Appendix B

Tameside & Glossop Integrated Care NHS Foundation Trust

Additional Services and Integration of existing services within Glossop

Glossopdale has a Community Specialist Paramedic, now permanently funded following a positive evaluation of the test scheme. As well as providing a blue light response in Glossop, the post holder supports and liaises with other parts of the neighbourhood team, to prevent people having to be conveyed to Tameside General Hospital unnecessarily.

Glossop has an established model of working together across agencies, to get the best outcomes for its population. A weekly meeting of health, adult social care and The Bureau, enables a team approach to supporting our most vulnerable residents. The aim of this is to prevent people going into crisis by pre-empting change and being proactive in the management of the situation. Many more people in the neighbourhood have agreed to allow us to work in this way and they are benefitting from a joined up approach which they are at the centre of.

There is a fantastic Community and Voluntary offer in the Glossopdale area, delivered in many forms by 'The Bureau'. There is more capacity than ever before, to enable people to access advice and support that are based on more than medicine, which links people to the community and encourages self-care and peer support. The Bureau is part of the neighbourhood team at all levels from the strategic management team, the neighbourhood operational group and the weekly MDTs clinic location.

Glossop was the first neighbourhood to introduce a new social prescribing service (supported by the Bureau) which provides people with non-medical service options to improve their health and wellbeing.

Home-based intermediate Services

Home-based intermediate tier services, offer intensive packages of care to people in their own homes (including residential and nursing homes) by an integrated team providing both health and social care input based on individual need.

In the Home

In addition to the home first model there are also community and specialist intermediate tier services in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting and form part of the out of hospital intermediate care offer to patients in their place of residence (whether that is at home or in a care home).

The intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services.

The intermediate tier services are described in detail in appendix one and include:

- Extensivist Care Services,
- Digital Health,
- Community therapy services
- Community IV Therapy Service
- Glossop community paramedic service.

Tameside and Glossop Integrated Care Trust has established a Glossop Integrated Neighbourhood Team, which is an integrated team comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector.

These Neighbourhood Teams to deliver high quality and connected core health and care services, tailored to the neighbourhood population in order to best meet the specific needs of the population and to improve outcomes. In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs. The team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required.

These Integrated neighbourhood and Specialist services will be provided from community clinic locations including the Glossop Primary Care centre, GP practises, care homes, community beds or in patients own homes. These services will be fully integrated and will enable more Glossop patients to be safely provided with intermediate care in their own homes or at community clinic locations instead of needing to have an inpatient stay in a community bed, based on clinical assessment.

With respect to home based Intermediate Care the Glossop health and care system is taking part in the NESTA 100 day challenge which is aiming to improve the way in which the neighbourhood supports people, who have been given the news that they have a life limiting condition. The focus is early support and relationship building, to promote living life and reducing anxiety.

Clinic Services

Other services that have been introduced and will be provided to Glossop residents from clinic locations in Glossop are;

- Neighbourhood Pharmacists
- Minor illness scheme
- 7 day primary care access via GTD
- Extensive Care service
- Community IV Therapy
- The Digital health service is providing access to Hospital clinicians for Glossop care homes and the Glossop community Paramedic
- A new mental health service ‘Improving Access to Psychological Therapies’ (IAPT) is currently being procured and will be provided in Glossop locations for the Glossop population.
- Physiotherapy and OT clinics will be delivered in the Glossop Primary Care centre for Glossop residents.

The GP practices in Glossop have purchased the patient information system, EMIS remote which enable sharing of knowledge, skills and potentially GP capacity across the neighbourhood

Attached at Annexe 1 is a document which outlines how the Intermediate Care offer will operate for the population of the Glossop neighbourhood.

Annexe 1

Intermediate Care Model for Glossop

Vision for New Model of Care for Tameside and Glossop

Tameside and Glossop health and care system has recognised that it needs to develop new models of health and social care to meet the changing needs of is population, including an aging population with more complex and long term health and care needs and the need to provide high quality and effective care closer to the patients' home.

The two key aspects of the new model of care is the creation of Integrated Neighbourhood teams in 5 localities and Urgent Integrated Care. The Integrated Neighbourhoods will bring together health and social care delivery and dramatically improve the coordination of care through individual care plans and the sharing of expertise. They will proactively identify those people with the most significant ongoing health and care support needs. The urgent integrated care will have responsibility for looking after local people who are in social crisis, or who are seriously unwell.

Vision for Enhanced Intermediate Care

The aim of the intermediate care model is to provide fully integrated services which support the rehabilitation and recuperation of patients, to enable them to continue living at home in all but most challenging cases. With a requirement for;

- Home-based intermediate tier services, offering intensive packages of care to people in their own homes (including residential and nursing homes) by an integrated team providing both health and social care input based on individual need.

