HOME ENHANCED CARE SERVICE

BACKGROUND

Paper 1
August 2009 - June 2010
1 OVERVIEW

This paper describes the key steps taken to develop and implement the Home Enhanced Care Service (HECS) whilst also managing the closure of 52 inpatient beds at the Royal Alexandra hospital. A description of the HEC service and a number of learning points are highlighted

This paper is complemented by a second paper which evaluates the HEC service at the end of its first pilot year.

Both papers are intended to generate discussion and engagement with key stakeholders to further improve and develop the HEC service, as well as inform the potential ‘spread’ of a ‘HEC type’ model to other localities in North Wales and further beyond.

2 HOW DID IT ALL BEGIN?

In late July 2009, the then North Wales NHS Trust received a report from Welsh Health Estates, indicating that the inpatient facilities at the Royal Alexandra hospital (RAH) in Rhyl would never achieve Firecode compliance, irrespective of the level of capital investment made. This posed a serious safety risk for inpatients, staff and visitors. Faced with this risk, the then Trust Board took the decision to close both inpatient wards (52 beds). One ward had GP beds; the other, Consultant beds.

The hospital is a Victorian building with a rich history, much loved by the local community and is a key landmark in the town. The hospital’s catchment population included some of the most deprived council wards in Wales, with a high concentration of elderly residents, many living alone. 70% of admissions to the hospital were for residents of Rhyl, Prestatyn and surrounding areas, with a further 20% of admissions were residents of Kimmel Bay, Towyn, and Abergele/Pensarn. The remaining admissions were residents of other areas within Denbighshire.

A commitment was given to re-provide community beds in the locality although it was acknowledged that it would take a number of years to deliver a new community facility.

A commitment was also given that, in the interim, a new model of care would be established in the locality to provide care in people’s own homes, this being funded by reinvesting funds from the hospital inpatient service. It was the intention that this new service would not only complement the future provision of community beds in the locality, but would also potentially reduce the future number of beds required. Some beds at RAH were also to remain open until the new model of care had been established.
In addition, bed capacity at both Holywell hospital and at Denbigh Infirmary was increased by the opening of 10 and 6 additional beds respectively to address any additional pressures that the loss of the RAH beds may have posed for overall community bed capacity within the central area of North Wales.

Stakeholders initially viewed the decision to close the inpatient wards with deep suspicion, perceiving the closure as largely a cost saving exercise. There was significant and vocal concern amongst the local population, elected members, partner agencies, local GPs, wider staff groups and their representatives. A ‘Save the Alex’ campaign was initiated. Addressing these concerns generated extensive and continuous engagement with stakeholders, initially to explain the rationale for the bed closures, and then to engage them on an ongoing basis in the development and implementation of the new model of care.

During this time, national work led by Dr Chris Jones was underway, culminating with ‘Setting The Direction’ (February 2010). The emphasis of this strategy - the provision of locality based multi-agency, multi-disciplinary care, enabling and enhancing the ability of GPs to provide more care for their patients at home – framed the work undertaken.

The challenges faced at the start of the HEC journey were five-fold and were addressed concurrently:

- The significant investment of time to engage with stakeholders;
- The development and implementation of a new innovative model of care;
- The need to retain some beds at RAH, without compromising patient or staff safety, until the new model of care was implemented;
- The commissioning of additional beds at Holywell Hospital and Denbigh Infirmary;
- The redeployment of over 50 WTE nursing staff (and other facilities staff) from RAH into suitable alternative posts, with this being done in such a way as to retain some beds at RAH until the new model of care had been implemented; and, facilitate the commissioning of the additional beds at Holywell hospital and Denbigh Infirmary.

Taking forward these complex challenges necessitated a formal project management approach, inclusive of stakeholder engagement, with work commencing immediately in August 2009. An overarching project board was established, to which a number of individual project teams reported. All project teams had explicit terms of reference and all memberships were multi-agency, multi-disciplinary from the outset. The membership of the Project Board and individual project teams is included as an Appendix to this paper.

