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Report on the assessment, criteria and discharge from Intermediate Care (IMC) and Transition provision

Healthwatch (HW) undertook IMC as a work stream to gain a better understanding of Intermediate Care (IMC) and Transition provision on Wirral. Feedback to Healthwatch raised the issue that patients, and their families, did not always know what was respite care, what was intermediate care and what was transition care.

HW wanted to establish if referrals are always appropriate for the patient.

HW would do this by:-

- establishing whether all professionals are using the same criteria for IMC and Transition beds
- learning about the Assessment and Criteria for IMC/Transition following discharge from hospital
- learning about the Assessment and Criteria for IMC/Transition following referral from home
- finding out whether all referrals to IMC and Transition are appropriate and best for the patient
- considering whether IMC or Transition in Care Homes is the best environment for the patient

Healthwatch believe that, together we should:-

- ❖ raise awareness about the need to better care for yourself
- ❖ highlight facts and fiction about services – giving a clear picture so people can make good choices
- ❖ ask people what they feel is good and not so good with health and social care services
- ❖ encourage people to take more responsibility for their own care

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This report is aimed at:-

- Members of the public
- Patients
- Carers
- Those who design and commission services for people
- Those who deliver front line services and support for people
- Regulators of services

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Table of Contents

What is intermediate Care/Transition provision 3

Terms of Reference 6

Introduction 7

Summary 8

Methods 9

Care Home Managers responses to questionnaire .. .. 10 – 18

Issues identified during visits to 6 providers of IMC 19

Conclusions and Recommendations 20

Glossary 21

Acknowledgements 22

Appendix 1 .. .. Workplan

Appendix 2 .. Information on alternative support in the community

What is Intermediate Care/Transition

What is intermediate care? (Ref. The National Audit of Intermediate Care Summary report 2014)

Intermediate care services are provided to patients, usually older people, after leaving hospital or when they are at risk of being sent to hospital. The services offer a link between places such as hospitals and people's homes, and between different areas of the health and social care system – Hospitals, community services, social care and GP's.

Intermediate care services are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less. They may last longer however if the needs of the patient dictate this. Intermediate care should be available to adults age 18 or over

What are the aims of intermediate care?
There are three main aims of intermediate care and they are to:
• Help people avoid going into hospital unnecessarily;
• Help people be as independent as possible after a stay in hospital; and
• Prevent people from having to move into a residential home until they really need to.

Where is intermediate care delivered?
Intermediate care services can be provided to people in different places, for example, in a community hospital, residential home or in people's own homes.

How is intermediate care delivered?
A variety of different professionals can deliver this type of specialised care, from nurses and therapists to social workers. The person or team providing the care plan will depend on the individual's needs at that time.

Bed based Intermediate Care in Wirral-

Settings - At the time of writing - service provided in six care homes (March 2016)

- Elderholme Care Home, Clatterbridge, Bebington.
- The Grove Care Home, Birkenhead.
- Daleside Care Home, Birkenhead.
- Hoylake Cottage Care Home, Hoylake.
- Leighton Court Care Home, Wallasey.
- Charlotte House, Bebington. (Winter pressure short contract)

Aiming –

To prevent unnecessary acute hospital admissions and premature admissions to long term care and/or to receive patients from acute hospital settings for rehabilitation and to support timely discharge from hospital.

To help people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing homecare support can be appropriately minimised.

Length of stay

Interventions for the majority of service users will last up to six weeks (though there will be individual exceptions)

Workforce

Multi-Disciplinary Teams but predominantly health professionals and carers in care home

Criteria for Intermediate Care Beds

Customers may access an intermediate care bed:

a) when they have an immediate rehabilitation need/potential. This may follow a loss of function, accident or other deterioration caused by a health need/episode. Therapy Assessments will need to clearly identify the potential for this and the goals to be achieved.
b) when they can participate cognitively and physically in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
c) when they are going in for planned elective surgery, where the likely need for rehabilitation has been established.
d) when there is clear evidence that the Individual aspires to return home
e) for up to a maximum of 6 weeks. It is the aim that the customer remains in the service as short as time as both clinically safe and practicable

Criteria for Transitional Care Beds

Customers may access a transitional care bed:

a) for a period of further recuperation before returning home following a health episode, hospital treatment or loss of function
b) for further assessment and planning post hospital discharge or due to a health episode where hospital avoidance/prevention is appropriate e.g. UTI or infection

c) when they are no longer in need of an acute bed but do require the benefit of a period of convalescence or rehab prior to moving home safely
d) when they are no longer in need of an acute bed but further assessment and/or care is required. This will be where the situation cannot be managed at home with support.

