The step-down alliance

Challenging patient flow is a vast drain on NHS resources – more patients than ever are stranded in an inappropriate acute setting while waiting for the health and social care economy around them to facilitate discharge. Mark Gould finds that wider cooperation may help alleviate the problem.

CEDARWOOD IS A NOVEL ALLIANCE BETWEEN GOOD Hope Hospital and the Midland Heart housing association, which identifies patients who can be transferred from the hospital setting and receive step-down care while permanent care packages or transfer destinations are arranged. It could be a key part of the solution to a lack of timely patient flow, until system-wide solutions in the health economy are found.

Cedarwood is based within a refurbished ward at Good Hope Hospital, part of the Heart of England NHS Foundation Trust (HEFT). It accepts patients who are medically fit for discharge from hospital but need extra support to build up their mobility and independence before returning home.

Midland Heart has redeveloped an existing ward in the grounds of the hospital in Sutton Coldfield to develop this purpose-built 're-ablement' facility with 28 private beds. The ward began taking referrals in November 2013 and has supported 520 people to date – up to 45 patients per month, who stay for an average of between two and three weeks. Beds are purchased directly through HEFT.

Initial figures suggest that the service is having a positive impact on length of stay, but a more detailed evaluation is currently being undertaken and it is hoped that its report will be issued by summer 2015.

A new normal

Midland Heart says Cedarwood is designed to replicate, as far as possible, 'normal' living conditions. All patients have private bedrooms around a reception and communal area, including a lounge, a restaurant, a domestic kitchen and gardens. Daily activities encourage patients to improve their independence and mobility. Domiciliary bridging packages of care are provided by care workers from St Giles Care Agency, and Healthcare at Home, the UK's largest homecare provider.

Where patients need clinical care or therapy it is delivered by Recovery at Home, another HEFT initiative designed to provide a 'virtual ward' that offers the same levels of clinical or therapy care as those delivered in the community. The service has dedicated nursing, physiotherapy and occupational therapy staff provided by the acute Trust but akin to community-based care.

Each patient has a bespoke care plan designed to help restore confidence and re-familiarise people with the skills needed to live independently, while reducing the chances of re-admission to hospital. This eventuality is also minimised by having a social worker assigned to the unit to ensure the right social care is in place once people return home.

A 'trusted assessment' team – comprising a rapid emergency assessment communication team (REACT), Community Health nurses and Advanced Nurse Practitioners, Recovery at Home and Cedarwood facilitators and social workers – identifies patients suitable for admission to Cedarwood.

There were initial challenges to keep Cedarwood consistently full, so extra therapy support was added to enable the unit to take patients requiring lower levels of intervention.

The development of step-down services is essential as it eases pressure on beds, says Corinne Slingo, Partner at DAC Beachcroft. Such innovation to redesign care pathways and increase patient flow should be commended. Developing these services requires robust management and carefully planned admission criteria to make sure the service is optimised in improving patient flow, while also maintaining safety within patients' needs.

GETTY IMAGES

A shared goal
The development of step-down alliances is essential to ease the pressure on hospital beds

Lack of patient flow in numbers

The first month of 2015 saw nearly

5,250 NHS patients

in England for a total of

151,000 days

either awaiting transfer from an acute ward to non-acute care, or because they were waiting for a care package so that they could be sent home. The latest figures represent a

36% rise

since January 2012. More than two-thirds of these delays were attributable to the NHS and nearly a third to social care.

FIGURES FROM THE GOVERNMENT STATISTICAL SERVICE

Avoiding step-down slip-ups

Organisations interested in developing step-down should consider the following key points:

- Low thresholds for re-engaging the healthcare provider in the event of a patient's health deteriorating while in the step-down facility, including access for re-admission where necessary. This is particularly key given that, unlike when a patient is discharged home, the patient's own GP will not re-engage with primary care provision while they are in the step-down facility.
- Facilities suitable for the delivery of social/personal care, with particular regard to the more rapid turnover of service users through the service, as transfer to the individual's final destination is achieved.
- Agreement as to the extent of any shared facilities and/or patient data to support the transition from the acute setting into the step-down facility (and beyond).
- Clear mapping of the care pathway to ensure absolute clarity as to accountability for the patient/service user at any given moment. This is critical from a patient safety perspective, as well as key for regulatory compliance and, in the event of an incident, accountability.
- A robust governance and assurance structure, to ensure the patient/service user's safety, and a strong reporting and learning culture. As a registered provider of social care, the step-down facility remains subject to CQC regulations, and as of 1 April 2015 must comply with the Fundamental Standards (including Duty of Candour, and Fit and Proper Person for directors). For newer entrants into the care market, these requirements can be onerous and increase corporate risk profiles.

"From the outset there must be clear communication with the patient and families, so that they understand the nature of the step-down service – that it is not a healthcare facility, but a new model of care provision that could unlock patient flow," Slingo adds. "There must be clear, agreed patient pathways between the acute provider and the step-down provider, to make sure roles and responsibilities remain clear, with effective communication and handover, to achieve both continuity of care and awareness of risk. Delivered well, this model is capable of revolutionising care pathways and unblocking patient flow through health and social care services." ■

To discuss the issues raised in this article, please contact Corinne Slingo on +44 (0)117 918 2152 or cslingo@dacbeachcroft.com