The individual project teams were:

- An HR Task Team to manage the complex redeployment process;
• A Communications Task Team to prepare information leaflets, respond to public and press enquiries and issue press briefings;
• A Clinical Services Task Team which oversaw the commissioning of 10 additional beds at Holywell hospital, with 6 additional beds also opened at Denbigh Infirmary;
• A Decommissioning Task Team which ensured the safe decommissioning of both inpatient wards.

In addition, a Service Modelling Task Team developed, implemented and has monitored the new HEC service since its inception on 28th June 2010. The Task Team met on a weekly basis (sometimes twice weekly) until February 2011 when the meetings became fortnightly. The task team’s membership included: a GP; Consultant; acute and community nursing staff; therapy services; staff from intermediate care services; pharmacy; social care; third sector; Welsh Ambulance Service; the GP out of hours service; the Community Health Council; and, a patient representative (previously a member of RAH’s League of Friends).

From the outset, members of the Task Team were committed to developing a model of care that is primary care based, with GPs enabled and supported to manage patients safely at home. The Task Team researched other models of care, most of which appeared to be secondary care led, either supported by a community based consultant or by a consultant working on an outreach basis from the acute sector. There was a strong view that, as GPs have a long term and continual relationship with the local population and often know their social and family circumstances best, it should be the GP who makes the decision whether or not an individual could be safely managed at home.

4 WHAT IS HECS?

Building upon the core principle of developing a primary care based model of care, HECS was developed to provide safe multi-agency, multi-disciplinary ‘step up’ and ‘step down’ care in people’s own homes for individuals who have an increased medical need and who, without this support, would be admitted to a hospital bed (acute and/or community) and/or who would remain in hospital for longer to have their medical need met. The patient’s own GP acts as the gatekeeper of the service (deciding whether or not a patient can be safely cared for at home) and also provides enhanced medical care to the patient at home. The GP is supported by a multi-agency, multi-disciplinary ‘team’, including regular formal Consultant support (Care of the Elderly). The make up of the team is provided in Section 5.4.

HECS falls within the spectrum of intermediate care services. Its uniqueness, however, lies the fact that it provides an intensive level of care to those with medical needs, with this care being provided at home by a primary care led ‘team’ for a short and focussed period. A 24/7 care plan is agreed for all those who receive HECS care. The focus of other intermediate care services
lies more with providing rehabilitation and promoting independence for individuals who may not have medical needs.

Following an episode of HEC care, it was nonetheless anticipated that a number of individuals would require ongoing care from ‘routine’ intermediate care and other community services, with others returning to the ‘normal’ care of their GP or District Nurse.

As HECS was designed to provide rapid, intense and short term support, the intention was that most patients would be under the care of HECS for a maximum of 14 days. This was able to be extended for up to an additional 14 days should the individual’s needs require this (for example, in the provision of terminal care). Should the individual’s condition deteriorate during their care under the HEC service, it was agreed that the individual would be admitted without delay or question.

All referrals for HEC care are managed via a single referral point – a ‘Communications Hub’ – this being located at RAH. The ‘Hub’ also hosts a daily ‘virtual’ ward round, attended by members of the multi-disciplinary/agency team to discuss all new patients and agree care plans. Care plans of existing patients are also discussed, including arrangements for the patient’s ongoing care following the end of the HEC care episode.

New referrals to the service are accepted Monday to Friday but no later than 12 noon on Fridays. New referrals are not accepted at weekends as the patient’s own GP would not be available to discuss and agree for the individual to be managed by HECS. This was considered a key safety and governance issue: the ‘cut off time’ for referrals on Friday ensures there is sufficient time for individuals (particularly ‘step down’ referrals) to be fully assessed by their GP and the wider HEC service, and a care plan put in place before the start of the weekend. All patients are visited and assessed by a member of the HEC ‘team’ within 2 hours of the referral being accepted for HECS care, including those referred on a ‘step up’ basis.