Specialist therapy input may or may not be required. As a minimum there is an expectation that people will participate in daily living skills as part of their care, rehabilitation and convalescence as reasonably practicable This includes those patients who:

a) are experiencing dementia with the ability to participate in a programme of therapy
b) may require preparation and support to access the next stage of their support journey

Transitional Care can be offered instead, or at the end, of intermediate care.

Reference sourced from Rapid Community Service Bed Provision Contract – Wirral Clinical Commissioning Group and Wirral Dept of Adult Social Services – September 2015

Terms of reference

This report will be shared widely with Commissioners and Providers, and regulators, placed on Healthwatch Wirral website and shared locally and nationally. It will be sent to other Healthwatch as well as local Scrutiny Committees.

The purpose of this project is to gain better knowledge of current provision of Intermediate Care and Transition Support provided for people at a time when they most need it. The intended outcome is to identify what works well, and not so well, in order to inform Commissioners of real time experiences and views, of patients, carers and staff to improve service design and delivery.

It was important that we understood what alternative support was available for patients at a time when they are due to be discharged from hospital, or at a time when hospital is not really a viable option.

It was important that we incorporated the skills of volunteers, and staff, whilst doing this work. We identified a small team of volunteers, who had received Enter & View Training, to carry out this project and utilised HWs statutory function of "Enter & View" to observe the IMC/Transition provision in the Community.

This report has been written by incorporating factual statistics and includes responses from the Professionals involved in IMC/Transition. The report also includes the HW Action Plan and a chart with the responses captured from the 6 Care Homes that provide IMC/Transition beds.

Introduction

The aim of the report is to:-

Gain a better understanding of the experiences and opinions of patients and professionals in relation to IMC/Transition. This includes finding out what is available in the community in terms of re-ablement and raising awareness of those services amongst professionals. HW will share the findings with Commissioners and Providers of these services to influence how services are designed and delivered.

HW will also share any information relating to IMC with the public to raise awareness ensuring people are informed about what is available and placing them at the centre of their own care.

Our objectives were to:-

- gain a better understanding of IMC
- have an independent view on how well the service is working
- identify good practice and make recommendations
- ascertain whether all professionals are using the same criteria for IMC and Transition beds
- learn about the assessment and Criteria for IMC/Transition following discharge from hospital, or a referral from home
- ascertain whether all referrals to IMC and Transition are appropriate and best for the patient
- Find out whether IMC or Transition in Care Homes is the best environment

Risks to the success of the project were ensuring that timeframes were realistic and that there were adequate resources to complete the work. HW also recognise that it is not always possible to speak with patients. With this in mind, the next steps will be to re-visit the Care Homes and focus on speaking with Patients and visitors – a further report will follow after these visits are complete. We also spoke with the Coordinator of IMC/Transition services, Karen Thomas, and asked if she would gain consent from patients who had recently been discharged so that they could be contacted by HW.

HW always strive to communicate in the appropriate manner.

Limitations to the scope of the project were the number of people required to conduct the visits. Therefore, we also conducted desk based enquiries and research.

Healthwatch Wirral will link this piece of work to Healthwatch England’s ‘Safely Home’ project which looks at what happens when people leave hospitals and care settings nationally.

Summary

The report contains the work plan (Appendix 1) written by staff and volunteers of Healthwatch. The report will share the findings of Healthwatch, during the 4 months allocated to carry out this work, with commissioners and providers of service and support.

Healthwatch Wirral spoke to the Manager and staff in the Homes where IMC/Transition beds are provided. This report will share findings on physio and OT provision and the general environment for the patients/residents.

