ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Intermediate Care and Reablement Update
Health Select Committee March 2021

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NHS
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Clinical Commissioning Group

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What is Intermediate Care and Reablement?

Health and social care nursing, therapy and reablement services providing:

i. **Fast response**

- Where there is an urgent increase in health or social care needs
- Response within 2 hours of referral
- Can be safely supported at home
- Typically 48 hours but may be up to 7 days

ii**. Short term home based support**

- To help with learning/ re-learning skills for every day living

iii. **Community bed based care**

- With or without nursing
- Where needs are greater than can be delivered at home but consultant led acute care is not needed

Why Change?

People told us

- They would like to be at home and as independent as possible
- Services were disjointed and hard to navigate

National evidence shows

- People do better at home
- A large number of people received care in a community bed who could have gone home with the right support
- Rotherham had significantly more community beds than other similar areas

Where are we now?

Our Aim

To create an integrated health and social care model for urgent and short term care based on home first principles. To support more people at home to re/gain independence and reduce reliance on long term care.

Our Objectives

- Streamline 7 disparate pathways to 3 integrated ones
- Increase capacity to support more people at home
- Reduction and consolidation of community bed base
- Integrate triage to ensure people receive the right support

Major Milestones Achieved

- 3 new pathways, aligned to national discharge standards
- Investment in additional home based nursing, therapy and reablement staff
- Reduction and consolidation of community bed base from 5 sites to 3
    - 24 bedded therapy led community unit with nursing at Athorpe Lodge
    - Consolidation of intermediate care beds onto a single site
- Working towards integrating triage & assessment

Impact of Covid

National Requirements

- New national discharge standards based on home first principles
  - Same day / 3 hour discharge
  - Assessment in the community
- Discharge to designated care settings for Covid positive patients
- Temporary national monies to support increased demand and discharge home

Rotherham Response

- Community Intermediate Care and Reablement pathways and Integrated Discharge Team provided a robust framework
- Focussed on planned changes which would provide maximum benefit to Covid response e.g. in-reach into the acute and discharging more patients home
- Hastened innovation and integrated working e.g. blend of virtual assessment and face to face
- But caused some delay e.g. development of the community hub
- Athorpe Lodge's flexibility enabled more complex needs to be supported
- But changed the expected interventions and outcomes of the unit

Contribution to National Discharge Standards

- c.95% of patients discharged home
- Commissioning of Covid +ve Care Home beds throughout the Pandemic included use of Designated Care Homes
- Weekly operational partnership meetings (daily at peak times) to discuss issues/ expedite discharges
- Acute and community bed occupancy dropped in wave 1 but not 2 and 3
- Some community bed occupancy was due to carers either shielding or Covid +ve preventing discharge home
- Rotherham 1 of 30/450 returns selected by NHS England as an example of good practice

Care delivered in a person's home

Cross pathway integration

- Proof of concept for an integrated community hub underway
- In reach to Emergency Department and Acute discharge with trusted assessments in place
- Development of Rotherham Health Record to share records across organisations

Integrated Rapid Response

- New step up pathway
- Integrated support roles

Therapy

- 7 day working
- Urgent KPI met over 90% of time
- Re-allocation of staff from bed base to home
- Regional/ national example of good practice
- Reablement training
- Closer working with mental health services
- Increasing support roles for greater efficiency

Reablement

- New adult social care support model
- Greater flexibility to change support according to individual level of need
- 1.8% more clients per month
- Increased productivity

Home Care

- Closer working across pathways
- New provider contracts to facilitate reablement ethos
- New trusted assessment model to facilitate short term care

