider, this would also reduce the competition between spot beds, SBS beds and the demand for ongoing long-term residential care from the council and self-payers for the same pool of beds.

### *3.7 Vane House*

The level of information available for this service was very limited and so it has not been possible to reach any conclusion on its effectiveness or cost effectiveness.

## 4. Key recommendations

The full report contained 45 recommendations covering all of the services included within the review. The absence of any detailed case level data on the central triage function, the services operated by CDDFT, and the limited data for the DC therapy team within RIACT mean that recommendations for these components are only included within those listed as being common to all services. Other than these, no other service specific recommendations were possible for these component services.

The following are the key recommendations:

## *4.1 Items common to all services*

4.1.1 There was an absence of service specifications: service specifications were only available for the Eastbourne and Ventress designated beds, and these were not comprehensive.

- Consider reablement specifications including specific performance levels (volumes, outcomes, average cost, etc) in support of what is needed to deliver each service

  The service specification for each service needs to link to

  documented pathways: showing how a person enters and passes through each service, who does what, when etc., and how the services complement each other, gaps, etc.

  skills and competency frameworks: which skills and competencies are <u>needed</u> for each role to deliver the required service and how these will be monitored in the field

4.1.2 No comprehensive operational performance and financial reports exist for any of the services

- Consider what is needed to manage and review the performance of each service – these are two separate functions that require different levels of data and timing
- Include targets and benchmarks for activity levels, outcomes, etc.
- Include measures that relate to the objectives / purpose of each service

4.1.3 No analysis of paid time for non-bed based services despite being > 95% of service costs. For instance, it was estimated that only 24% of paid time was actually spent in contact with clients by the Reablement service.

- Consider implementation of manual timesheets to gain an understanding of staff utilisation, time spent with clients and average time a client spends with the service
- Consider the appropriateness of a longer term solution, possibly electronic monitoring system, having gained an understanding of operational issues.

An understanding of how paid time is used is critical and this issue cannot await decisions about selection of a suitable system, implementation, etc.

## *4.2 Reablement in-house*

4.2.1 Assessment to help define the reablement plan

- Consider location in which assessment completed: undertake a functional assessment with the client in their 'home'

- Consider including a ‘score’ to assist gauging individual progress and overall service performance
- Consider ‘score’ on ability prior to crisis / event to inform on client’s perspective of what ‘return to normal’ means for them.

4.2.2 Outcomes appear low with only 29% of cases requiring no ongoing support, apparent gaps in continuity of packages, high level of 15 to 20 minute calls, high ‘discharge’ rate in early weeks, available data indicates low staff utilisation rate

- Consider manual time sheets to understand components of paid time, staff utilisation rates, contact time per client and how it changes over duration, etc.
- Consider a sample of cases with low call durations: were they being reabled, should they have been moved on?
- Consider a sample of cases leaving in early weeks: were they being reabled, should they have been referred to the service?

## *4.3 Reablement external providers*

4.3.1 Similar outcome issues as seen with in-house team, plus

- Consider need for external providers if in-house team improves staff utilisation rates, outcomes, etc.
- Consider specific reablement specification with appropriate monitoring of performance and outcomes (not just contract compliance)
- Consider providers who can offer dedicated trained staff

## *4.4 Spot Beds*

4.4.1 Care homes are unlikely to be able to provide active reablement, outcome performance varied with an average of only 37% of clients not requiring ongoing support, financial and activity data did not allow average cost to be compared

- Consider role of spot beds and their ability and suitability to deliver reablement
- Consider a specific reablement specification with appropriate monitoring of performance and outcomes (not just contract compliance)
- Consider a sample of cases and costs to determine effectiveness and cost effectiveness, and reduce the range in outcome performance across the ‘top’ 5 care homes
- Consider benefits of and scope for establishing core grouped beds to improve outcomes

## 5. Improvement Plan

Based on the recommendations contained within the full report we would strongly advise that an improvement plan be developed with clear responsibilities, completion dates, milestones and outcomes for each element. Further, the ensuing actions should be prioritised in terms of

- 1 month to resolve any base line issues
- 3 months to establish an understanding of paid time and outcomes
- 6 months to evidence capability to improve and achieve progress

Progress against the plan should be reviewed at least monthly until all elements are complete AND changes in performance are visible and measurable. After that, ongoing operational performance management should be used to ensure that improvements are sustained.

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