The next phase will be to speak with patients about what the experience of IMC/Transition is really like. We will also contact patients who have recently been discharged from IMC/Transition to gather their views and opinions.

This report will be distributed widely to those mentioned earlier in this report and placed on our website.

Healthwatch Wirral were inspired by Healthwatch England's 'Safely Home' project which looks at what happens when people leave hospitals and care settings nationally.

Methods

Healthwatch utilised the remit of Enter & View to visit the 6 homes that provided IMC/Transition beds

We spoke with Staff, including Physios and OTs, within the Care homes looking at the environment, equipment and talking about what worked well and not so well. All Managers, or their deputy, were available and conversations were open and honest, based on their own experiences.

We aim to conduct further conversations with patients, recently discharged, who were keen to talk to us about their experiences. We will be conducting further visits to talk to patients who are currently in IMC/Transition beds and Care Homes have been contacted to let them know. Although dates for the visits are unannounced.

The questions asked of the Managers, or deputies, were compiled using the experience of people who had used the service and some professionals who had expressed an interest in supporting HW with this project.

The visits were held over 2 days and HW were welcomed and well received by all of the Providers.

Questionnaires (questions listed on the left hand side of the chart on page 10) were compiled and sent to identified professionals from DASS, Wirral Community Trust, Wirral University Hospital Trust and NHS Wirral who are involved in IMC provision. This was in an effort to learn about the provision, assessment process and criteria. We also asked about discharge procedures for IMC and Transitional beds, following discharge from hospital or referral from the patient's home.

A meeting was held with a professional from the Community Trust and a local GP to obtain information and gather their views of IMC provision in Wirral.

Healthwatch sent an introductory letter stating the purpose and objectives for each visit and a list of questions was sent to the home for the manager to complete prior to the visit. We also sent a poster and feedback box to enable staff and visitors to give their views.

Trained volunteers, known as Authorised Representatives, and Healthwatch Staff Team visited the 6 providers of Intermediate Care on 16th and 18th February 2016. They listened to staff, service users and visitors about their views and experiences of the service provided at each setting.

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Care Home Manager responses to questionnaire

	Elderholme	Hoylake	Grove	Daleside	Charlotte	Leighton
Do you provide a separate unit for IMC residents?	Yes	Yes	Yes	No, Daleside provides mixed accommodation for 21 IMC. 16 are Transitional and 5 IMC.	Yes, 28 beds Charlotte House is the Winter Pressure Project contracted to the end of March 2016. They have been asked to consider 12 beds on a permanent contract.	Yes, 12 IMC and 12 Transitional
Do you assess patients at the hospital prior to them being discharged to your care?	No	No	No	No	No The assessment is sent to the IMC professional hospital lead at Charlotte House who looks at the assessment and orders any equipment required	No
Do you receive correct information from the hospital or other healthcare professional about a person who is being referred to IMC?	Yes but do not regularly receive appropriate information relating to medicines or allergies. The Home have only recently been allowed to receive emails with information, previously these had to be faxed. The Home now take paper copies for	Yes, information received is a bit better. However, there is often personal information missing. The report received on the patient is hard to decipher and, often, contradictory. The new format listing needs/issues is not as good as the previous version.	Yes, but basic information is regularly missing. Patients are often referred to IMC who are, in the opinion of the Home, inappropriate referrals. Examples : A referral from WUTHFT were a SW, or Senior Manager, overruled an	No, information is often incorrect. There are often problems around medication also.	No, It is often incorrect	Not always, sometimes the paperwork does not accurately reflect the person referred to the homes care. ie no next of kin, no previous GP. The team who conduct the assessment at the hospital are not always nursing staff.