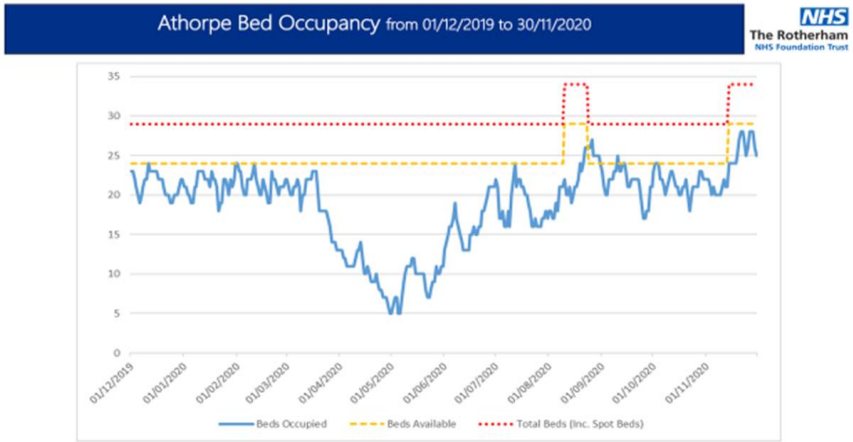
- Increased demand due to Covid against backdrop of staff absence/ isolating
- Increased complexity of patients reflected in length of stay across pathways/ need for long(er) term care

Community Bed Base

Evidence of System Change from Home First Approach

- 95%+ patients discharged home from the acute
- Resulting in greater complexity in community beds, particularly nursing
- 64% (160) people at Athorpe requiring multiple handling
- 34% able to be discharged home

Impact of Covid: Occupancy levels at Athorpe Lodge



Intermediate Care Beds

- Beds consolidated at Davies Court
- Lord Hardy Court repurposed to support Learning Disability Clients
- Enabled temporary additional capacity to support Covid
- 67% people discharged home
- Predicted year end admissions 2020-21 336 compared to 673 in 2019/20

Working together to improve lives

Integrated Rapid Response Co-ordinated Care

Mr X is 93 and lives at home with the support of his wife. He was referred to the Integrated Rapid Response (IRR) team following a fall with reduced mobility and some confusion. He was diagnosed with a urinary tract infection and prescribed antibiotics by the GP.

Intervention

A nurse assessed what he can normally do compared to now and the cause of the fall. Mr X was only able to take a few steps with the support of 2 people and was unable to climb the stairs to get to the toilet or go to bed. He wasn't drinking much as he had no commode and some incontinence problems. He had low blood pressure when he stands and irregular pulse increasing the risk of falls.

Mr X wanted to stay at home. To achieve this IRR arranged for 2 people to call initially 4 times a day to monitor his obs and support mobility. They provided a commode, urinal and repose cushion to prevent pressure damage and arranged for the family to bring Mr X's bed downstairs. They then worked to get the right support for Mr X's needs including:

- Therapists who provided a walking aid, grab and stair rails and helped with stair mobility.
- Rothercare provided a falls alarm.
- Reablement helped get him back to independence again
- The community physician altered his meds which improved his blood pressure and reduced the risk of further falls.
- District Nurses followed up on skin integrity

Outcome

Mr X has continued to improve and has remained at home with his wife. An admission was successfully avoided.

Mr Farr's partner thanks the team at Athorpe Lodge for helping him get back to independence.

Mr Farr was admitted after 5 falls. He was confused and dis-oriented. He is now home, independent and sociable. He no longer requires a care package.

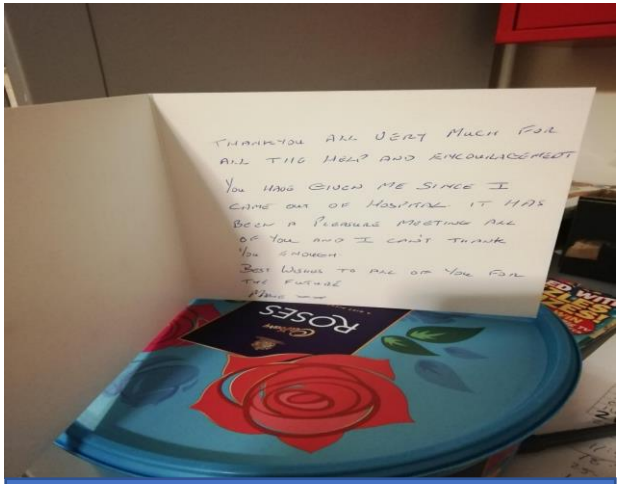
Pictured: Caitlin Ionita, Clinical Lead, Jane Moore, Senior Unit Manager and Michelle Murdock Therapist

Restoring Independence at Home

Mrs T is a 76 year old who was admitted to hospital with an exacerbation of sciatica. She lives at home with her husband who is her informal carer and has some health needs of his own.

