Intermediate Care Update **Overview & Scrutiny**

September 2017

Recap…

Intermediate care delivers a short burst of extra care and rehabilitation outside hospital to help people recover and regain their independence as quickly as possible.

It can provide support in many situations, such as: when an older person has an illness like a water or chest infection that can easily be treated at home rather than hospital; when an existing health condition worsens; when an older person has fallen and lost their confidence; if someone is weak and needs help to settle back home following a hospital stay; or if their carer is unwell and not able to look after them.

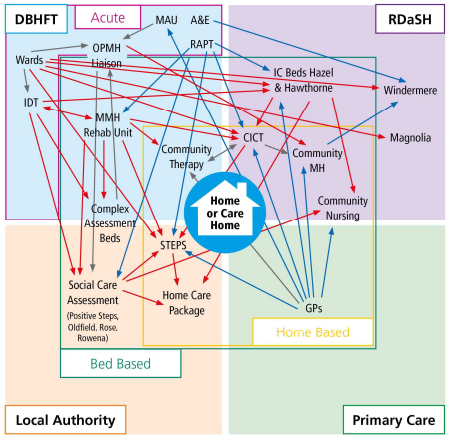
NHS Doncaster CCG and Adult Social Care in DMBC are working together to develop intermediate care services further so:

- there's more of this type of community support;
- they can be easily accessed when people need them; and
- they are equipped to meet the needs of an increasingly ageing local population.

Vision for intermediate care in Doncaster

We are moving away from the current configuration of;

- **two** community teams
- **four** bed based services (100 plus beds)
- **two** hospital based assessment teams
- with **six** access routes
- delivered by **four** providers
- providing more step down than step up support…



…to a more streamlined, integrated health and social care service, providing a more even balance of step up and step down support**.**

Offering;

- **a single point of access and assessment.**
- rapid response and short term interventions,
- medium term rehabilitation and re-ablement in the community
- and a smaller integrated health & social care bed based service.

Testing & early implementation of new model

- Currently testing some of the proposed changes, refining the future model and preparing staff for transition.

- Initially this phase was due to run to May 2017 when we were due to have agreed a new joint health and social care model for commissioning.

- Now extended testing until October 2017 to align with place plan timeline and the new arrangements for joint commissioning are implemented.

- A series of test projects have been established including;
  - Rapid Response pathway.
  - Proof of concept for a shared digital care record.
  - Closer alignment of the social care reablement service (STEPs) and health's reablement service (CICT).
  - Simplifying access.

Rapid Response Update

- **Rapid response pathway opened to Yorkshire Ambulance Service for people who had fallen on the 23 January 2017**
- **Extended to GPs from beginning of March and wider range of conditions now being seen.**

  Brings together existing responses to support people at home.

  Operating 8am – 8pm – 7 days per week.

  Single point of coordination and care planning.

  Speedy access to a multi agency assessment *(Therapy, Nursing, ECPs, STEPs Case Managers, Geriatrician, AGE UK and MH*)

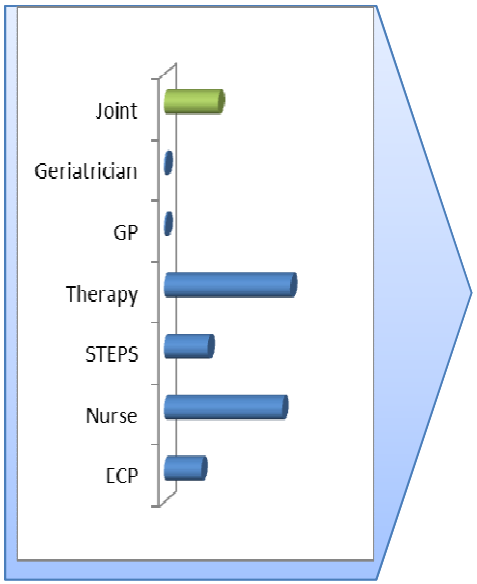
  Support for up to 72hrs.

- **The pathway will be opening up to people with respiratory conditions from October.**
- **Monthly dashboard now produced includes patient, staff and referer feedback.**

Overview of rapid response activity January- July 2017

177 referrals

First responder



4 patients transported to A&E by ambulance service following discussion with rapid response triage practitioner.

