Intermediate Care Update **Overview & Scrutiny**

23rd Nov 2016

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.

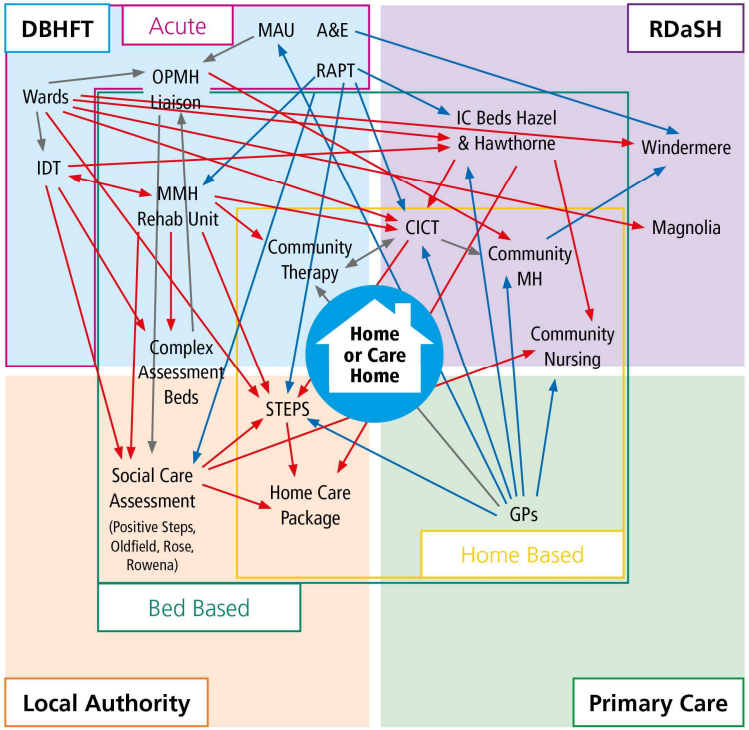
It can provide support in many situations, such as: when an older person has an illness like a water or chest infection that can easily be treated at home rather than hospital; when an existing health condition worsens; when an older person has fallen and lost their confidence; if someone is weak and 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.

What do we want to change?

We want to move away from the current configuration of;



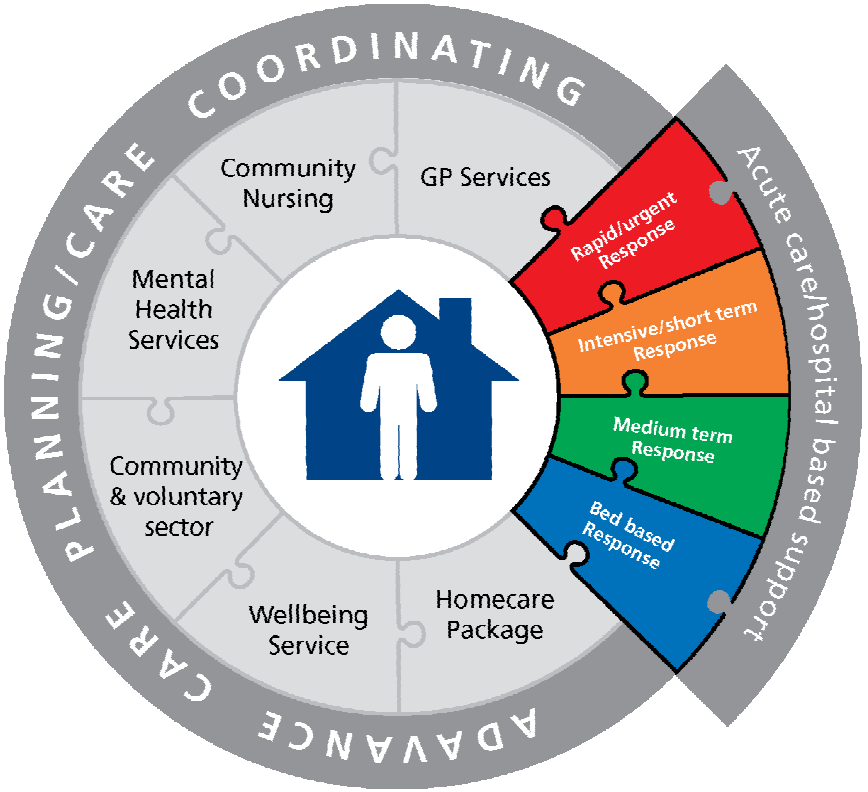
- **two** community teams
- **four** bed based services (100 plus beds)
- **two** hospital based assessment teams
- with **six** access routes
- delivered by **four** providers
- providing more step down than step up support…