Importantly, a 24/7 care plan is agreed for each individual, encompassing health, social and personal care. During the HECS episode of care, personal care is provided free of charge to the individual. During the out of hours period, health and personal care support is provided by health care support workers as and when required. These staff are based within the GP out of hours IT system and are thus easily identified should they require additional support out of hours.

A key factor in establishing the HEC service was to establish the service as a pilot in a discrete locality area in the first instance. This was to ensure that the model of care was safe and effective and to allow close monitoring and corrective action if necessary.
5 KEY LEARNING POINTS

A formal ‘lessons learned’ workshop was held involving all those who had played a part in the establishment of HECS and in the closure of the two inpatient wards at RAH. A comprehensive document, outlining a wide range of ‘lessons learned’ was produced, with the hope that this would be of benefit to others who face similar significant service change challenges.

However, there are four central learning points that can be drawn from the planning and development of the HEC service whilst also managing the closure of inpatient beds. These focus on:

- Establishing the new service as a pilot;
- Ensuring sound governance for a primary care based model of care;
- The HR challenge of concurrently developing a new model of care, commissioning beds at two other community hospitals whilst undergoing a major staff redeployment exercise;
- Creating the multi-agency, multi-disciplinary team.

5.1. New Service as a Pilot in a Discrete Locality

The new service is supported by recurrent funding from the previous hospital inpatient budget (as were the additional community hospital beds at Holywell hospital and Denbigh Infirmary). The service was initially established as a 6 month pilot which was then extended for a further 6 month period. The first pilot period commenced on 28th June 2010.

The North Denbighshire locality was chosen as the pilot area as, historically 70% of all admissions to RAH were residents of Rhyl, Prestatyn and surrounding areas, these areas forming the North Denbighshire locality. There are a total of 9 GP practices in the locality, two of which are in the top 5 largest GP practices in NHS Wales (in terms of individual practice lists), with a number of single handed GP practices and practices with 3 /4 partners. Almost 59,000 patients are registered with one of the 9 GP practices in the locality.

During the first 6 month pilot, 4 out of the 9 practices agreed to take part in the service (this including the two largest practices), accounting for 73% of all patients registered with a North Denbighshire GP practice. The remaining 5 GP practices all agreed to take part during the second 6 month pilot period.

Establishing the service as a pilot provided the opportunity for confidence in the new model of care to grow amongst the first ‘cohort’ of GPs and also

1 During the pilot period, patients registered with one of the participating practices who live in Denbighshire or Conwy were eligible to receive HEC care. Some residents of Flintshire are registered with a GP practice in Prestatyn and were not included in the pilot period.
supported the development of good working relationships between them and the wider HEC ‘team’.

Initially, GPs were concerned that the new service would generate a high and unmanageable volume of workload for their practice but experience shows that the GPs feel well supported by the wider multi-disciplinary/multi-agency team; that the additional workload associated with the service has proved to be manageable overall; and, that the care they can provide for their patients at home is safe and responsive.

Establishing the new service as a pilot also meant that staff for the wider team were appointed on a ‘temporary’ basis, initially for 6 months and then extended for a further 6 months, with staff either employed on a ‘fixed term’ or ‘secondment’ basis. The ‘temporary’ nature of their employment gave an opportunity to review and alter the skillmix or WTE should the learning and feedback from the pilot have indicated the need for this. There were concerns – which proved unfounded - that staff would not be attracted to apply for ‘temporary’ posts in a ‘new’ service. However, the ‘temporary’ nature of the contracts did cause a degree of staff anxiety about their longer term futures.

5.2 Primary Care Based Model of Care

There was a firm commitment from the outset to implement a primary care based model of care, although the means of achieving this took a significant period of time to define and agree this being in large part due to the complexities inherent in ensuring sound clinical governance arrangements.

