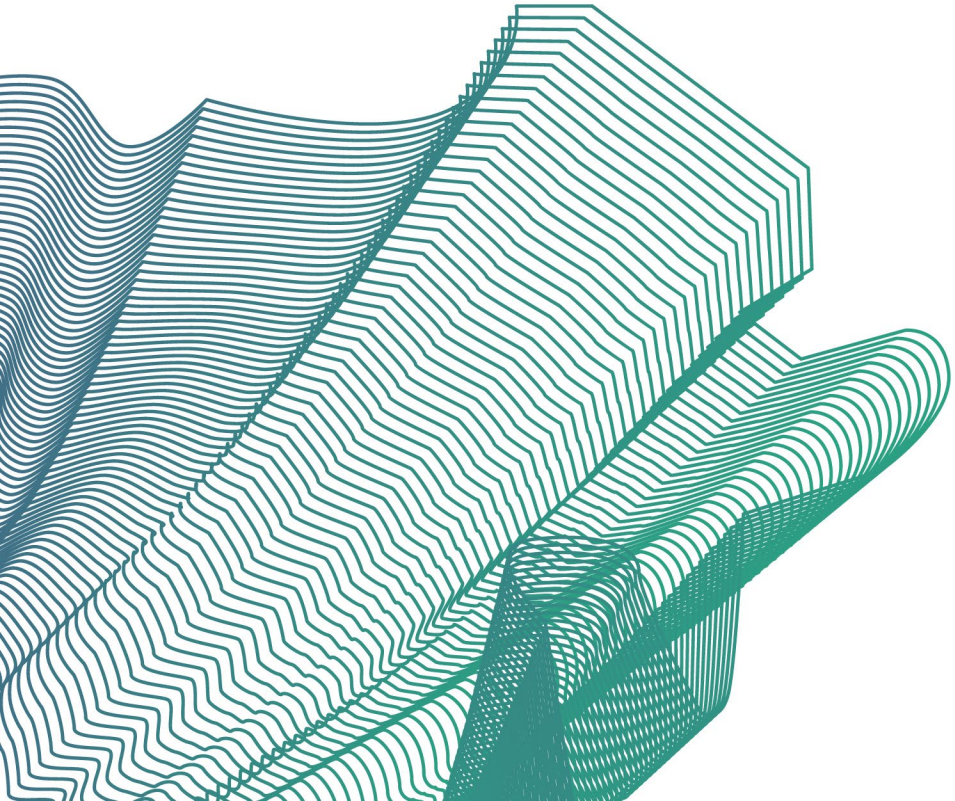
ROTHERHAM
INTEGRATED CARE PARTNERSHIP | HEALTH AND SOCIAL CARE

Intermediate Care and Reablement Update
Health Select Commission

March 2023



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What is intermediate care?

- Intermediate care services are provided to patients, usually older people, after leaving hospital or to those at risk of admission.
- It is a joint model across health and social care which aims to optimise a person to regain confidence, build on their strengths and be independent for as long as possible
- This can be in a range of settings including the persons own home, bed-based services including nursing, therapy, reablement and care provided in our commissioned bed bases at Davies Court, Lord Hardy Court and Athorpe Lodge

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What is the urgent community response?

- A new national standard introduced in April 2022 as part of the offer
- ‘The urgent community response is the collective name for services that improve the quality and capacity of care for people through the delivery of urgent, crisis response care within two hours (from April 2022) and/or reablement care responses within two days (from March 2024)’

NHS England 2020

What's working well

National Milestones achieved:

- 8am - 8pm 7 day geographic cover ✓
- 9 clinical conditions met ✓
- Submission of community service data set ✓
- Aligned to 111/999 Directory of Services ✓
- Meeting /exceeded 70% response standard within 2 hours ✓

9 Clinical Conditions

Including but not limited to:

Clinical Condition	Response
Fall	With no apparent serious injury (Rothercare response) or minor injury (rapid response team) utilising lifting equipment/manual handling Including 'PUSH' model with Yorkshire Ambulance Service
Decompensation of frailty	Which may result in sudden or disproportionate decline in function eg urinary tract infection
Reduced function/deconditioning /reduced mobility	Gradual or sudden decline. Urgent response /reablement to regain functions of daily living
Palliative/end of life crisis support	Enable somebody to stay/return home in line with their wishes, providing symptom/pain control

9 Clinical Conditions continued

Clinical Condition	Response
Urgent equipment provision to support A person experiencing a crisis/at risk of hospital admission	Assessing a person at home and making safe. Providing short term nursing, therapy and/or reablement
Confusion/delirium	Assessment and management of physical health leads at home
Urgent catheter care	Blocked and/or catheter related pain where district nurse service unable to respond
Urgent support for diabetes	Urgent injections/hypoglycaemic episode
Urgent carer breakdown	Where a carer is not able to meet the health care needs of the individual which may otherwise lead to a hospital admission

Response Standard

Month 2022	% referrals that met the 2 hour standard	Number of 2 hour referrals received per month	Number of 2 hour contacts per month
April	90%	105	735
May	81%	75	390
June	86%	185	835
July	89%	235	1805
August	89%	185	1580
September	88%	165	1410
October	77%	220	1370
November	76%	340	1510