Mrs T was discharged from hospital with 4 calls daily. It was initially thought that one enabler per call would be enough but this was increased to two as Mrs T was in a lot of pain and mobility and transfer of weight was poor. An occupational therapist carried out an assessment at home and ordered additional equipment. The lunch and tea calls were cancelled quickly as Mrs T was coping well and after 3 days it was possible to reduce 2 carers to 1.

All care ended within 2 weeks as Mrs T was restored to complete independence with personal care again.



'Thank you very much for all the help and encouragement you have given me since I came out of hospital. It has been a pleasure meeting all of you and I can't thank you enough'

‘You’ve given me back my dignity ….’

Mrs W is an 86 year old lady who was admitted to hospital with a fractured tibia. A brace was fitted and she was transferred to Athorpe Lodge for rehabilitation to increase her mobility and confidence. On admission, Mrs W had very limited mobility and required the assistance of 2 staff members and rotunda for transfers.

Mrs W explained how her mobility and confidence has improved at Athorpe and most importantly given her back her independence and dignity. She can now carry out personal tasks alone without having to rely on others.

‘I’ve enjoyed my time at Athorpe. I wouldn’t have progressed this far without these services. Everyone from the nurses, care and therapy staff have encouraged me along the way.’

Amanda Briggs, April Blackwell and Jess Dunlop help Mrs W return to independence

Mrs S walks again

Mrs S was discharged from the acute hospital to Athorpe Lodge in December 2020 following a fall at home resulting in a fractured neck of femur. She normally lives at home with her son with additional daily support from her daughter and carer visits 4 times a day.

Mrs S couldn't walk when she arrived at Athorpe, needing the assistance of 2 people and equipment to move from her bed to a chair. She tired easily and initially was mostly cared for in bed. She had difficulty communicating and engaging in therapy due to anxiety and Alzheimer's.

The team worked with Mrs S to build up her lower limb strength to enable her to sit out longer and improve her stamina. Regular therapy sessions helped reduce her anxiety levels, which improved her engagement in therapy as well as managing her Alzheimer's. Gradually with the support of therapists and use of equipment Mrs S began to stand and then progressed to walking

Health and social care worked together from admission to plan Mrs S' discharge to ensure that everything was in place when she returned home. She left Athorpe in February, initially with 2 care staff visiting 4 times a day.

Mrs S continues to make good progress and is already finding that some days she only needs 1 carer. She and the family are delighted to have her back home.

'Covid is particularly difficult for people with Alzheimers. They are away from their family and PPE is a barrier to communication and rapport' Linda Van Roo, Intermediate Care Team Leader explains

Workforce

- Increase in activity due to Covid
- Backdrop of staff shielding, isolation & sickness
- Re-allocated staff in wave 1 only
- Reduced flexibility for cross pathway/ base working due to infection control
- Temporary national Covid monies available
- But:
  - people won't move for short term contracts/ takes too long to train up
  - national skills shortage
- Working with independent and voluntary and community sector

Next Phase

- National drivers
  - Further development of the home first discharge to assess model to support sustainable discharge standards
  - Community standards
    - 2 hour urgent response
    - 2 day reablement
- Community Review: Learning from Covid
  - Understanding and incorporating best practice
  - Integration of home first admission avoidance and discharge pathways
  - Staffing resource
    - capacity and demand
    - skills mix
    - extension of trusted assessment model
  - Managing greater complexity at home
  - Community bed base model


Questions
Comments
Feedback