Initially, the task team explored the potential of agreeing a Service Level Agreement with one GP practice to provide the medical care for patients across a number of GP practices. It proved difficult to clarify the ‘responsibility boundaries’ between the patient’s own GP and those of the GP practice which provided care via an SLA. In addition, there were challenging ‘responsibility boundaries’ between the ‘day time’ GP (patient’s own GP and the GP practice with an SLA) and the GP out of hours service.

Another avenue explored was for the Health Board to employ a GP to provide day time medical support for patients. This did not overcome the clinical governance difficulties identified with an SLA arrangement, although this did provide vicarious liability for the care provided by the GP through the Health Board. The ‘responsibility boundaries’ with the patient’s own GP remained unclear as did the ‘responsibility boundaries’ with the GP out of hours service.

Discussions with the Local Medical Committee led to the development of a new Local Enhanced Service (LES). The LES specifies the enhanced medical care to be provided by the patient’s own GP practice. Patients can only receive HEC care at home if their GP practice agrees that the patient can be safely managed at home (either as a ‘step up’ or ‘step down’ patient). The patient’s own GP practice acts as the ‘gatekeeper’ for the HEC service and

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Chair and on behalf of Service Modelling Task Team/HEC Monitoring Group
provides continuity of care as the GP practice already has responsibility for
the patient under the GMS contract. This overcame the clinical governance
concerns posed by the other primary care models considered.

5.3 The HR Challenge

The challenge of developing and implementing a new and at that time ‘untried’
model of care, whilst at the same time, managing a major staff redeployment
exercise, which also included opening additional beds at two other community
hospital sites required an intense joint partnership effort between line
managers, staff side and staff members. The challenge centred on
‘balancing’ a number of equally important drivers: first, finding suitable
alternative employment for over 50 WTE nursing (and other staff); second,
enabling some staff to have the opportunity to be involved in the new HEC
service for which ‘temporary’ posts were available; third, supporting other staff
who wished to take up new posts associated with the additional community
hospital bed capacity; fourth, ensuring that the redeployment of staff was
phased in a way to enable a gradual reduction in inpatient beds at the RAH;
and fifth, ensuring that some beds remained open until the new HEC model of
care had commenced.

The successful management of this complex change process was the direct
result of strong and supportive partnership working with staff side, including
regular one to one and team meetings with staff.

The change process adopted has been shared with the TUC as an example
of good practice.

5.4. Creating the Multi-Agency, Multi-Disciplinary Team

As a new ‘untried’ service, it was difficult to know with certainty the workload
implications for all staff and partner groups prior to the service commencing.
Professional expertise and opinion informed the skillmix and WTE for each
staff group, and thus the level of investment made. The ‘untried’ nature of the
service also lent weight to employing staff on a ‘temporary’ basis as it was not
possible in advance to ensure that the skillmix and WTE levels were
appropriate.

Based on professional opinion and discussions, it was anticipated that the
service could manage up to 10 new referrals per week with 15 patients on the
caseload at any one time. The staffing levels set for each professional group
were based on this anticipated workload, although it was acknowledged that it
would take time for the service to develop and that the complexity of care
provided may mean that fewer patients could be safely managed than the
number anticipated.

On this basis, the multi-agency/multi-disciplinary ‘team’ established to support
the service was:

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• 1.00 WTE Advanced Nurse Practitioner
• Three WTE District Nurses
• 1 WTE physiotherapist; 0.8 WTE occupational therapist
• 2 WTE social workers (across two counties)
• 11 WTE health care support workers (to provide 24/7 health and personal care)
• 0.47 Band 2 and 0.68 Band 5 to support the co-ordination of referrals

In addition, third sector organisational support was agreed across a wide range of agencies, as was access to Consultant time (Care of the Elderly) who both attends the 'virtual' ward round once a week and provides input into discussions regarding patient care. Additional resources were also made available to community equipment stores. Payments were also made to GP practices for each patient managed by HECS. A non pay and travel budget was also created.