Types of care and support provided

- wound care
- medication review
- eqiuipment provided
- reablement package
- assessment
- Signposting Info & Guidance
- Bloods review
- falls assessment
- therapist assessment
- observations

Sample- data collection incomplete

Outcome of referrals accepted.

135 (76%) supported at home

3 patients attended A&E

24 patients admitted to hospital.

What is it like to refer to the rapid response pathway?

I am a Paramedic working in Doncaster and I have found the new rapid response pathway really easy to use, I've made a few referrals now.

What I find good about the pathway is the responsiveness of the call back, knowing that I will not be waiting for a long time is important to us as we are aware of other emergency calls that may require our help.

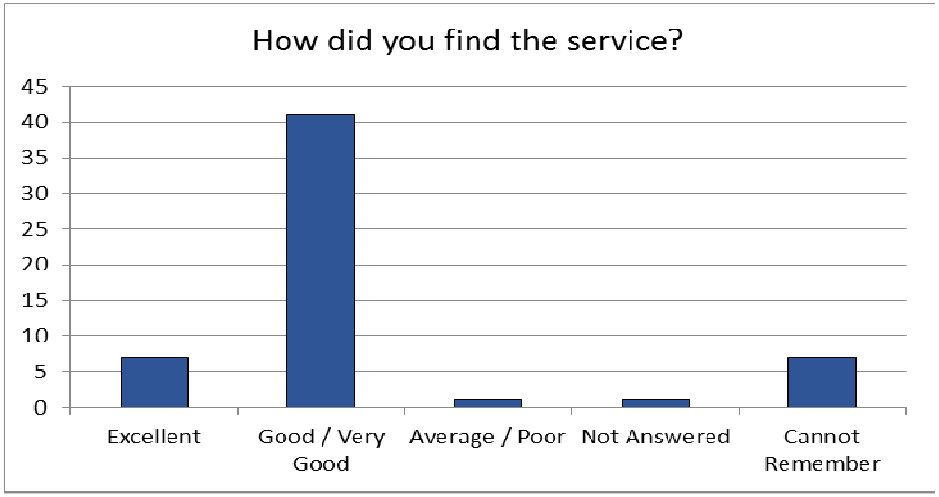
I like how the handover process is to the point, with relevant questions. I feel reassured that I know exactly when someone is going to turn up. In the past, there would have been a chance we would take someone to ED as we wouldn't know for certain if they could be safe if things got worse. Also, the triage team seem quite flexible in the help they can offer and the type of patient they are willing to see.

I've usually made the decision that a patient is safe to stay at home, so I haven't used SPA to discuss someone who I'm not sure if they could be treated at home or not. Just knowing the pathway is there helps making that decision easier.

I've not had much feedback from patients, but families are especially happy with the support the pathway gives their relative when staying at home for care.

Patient/ user feedback

57 follow up calls

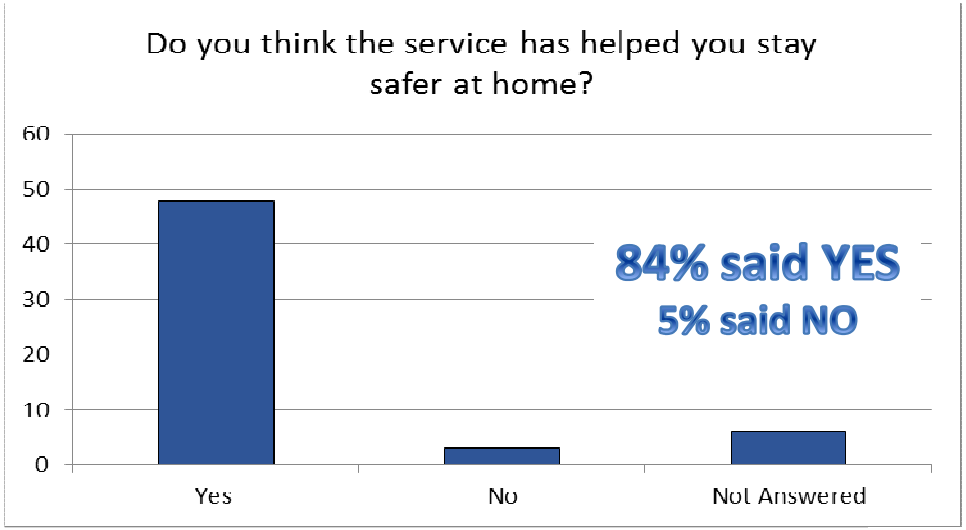


"Very good as I wouldn't have known where to get help and the rapid response service sorted it all for me".