	Files		assessment resulting in an inappropriate referral. 80% of patients have cognitive impairment or behavioural issues. Sometimes the information says “Fall” – it is not clear whether the fall was a “trip” or whether there were other reasons for the fall.			
How long are IMC/Transition patients with you?	Patients often breach the 6 week allocation because they are poorly, the referral was in appropriate or their needs are complex	Any length of time maybe even 12 weeks. days can also be added onto the end of the 6 weeks – resulting in stopping someone else accessing the IMC bed.	One patient was in 18 weeks, another 14 weeks – generally the norm is 10-12 weeks.	6 weeks usually but can be less or more. The EDD is decided in the first week and the MDT at the home decide the goals and aims for the person and justify any breach of the 6 week stay. There is no cost to the service user unless they are ready to go home and refuse to do so.	2 -4 weeks	Up to 6 weeks

Do you think all patients referred to IMC/Transition are appropriate?	No - Patients maybe EMI, 2 patients were dying and referred to IMC. There needs to be quicker reaction by the Cognitive Team	No	No	No	No, some have cognitive problems or dementia.	Generally not. Some referred have cognitive problems. Two residents have been put on DOL's The service often creates high expectations for relatives. Families should be given more choice of homes that their relatives will be sent to.
Have you ever refused a referral for IMC?	Yes	Yes - but it was not easy	Yes - information regarding the patient was conflicting and Home felt it was unsafe to accept the patient.	No, but on one occasion a person was accepted early but arrived late without the appropriate meds and equipment.	Yes, because no meds or equipment were sent	Yes
Do you provide Transitional Beds?	Yes - 12 IMC 12 Transition	Yes	Yes	Yes, they can require more intense care and often need more than 6 week stay. They can be stepped up to IMC.	We provide 28 'Winter beds' to relieve pressure.	Yes, IMC require more rehabilitation than Transitional who are often generally for ongoing assessment
How many patients are allocated an IMC bed after Transition?	This information is held by DASS	This information is held by DASS	The Home to let HW know this figure	Not known	Not known	Not known
Have you had to have an IMC	Yes	Yes - a patient was re-admitted to	Approx 10% of patients are re-	Yes	Yes	Yes, quite often

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resident re-admitted to hospital?		hospital 4 times within their 6 week stay at IMC.	admitted to hospital but don't hold this data accurately. A patient arrived at Home by ambulance - the Home were concerned that the patient was very poorly and asked the ambulance to take the patient back to hospital.			
Have any IMC patients died in your care?	Yes	2 in 2 years - both cardiac arrest	2 -	No IMC residents have died but a transitional resident has.	No	Yes
Can Residents keep their own GP?	No	No	Its easier for all IMC residents to be under one GP. GP does a ward round once per week.	No, they are transferred to a local practice for the duration of their stay.	No	Yes IMC are looked after by Liscard Group Practice and have to register with them
Do you have any special arrangement with a Local GP to look after your IMC residents?	Civic - there are 3 visits per week from Civic - which enables issues to be identified quickly	Marine Lane	Claughton	Yes, Sunlight Practice in New Ferry. A GP and Practice nurse attend MDT meetings.	Civic Medical Centre	Liscard Group Practice. The home has an excellent working relationship with the practice and the MDT meets weekly at the Practice

Who is the named Care Manager for IMC	Manager or Shift Leader. There are two meetings per day by staff	Manager of Home	Kerry Manager - Unit Manager	Rachel	Manager / Nurse in charge	Nurse in charge
Who puts the resident's care plan together?	Qualified Nurses - Admission plan is put in place when information is received by Shift Leader - activities are not included because of the length of stay	Nursing and Therapy assessments - the resident signs a Care Plan agreement which is discussed with them daily.	Nurses and Senior Care Assistants. Patients are encouraged to add their likes, dislikes and any activities they would like to take part in	Manager and MDT	Nurse and Therapists	Nurse in charge
How is discharge from IMC/Transition planned?	MDT meeting (SW, Physio and OT drive the discharge) There is a projected and estimated discharge date which is documented	MDT with GP, SW, therapy and Nursing staff (best interest meeting - sometimes hard to convene). The team also look at what is available in the community	Physio team plan the discharge. There is a slight disconnect as Physio's don't always tell the Home the plan so that Take Home meds can be delayed	MDT meet every Tuesday to make decisions about discharge. Home visits are arranged. EDD is discussed during first week of stay	Daily ward rounds, discuss discharge, social worker involved	MDT
Do you follow up residents after discharge from IMC?	No	Therapy Team might because of equipment and they may talk to STAR	Some Patients stay in touch - just to say "Hello"	No	Yes	Therapists and Social workers do. Care home staff do not.
Do you have allocated Care staff for IMC/Transition?	Yes	Yes - staff are dedicated to the IMC/Transition unit	Yes - only change if staff are ill	No, all staff work together. Care home staff and therapy team work very well together.	Yes	Core dedicated staff