The full year pilot year investment to establish HECS was £734,300.

6 SUMMARY

This background paper has outlined the key steps taken to establish the HEC service and manage the closure of 52 inpatient community hospital beds. The paper has described the model of HECS, and has also highlighted some of the key challenges faced.

The HEC service started to receive referrals on 28th June 2010 (with the staff having taken up post one week earlier for induction) and has thus just reached the end of its first year. A separate paper has been written which focuses on evaluating the impact of HECS during this pilot year.
**APPENDIX – MEMBERSHIP OF PROJECT BOARD/TEAMS**

NB: A number of job titles for health and other members of the Project Board and teams have altered during the course of the work undertaken as has their employing organisation.

### PROJECT BOARD

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Reena Cartmel/Liz Powell</td>
<td>Deputy Director of Nursing/Assistant Director of Nursing</td>
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<tr>
<td>Ellen Greer</td>
<td>Associate Director – Head of Planning</td>
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<tr>
<td>Liz Morgan</td>
<td>General Manager – Community Services</td>
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<tr>
<td>Dr Chris Stockport</td>
<td>GP, Clarence House</td>
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<tr>
<td>Dr Olwen Williams</td>
<td>Chief of Staff, Medicine</td>
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<tr>
<td>Keith Jones</td>
<td>Head of Nursing, Community Services</td>
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<tr>
<td>Yvette Drysdale</td>
<td>Assistant General Manager, Community Services</td>
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<tr>
<td>Heather Bebbington</td>
<td>Employment and Equalities Manager</td>
</tr>
<tr>
<td>Trevor Hartley-Williams</td>
<td>Business Case Manager</td>
</tr>
<tr>
<td>Carol Dent</td>
<td>Staff side representative</td>
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<tr>
<td>Helen Ashcroft</td>
<td>Assistant General Manager – Surgery</td>
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<tr>
<td>Jane Trowman</td>
<td>Director of Nursing, Denbighshire LHB</td>
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<tr>
<td>Lindsay Haveland</td>
<td>Denbighshire Voluntary Services Council</td>
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<tr>
<td>Neil Ayling</td>
<td>Head of Adult Services, Denbighshire Voluntary Services Council</td>
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<tr>
<td>Helen Thomas</td>
<td>Service Manager, Conwy County Council</td>
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<tr>
<td>Paul Clarke</td>
<td>Facilities Manager</td>
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<tr>
<td>Rod Taylor</td>
<td>Deputy Director of Estates</td>
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<tr>
<td>Gail Roberts</td>
<td>Clwyd Community Health Council</td>
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<tr>
<td>John MacLennan</td>
<td>Conwy Confederation of Community Health Councils</td>
</tr>
<tr>
<td>Chris Dann</td>
<td>Clwyd Community Health Council</td>
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### SERVICE MODELLING TASK TEAM/HEC MONITORING GROUP