Vision for intermediate care in Doncaster

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

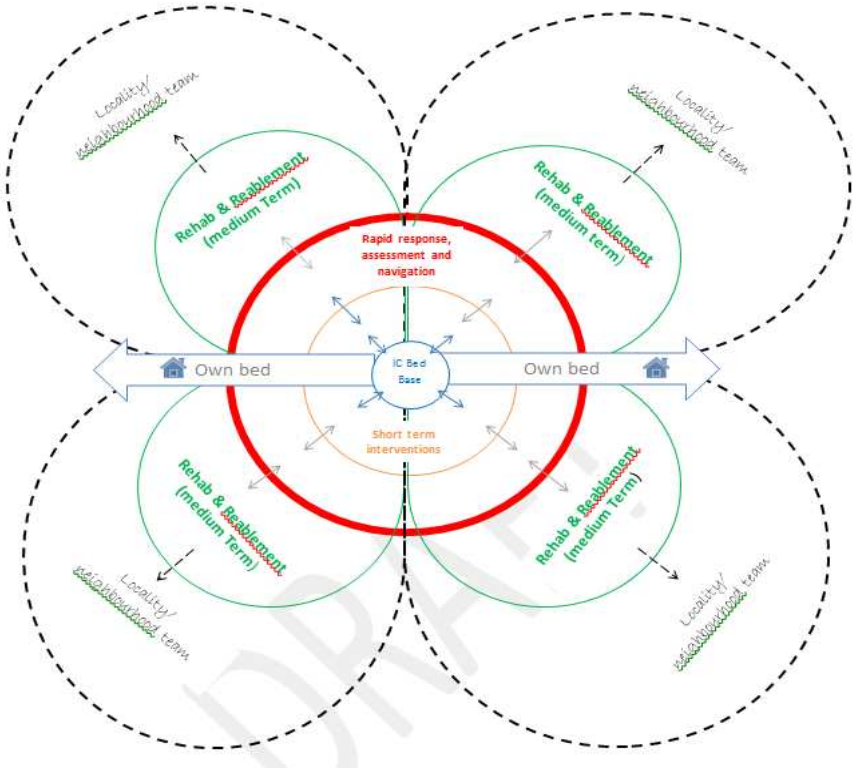
Offering;

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



Vision for intermediate care in Doncaster

The new model will complement the locality based neighbourhood teams and community led support, in order to maintain existing social networks, utilise community assets and link closely with primary care.



This reflects current thinking and will develop alongside the place based plan, neighbourhood model and as a result of testing

What next?

- Between **November 2016 and May 2017** we will be testing some of the proposed changes, refining the future model and preparing staff for transition.

- By **May 2017** we will have agreed a joint health and social care model for commissioning and providing intermediate care and will start full implementation (**May 2017 onwards**).

RAPID RESPONSE

What are we testing?

Developing a Rapid Response- initially this will be an MDT/ interagency rapid response to falls via the ambulance service.

It will bring together existing falls responses to provide co-ordinated rapid assessment, care planning and brief interventions following a fall.