				Communication is good and there are handover procedures for each shift. The SW attends 5 days and is on call.		
Does having an IMC facility have any impact on staff (extra work)?	Yes – big impact on staff - there are also issues around Social Workers - the Home feel they would benefit from appointing their own SW	Tremendous impact on staff workload – there were 206 admissions in last financial year	Yes, IMC is demanding by nature. Staff can be treated like waitresses due to patient's cognition.	No, the home has provided IMC for a long time	Yes, therapy staff do not always work together with care home staff.	Yes
Who quality controls you as an IMC provider?	Social Services – a questionnaire is sent in to June Walsh and Karen Thomas monthly	DASS – monthly meeting for providers	June Walsh - Provider report.	DASS plus the home uses its own questionnaires to gain feedback.	DASS	Contracts team at DASS
Do you have any plans to increase your provision of IMC?	Yes – 48 at the moment - would like to do more	The Home has currently given notice on IMC beds.	19 at the moment one more IMC bed in next few weeks. There is a potential for 23 beds – 3 beds are residential on the IMC unit	Yes by 3 beds	May consider 12 bed unit but not sure due to inappropriate/unsafe and late admissions, lack of communication with therapy staff/social worker.	No
If you have empty IMC beds do you use them for anything else?	No	No	No	No	No	No
Do CQC inspect IMC units differently or	Not known	A general observation - CQC	We understand that CQC should	Do not know	Not sure	Usual model used by CQC

do they use their usual model of inspection?		do not know enough about IMC	inspect IMC differently			

Issues identified during visits to 6 providers of IMC on 16th and 18th February 2016. These were compiled from speaking with Staff, Physiotherpists (Physios) and Occupational Therapists (OTs) and patients.

- Physios and OT should be available over 7 days. These staff are employed by the Community Trust.
- Improved communication and working relations between community and care home staff required in most care homes.
- Some homes stated that when they provided, and were in charge of, IMC prior to the contract the process and procedure was better and 85% of patients were discharged to their own home within 6 weeks
- Discharge process to IMC homes could be better
- Assessment paperwork complicated to read, often contains anomalies and not accurate
- Homes often have to phone referrer to check assessment paperwork is accurate
- GP's often do not receive accurate discharge paperwork quickly
- Inappropriate/unsafe referrals continue to be made
- Complex cases are referred resulting in re-admission to hospital
- Medication and equipment not always provided to the IMC Care
- Patients are discharged too late in the day (after 8pm)
- More Social workers required
- To clear hospital beds patients are made 'to fit' assessment criteria
- Some providers are still adapting or refurbishing facilities required by contract despite contract commencing September 2015
- A majority of homes would prefer to employ their own therapists and lead on IMC
- Homes have no control on who is referred to them
- Would a separate Enablement Unit be a better solution for patients with cognitive problems or dementia? Some care homes may not have suitably trained staff to look after them
- Relatives should be given more choice on which Care Home their relative is sent to
- The patients GP should be involved in the discharge assessment before their patient is sent to IMC
- Meetings arranged and attended by the Providers of IMC are not attended by any representative from the hospital
- The referrers do not appear to inform families about IMC, effectively, thus creating high expectations about their relatives care at Care Home IMC facilities
- Should CQC inspect IMC facilities separately?

Conclusions and Recommendations

Recommendation 1 – Clear information exchange

Information is often unclear and out of context and order – the information resembles a diary of the Patients journey and does not explicitly highlight the needs of the Patient and why the individual is ready for referral to IMC or Transition

Recommendation 2 - Patients who are re-admitted for IMC or Transition should have their period of support, routinely, extended.

If a patient is re-admitted to hospital the bed must be kept for 48 hours – after that the bed must be allocated to some else. However, for patients referred back to IMC or Transition within the 48 hours this time should be, routinely, added to the end of their 6 week allocation.