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Ellen Greer</td>
<td>Associate Director – Head of Planning</td>
</tr>
<tr>
<td>Dr Olwen Williams</td>
<td>Chief of Staff – Primary, Community and Specialist Medicine CPG</td>
</tr>
<tr>
<td>Dr Indrajit Chatterjee</td>
<td>Consultant Physician, Care of the Elderly</td>
</tr>
<tr>
<td>Dr Caroline Usborne</td>
<td>Consultant in Palliative Care Medicine</td>
</tr>
<tr>
<td>Dr Rita Kronstorfer</td>
<td>Consultant Psychiatrist, EMH</td>
</tr>
<tr>
<td>Dr Langdon</td>
<td>GP, Kings House Surgery</td>
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<tr>
<td>Dr Stockport</td>
<td>GP, Clarence House Surgery</td>
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<tr>
<td>Liz Morgan</td>
<td>General Manager, Community Services</td>
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<tr>
<td>Keith Jones</td>
<td>Head of Community Nursing Services</td>
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<tr>
<td>Yvette Drysdale</td>
<td>Assistant General Manager, Community Services</td>
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</tbody>
</table>
Jan Tomlinson Staff side representative, UNISON
Lesley Hall Associate Director of Human Resources
Lynn Prior Community Services Manager
Eva Edwards Hospital Manager for Central Hospitals
Dee Begbie Hospital Manager for Holywell and Flint
Angela Thompson Clinical Nurse Lead for Royal Alexandra and Prestatyn
Lindsay Haveland Denbighshire Voluntary Services Council
Dilys Percival Head of Occupational Therapy – representing all therapy services
Rebecca Weston Pharmacist
Sefton Brennan GP out of hours service
Nia Boughton GP out of hours service
Glynis Tabberer Intermediate Care Services Manager
Joanne Balmer Chronic Conditions Management Manager, Denbighshire LHB
Wendy Hooson Integrated Services Planning Manager, Denbighshire LHB
Marie Waugh Long Term Conditions Co-ordinator, Conwy LHB
Helena Thomas/Sue Wright/Cathy Curtis Nelson Denbighshire Social Services (one of the three attended meetings)
Joanna Griffiths/Helen Thomas Conwy Social Services
John Bartley Welsh Ambulance Trust
Alistair Edwards Information Analyst
Iwan Bonds Management Accountant for Medicine CPG
Maureen Whittam Clinical Governance Manager
Jenny Breuer Former Chair of Hospital League of Friends
Chris Jones Clwyd Community Health Council
Gail Roberts Clwyd Community Health Council
Chris Dann Clwyd Community Health Council

HR TEAM

Heather Bebbington Employment and Equalities Manager
Mandy Grimster Employment Officer
Yvette Drysdale Assistant General Manager – Community Services
Ellen Greer Associate Director – Head of Planning
Carol Dent Staff Side representative
Shirley Hocking Staff Side representative
Jan Tomlinson Staff Side representative
Steve Wright Staff Side representative
Liz Morgan General Manager – Community Services
Eva Edwards Hospital Manager
Lynn Prior Community Services Manager
Dee Begbie Hospital Manager
Paul Clarke Facilities Manager

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COMMUNICATIONS TEAM

Yvette Drysdale Assistant General Manager, Community Services
Ellen Greer Associate Director – Head of Planning
Steve Morris Patient representative
Donna Kearsley Patient representative
Ann Shield Patient and Public Involvement, Conwy LHB
Lindsay Haveland Denbighshire Voluntary Services Council
Dawn Davies Communications Manager
Cllr Pauline Dobbs Denbighshire County Council
Johnny O’Hagan Team Leader, Denbighshire County Council
Gareth Griffiths Hospital Chaplain
Vicky Russell Patient and Public Involvement

CLINICAL SERVICES TRANSFER TEAM

Paul Clarke Facilities Manager
Ellen Greer Associate Director – Head of Planning
Keith Jones Head of Nursing, Community
Janice Malandrinos Patient Services Manager, Holywell hospital
Liz Morgan General Manager – Community Services
Yvette Drysdale Assistant General Manager – Community Services
Russ Shepherd Assistant General Manager – Facilities
Dee Begbie Hospital Manager – Holywell Hospital
Eva Edwards Hospital Manager – RAH
Stuart Harmes Head of Podiatry and Orthotics
John Bartley WAST
Ian Walker Pathology (received minutes)
Bethan Wyn Owen Radiology (received minutes)
Dilys Percival Therapies (received minutes)
Wendy Mailer Pharmacy (received minutes)

DECOMMISSIONING TEAM

Rod Taylor Deputy Director of Estates
Garry Pickup Operational Estates Manager
Steve Jones Security Officer
Bill Roberts Fire Officer
David Casey Infection Control Manager
Eva Edwards Hospital Manager

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Chair and on behalf of Service Modelling Task Team/HEC Monitoring Group