Urgent Community Hub

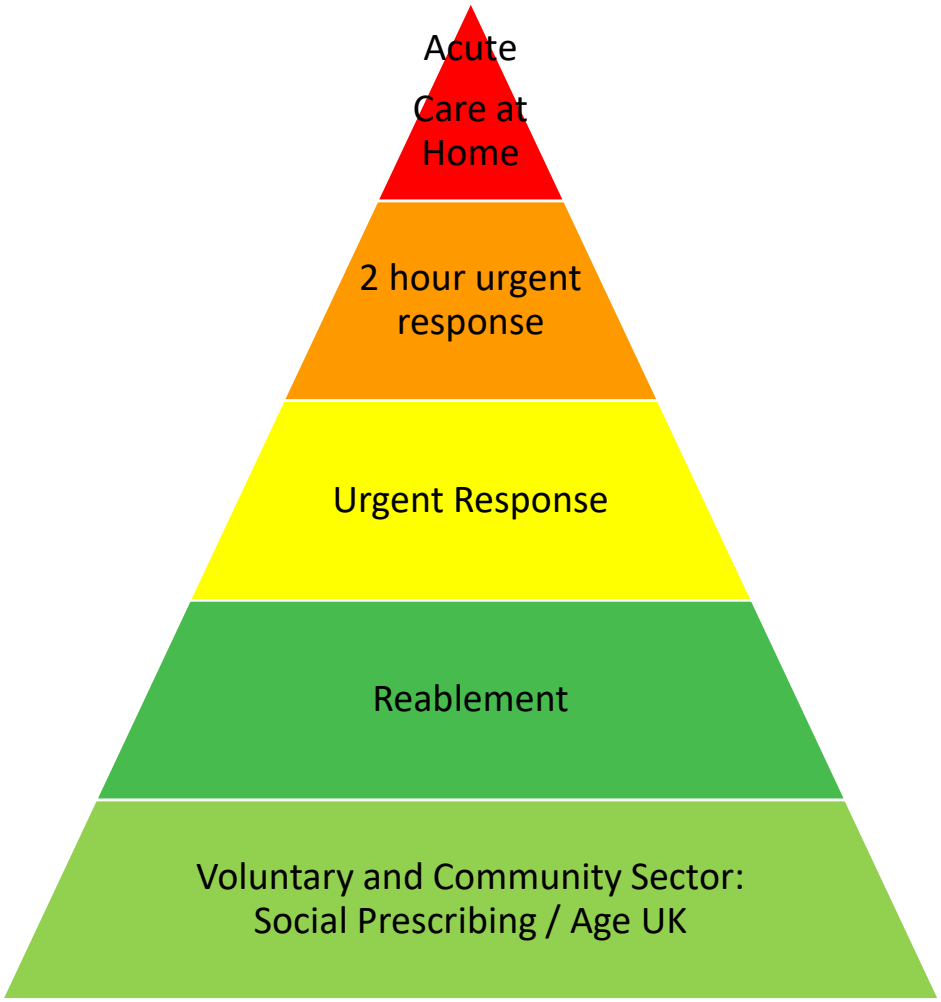
- Integrated point of access: 01709 426600
- 24/7 referral, triage and resource allocation for urgent unplanned care
- Right level of care, right time, right place, according to patient's need
- Alternative pathways to avoid unnecessary conveyances, admissions and support discharge
- Health, social care and voluntary sector co-located at Woodside
- Real time referral and triage and discussion of complex cases
- 111/999 DOS updated
- Yorkshire Ambulance PUSH model now live with Rothercare/Hub

The groundwork
1. Investing in our people

- Additional roles and new ways of working
  - Investment in all home based intermediate care services, utilising national monies
  - Integrated health and social care support workers
- Continued training and development
  - Competency framework
  - Complexity tool identify the right person to respond
- Career pathway progression, including degree apprenticeships
  - Social work apprentice in the reablement assessment team supporting patient flow
  - Therapy apprenticeships

2. Urgent Community Hub

- Right care, right time, right place
- Providing alternative pathways to avoid unnecessary conveyances & admissions and support discharge



- Open to referrals from clinicians & practitioners, 111 and 999
- Co-location of nursing, therapists, reablement, integrated discharge team, social worker, pharmacy technician, social prescriber
- Core service 24/7 with specialist staffing according to demand
- Daily MDT to review capacity/demand and complex patients
- Referrals to intermediate care bed base at Davies Court, Lord Hardy Court and Athorpe Lodge for step up (admission avoidance) and step down (discharge from acute beds) placements
- With community follow up to manage ongoing care & flow
- Social prescriber link to voluntary sector
- Age UK after care & safety netting service for people discharged home

3. Reablement

- Supporting strengths based independence at home
- Maximises a person's independence to prevent, reduce and delay further escalation of needs
- Responsibility for reablement service transferred to Adult Care Provider Services from December 2022
- Created additional daily capacity due to programming efficiencies
- Service operational 7.00am to 10.00pm 7 days per week
- Customers on service for no longer than 6 weeks
- Reablement service review
- Home care providers reablement focus

Frailty Assessment

- Two approaches currently used in parts of the community

i. Clinical Frailty Score (5 & above). A clinical assessment of individual need assessed against specific domains

ii. Electronic frailty index: digital system search of primary care records for frailty markers to identify mild, moderate and severe frailty

- Frailty scores are used in the acute trust when patients come via ED

On-going Challenges

- Increased demand
- Aging population
- Increase in complexity and dependency
- Cost of living
- Impact of strikes across health and care
- Ongoing recruitment and retention issues
- Space for training and development due to system pressures
- Access to information across teams/organisations
- Adult Social Care discharge fund/Short term national funding schemes

Next steps

- Grow urgent response
- Embed urgent community hub, incorporating discharge
- Capacity and Demand modelling for Community Hub
- Reaffirm escalation and assurance of discharge - flow through acute and community
- Procure and implement remote technology to support more complex people at home


Questions
Comments
Feedback