Recommendation 3 – Care Home and Staff training needs are fully met

Training – one Home identified that there are training needs still not being met. Wound Dressing and Vena Puncture training would benefit the patients and staff CPD. HW will recommend to the Care Home Owner that this training is undertaken as soon as possible.

Recommendation 4 – Physiotherapists and Occupational Therapists should ensure that support is maintained throughout the patient's full stay in an IMC or Transition bed.

Once a patient is optimised – the Physio Team or OTs do not visit the patient. As there are patients who may have cognitive issues HW would recommend that Physios and OTs continue to support the patient; also ensuring that the IMC Home provide continued appropriate support to the patient to enable them to go home fully able to care for themselves.

Recommendation 5 – All Health and Social Care Teams related to discharge from hospital understand, and use, what is available in the community. This would also include Teams in the community who need to find additional support for patients without admission to hospital,

There are other options to IMC or Transition and they appear to be under-utilised. This could be because staff are unaware of them or because it is not clear what the services do. It would be beneficial to inform the patient's GP of probable discharge date from hospital to ascertain, keeping everyone in the loop, whether the patient could be supported at home by utilising one of the services below.

Services we learned about are:-

- Early Supported Discharge if in hospital and not appropriate for IMC bed
- Rapid Response (including 72 hour Package of Care) if at home and could be managed there rather than come into a bed
- Short Term Care if patient has had all support available and cannot be maintained at home and need to consider long term care
- Respite if it is a carer break rather than rehabilitation that is required

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Glossary

OT	-	Occupational Therapy
Physio	-	Physiotherapist
HW	-	Healthwatch Wirral
HWE	-	Healthwatch England
IMC	-	Intermediate Care
GP	-	General Practitioner (your doctor in the community)
CPD	-	Continuous Personal Development
MDT	-	Multi Disciplinary Teams
STAR	-	Short Term Assessment and Re-ablement
EMI	-	Elderly Medically Infirm
EDD	-	Estimated Discharge Date
SW	-	Social Worker
CQC	-	Care Quality Commission (Regulator)
DASS	-	Dept of Adult Social Services
CT	-	Wirral Community NHS Foundation Trust
WUTHFT	-	Wirral University Teaching Hospital NHS Foundation Trust

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- Healthwatch Quality Assurance team : Diane Hill, Carmel Calvert and Alison Shead
- Healthwatch Staff Team

All of the Staff from:-

- Leighton Court Care Home
- Daleside Care Home
- Hoylake Cottage Hospital
- Grove House
- Elderholme
- Charlotte House

All of the Patients and visitors we spoke with from the above Care Homes

- Karen Thomas – Rapid Community Response Service Manager – Wirral Borough Council
- Val McGee - Director of integration and partnerships - Wirral Community NHS Foundation Trust
- Ewan Sim - Medical Director - Wirral Community NHS Foundation Trust
- **Yarni Finney -** Clinical Coordinator for Intermediate Care – Wirral Community NHS Foundation Trust

Action Plan for **Intermediate Care project**
Outcome to: - to identify good practice and make recommendations to Commissioners

Appendix 1

Task	Risk	Solution	Resources required	Action	Responsible and timeframe
Gain a better understanding of IMC/Transition provision in Wirral	Timescales Diaries Not identifying all the services that are available	Realistic Timeframes Contact invitees as soon as possible - ask for deputies, where possible Ensure the list of people to invite is as robust as possible	Staff Volunteers Venues	• Pull together a T&F group utilising staff and volunteers • Set TOR with realistic meeting dates • Identify questions that need to be asked • Identify who can answer those questions • Utilise E&V to speak with Patients/Carers and staff for views and experiences • Analyse and triangulate data • Report and recommendations • Share the report with H&CPP to inform Avoiding Admissions project	
Identify desired aims and outcomes.				Aims :- • Ascertain whether all professionals are using the same criteria for IMC and Transition beds • Are all referrals to IMC and Transition appropriate and best for the patient • Ascertain whether IMC or Transition in Care Homes is the best environment Outcomes :- That the assessment, referral mechanism and provision of IMC and Transition is communicated to those referring into the process, those providing the service and those receiving the service.	