I feel the service makes you stop and think and use a more common sense approach. It makes you stop and think about not taking risks and using the equipment you have.

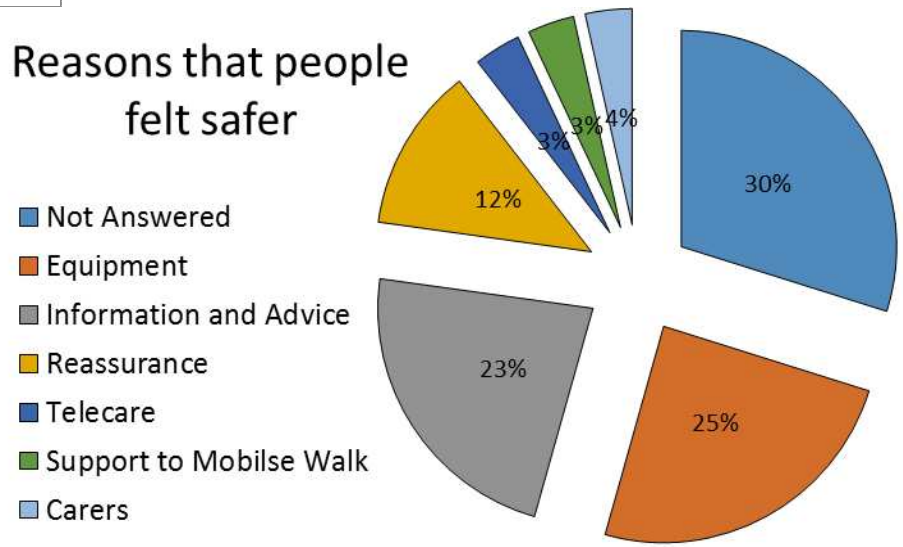
Patient/ user feedback

57 follow up calls



"They were here ever so quickly and they were so kind"

Found the service very good, fell a bit before that and was taken to hospital as head was cut. This time felt it was better than having to go to hospital and get sorted at home.



Involving carer's in developing the new model…

Earlier this year an electronic survey was carried out by Co-Create with the support of Doncaster Healthwatch to find out the views of people in caring roles and to help inform the development of the new intermediate care model.

The survey asked questions about

- **where they felt their loved ones are best cared for,**
- **where they go to access support**
- **and the impact of caring on their own life.**

- 51 respondents, 17 of whom were identified as current carers and 31 identified as providing practical, emotional and/or financial support to an older person. Over 50% of the respondents were aged 50 and over and 74% were employed – some finding it difficult to cope with looking after a loved one and working full time.

The **key themes** were that

- Carers and future carers often feel overwhelmed.
- They don't always know where to go for help and had not routinely been offered carers' assessments.
- The majority of respondents indicated a preference for home based care rather than hospital based.

Most respondents felt that the place where their loved ones are safest and most cared for is at home and also the place where they will receive the safest treatment.

Support such as regular visits from a carer, befriender or health care professional, pendant alarms and daily living aids were identified as things that would make people feel that their loved one was better cared for and/or safer at home.

Support to take medication on time, more GP involvement and respect for the carer's view were some of the other suggested support mechanisms identified by the respondents.

86% of respondents felt that the place where their loved ones are safest and most cared for is at home and also the place where they will receive the safest treatment.

What things would make you feel that your loved one was better cared for/ safer at home?

"A system that listened to and respected us – we are best placed to know what is needed"

Recommendations being implemented in response to findings;

1. Development of a trusted assessor model so that a range of practitioners can routinely carry out carers assessments when someone is referred to intermediate care.

2. Ensure two way communication with carers is built into any new pathways.

3. Develop further links with carer support services and other voluntary sector services e.g. AGE UK.

4. Provide opportunities for on-going involvement of carers in evaluation and development of services.

Case Study

– a carer’s experience of rapid response.

TBC.

Next steps

Continue to;

- develop and evaluate the rapid response pathway.
- align more points of referral to make it easier to access services and reduce duplication.
- develop proof of concept for a Doncaster digital shared care record.

- Share findings from designing for diversity work and agree actions.
- Implement a new integrated approach to commissioning and contracting intermediate care services across health and social care (as part of the Doncaster Place Plan)