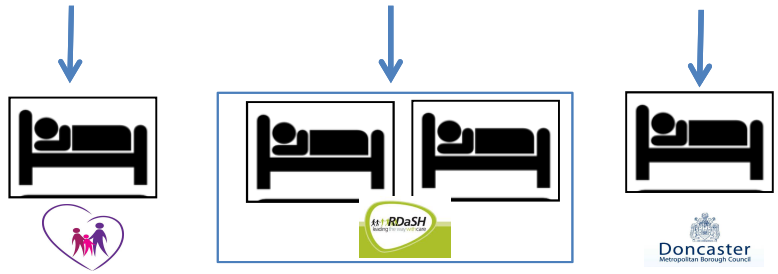
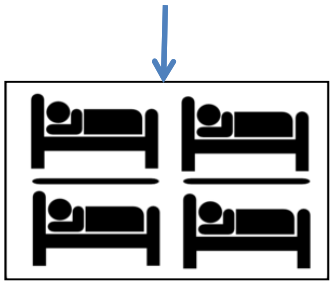
Now →	Future
 XX who fall and call 999 are conveyed to hospital- we know many of these don't have a major injury and don't need hospital based treatment but may need a rapid assessment, and some additional support for a few days. The ambulance service currently have to phone **three** different numbers to arrange for follow up at home. It is often easier to transport someone to hospital so they get a rapid assessment in A&E but this not always best for the person who has fallen and it increases the likelihood of them being admitted and them loosing independence.	**ONE** number. Co ordinated multi agency rapid response in community. Assessment and short term support at home instead of transporting to hospital. Exploring links with fire service to offer pick up service. 

BED BASED RESPONSE

What are we testing?

Start to bring the intermediate care bed base together as one service and use existing resource more flexibly to improve flow.

Increase options for step up and develop home based/ chair based short term interventions.

Now →	Future
Four separate bed based services, provided by 3 different organisations, with separate referral processes. All have slightly different criteria but the review identified they all work with people who have similar needs. Most referrals are to facilitate discharge from hospital rather than avoid admissions. 	Patient will be assessed as needing a bed based response and matched to bed to make better use of resource and simplify access. 

SHORT TERM RESPONSES

What are we testing?

Scope the options to use some of the bed based resource to deliver more short term home based interventions.

Now →	**Future**
Mr M, is 78 years old and has had an elective total knee replacement surgery in hospital. He was very independent prior to his operation, living in his own bungalow, seeing family and friends and driving his car. Mr M has COPD and angina which he normally manages well with support from community health services. Two days after surgery he is assessed by the Integrated Discharge Team (IDT) as needing some rehabilitation to restore his confidence and improve mobility due to his COPD. He was transferred to an intermediate care bed based unit to receive his rehabilitation and after 18 days he was discharged home with no follow up as he was fully independent again.	In the future Mr M would receive short term support from a community based team of therapists, nurses and support workers who will help him settle back in at home for a few days after his surgery and maintain his links within his local community. 

MEDIUM TERM RESPONSE

What are we testing?

Developing an integrated model of health and social care community based rehabilitation and re-ablement by starting to integrate the current health reablement service (CICT) and social care reablement team (STEPs)

Now →	**Future**
One health reablement team and one social care reablement team. Working with similar people. Trying to work together to meet people's needs but with lots of duplication, separate processes and proceedures. 	One integrated team providing a range of reablement interventions tailored to the individual's needs and building on existing support community networks/ resources. 

Other activities;

- Workforce development plan- what skills do we need to start to develop for the future?
- Developing a proof of concept for a shared digital care record (linked to the digital road map for Doncaster)
- Further engagement with patients, carers and the public in developing and refining the model- with a programme of activities underway (lead by Co create, Healthwatch and the health ambassadors)
- Linking in with wider work on assistive technology.
- Evaluation.

Commissioning health and social intermediate care in the future…

- We already work together to commission some health and social care services in Doncaster, but there is a need to take a more integrated approach to joint commissioning in the future.

- There are a number of potential models for jointly commissioning health and social intermediate care in the future.

- Need to work out which of these is the best fit for Doncaster and test this out with intermediate care.

- This work will take place alongside the testing and a joint approach agreed no later than **April 2017**