Action Plan for **Intermediate Care project**
Outcome to: - to identify good practice and make recommendations to Commissioners

Identify who to Invite to meetings	Is there anyone missing from the list of invitees?	Ask those invited to speak with us to identify who we need to speak with.		Possibles:- • Val McGee from Community Trust (8.2.16) • Val Tarbeth – CCG/NHSE • Jacqui Evans - DASS • Dr Ewan Sim • Physio/OT – CT (Re-ablement team) • IMC Care Home Managers (at E&V) • Patients and Carers (at E&V) • Amanda Kelly – DASS • Integrated Care Coordination Teams's • WUTHFT • Local Solutions for 72 Rapid Response care information • Yarni at Leighton IMC lead	Plan To be confirmed following E&V and other tasks
Identify questions in relation to referrals, funding and discharge	Are the questions able to drill down enough E&V are we able to fit this work into the timeframe	Learn from the questions asked and keep reviewing Ensure the staff and volunteers commit the relevant time and review frequently		• Who pays for IMC – is the money pooled? • Who refers in the most? • Who can refer to IMC? • Does the family influence the decision to refer to IMC/Transition? • Where are younger people being referred to (is there any age criteria?) • If Norovirus or other contagion would patient be sent elsewhere or kept in hospital? • If Care Home was suspended would patient be sent elsewhere or kept in hospital? • Who tracks the patient if they breach IMC stay or go into Transition bed?	

Action Plan for **Intermediate Care project**
Outcome to: - to identify good practice and make recommendations to Commissioners

Learn about the assessment and Criteria for IMC/Transition following discharge from hospital	Identifying who is the best person to ask	Call Val McGee, Val Tarbeth or Dr Ewan Sim		Request copies of assessment documents which hold the criteria for managing discharge from IMC	
Learn about the assessment and Criteria for IMC/Transition following referral from home	Identifying who is the best person to ask	Call Val McGee, Val Tarbeth or Dr Ewan Sim		Request copies of assessment documents which hold the criteria for managing discharge from IMC	
Engagement	Are questions relevant Will this work need more than the dedicated 3 months	Ensure questions are tailored to the relevant individuals Review weekly		Utilise our current outreach model in the Community. Plan for Enter & View in each Home where IMC is provided. Design a series of questions for the Care Homes, WUTHFT, CT, CCG and DASS. Send questions to identified professionals and ask if they can attend a meeting, if appropriate Talk to Patients, Carers and staff during Enter & View visits to Homes where IMC is provided	
Plan Enter & View visit to Care Homes who provide IMC	Timeframes Availability of staff and volunteers	Set realistic timeframe Keep the T&F group small and allocate tasks realistically		Visit Elderholme, Hoylake Cottage Grove House on 16.2.16 Visit Daleside, Charlotte House & Leighton Court 18.2.16 Send in questions to Care Manager prior to visit	

Action Plan for **Intermediate Care project**
Outcome to: - to identify good practice and make recommendations to Commissioners

				Undertake Risk Assessment prior to visit Undertake the visit speaking with Patients, Carers and Staff Plan a meeting of the QA team to ensure objectives have been met.	
Research and request relevant data				Request data :- • How many patients are re-admitted to hospital following IMC/Transition? • How many patients are allocated a Transition bed following IMC?	
Equality and Diversity	Communication methods Cost of resources	Use staff skills and attitudes to build communication methods appropriate for the audience Utilise current relationships to share resources where possible		Utilise our current Outreach model in the Community and engage the groups who are usually considered harder to reach (eg Janice Connolly at MSDP One Stop Shop West Kirby Tescos in Bidston	
Report and Recommendations				Compile a report which is shared with the Commissioner and Provider and in the public domain. Report should include recommendations eg: • Transfer to IMC/Transition should always include someone who knows the patient • Referrers should look for other solutions eg. 72 Rapid Response Dom Care • HW should highlight to the CCG what other options are available.	
CQC				Do CQC use the same model of inspection for IMC	