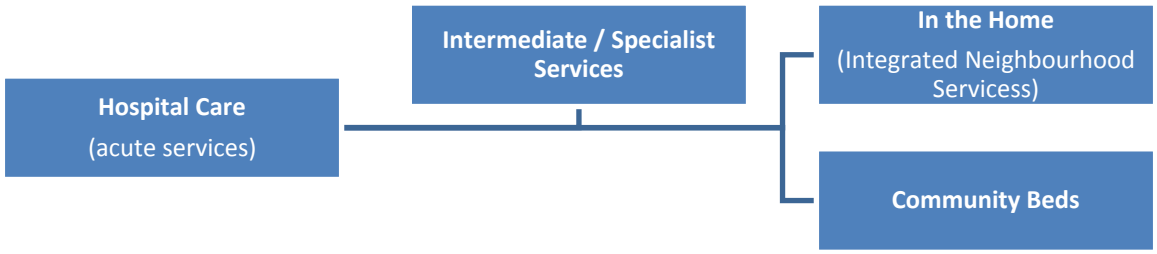
- Community intermediate care beds where it is deemed that service users, although medically fit, have a higher level of need and require a period of 24-hour care whilst undergoing intensive short term rehabilitation packages.

What Intermediate Care looks like now for Patients?

When Mrs Smith slipped and fell in her own home she pulled her alarm cord. The community response team visited Mrs Smith and called 999 as she had pain in her leg and was struggling to stand. The paramedics took Mrs Smith to Tameside Emergency Department where an x-ray was and showed that there was no fracture. Mrs Smith was admitted to the medical assessment unit and then to a medical ward to have assessments undertaken by the Occupational Therapist, Physiotherapist and Social Worker. Following 10 days in hospital Mrs Smith was dependent on the nursing and caring staff to support her and it was recommended that she be discharged to an Intermediate Care Unit. In IMC further assessments were undertaken by the OT, Physio and Social Worker and Mrs Smith received rehab to improve her mobility and promote independence following her fall. After 4 weeks in the unit Mrs Smith was assessed to return home by the social worker and the OT. The social worker arranged for carers to visit her 4 times a day to provide personal care and preparation of her meals.

Proposed Intermediate Care Model for Glossop

There are four interfaces where intermediate care services are provided to patients;



Below is a description of how services will be provided at each of these interfaces to make up the intermediate care offer to Glossop residents.

Hospital Care

The urgent element of the Intermediate Care model are the Acute care, hospital based services which are in place to respond to the urgent/crisis health and/or social care need for patients. The acute care is supported by the Home First and IUCT service to ensure patients are supported through the most appropriate pathway out of the acute hospital with “home” always being the goal.

Home First

One of the key principles of the model is that wherever it is possible for a person to have their care requirements met within their own place of residence and that the system will be responsive to meeting this need in a timely manner. Tameside and Glossop Integrated Care Trust has implemented the “Home First” service model, which responds to meet an urgent/crisis health and/or social care need for patients. The Home First offer will ensure that individuals are supported through the most appropriate pathway with “home” always being the default position. However, it is recognised that not all individuals intermediate care can be managed safely in their own home and there is a need for an alternative community based bed, for a short period of time, to enable the appropriate interventions to be undertaken with the

individual to enable them to return home, whether this be following an admission to the Hospital or to avoid the need for an admission in the first place. The Community bed base will provide this additional support and is the bedded component of the intermediate care Model.

Integrated Urgent Care Team (IUCT)

Integrated Urgent Care Team (IUCT) made up of therapists (physio and occupational), nurses, social workers and other care and support staff. The team works between the hospital and the community, supporting people or who are experiencing some difficulties within their own home or who have been discharged from hospital, intermediate care or other health and social care environments. The team will have a key role in responding to people with urgent care needs. The Team can provide care calls for up to 72 hours until longer term care can be put in place. Ongoing support will then be provided working with the Neighbourhood Teams, who will manage their ongoing care and support needs where possible. IUCT is fundamental to the intermediate care offer and is a key interface between the Integrated Neighbourhoods, community services and the acute setting ensuring that people are supported in the environment that is suited to their own care needs.

<u>Intermediate / Specialist Community Based Services</u>

In addition to the home first model there are also community and specialist intermediate tier services in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting and form part of the out of hospital intermediate care offer to patients in their place of residence (whether that is at home or in a care home).

The intermediate tier services will provide short term intensive interventions to patients who require higher intensity or more specialist intermediate care than is available within the Neighbourhood services.

The intermediate tier services which will provide services for the intermediate care offer include;

Extensivist Care Services

A new Extensivist service has commenced to work with those individuals living with complex ongoing health and care needs, to improve their health and wellbeing and reduce demand on services by ensuring that their care is managed more effectively. This will be staffed by specialist Extensivist GPs with clinics being provided from the Glossop primary care centre, who will work with a cohort of high risk patients identified through risk stratification.

Intravenous Therapy (IV) Service

7 day Community IV therapy service to provide IV therapy in the home setting to allow early discharge from hospital or avoid a hospital stay for IV therapy.

Digital Health

Digital Health Service is a new innovative service which provides Care Homes and the Community Response Service with access via SKYPE to an Advanced Nurse Practitioner for clinical consultation and advice to avoid unnecessary ED attendances for our elderly population.

Community Therapy services

These community based services provide assessment and treatment in a number of settings, including Glossop Primary Care Centre, nursing and residential homes, clinics and group sessions. These services include;

Community Physiotherapy/Occupational Therapy - The Team provide a service to patient who require physiotherapy assessment/treatment in their own homes this would include residential and nursing homes. The Occupational Therapy (OT's) is provided by internal referral only from the physiotherapists in the Team. The Team also provide assessment and provision of mobility aids for patients to maintain independence. The Team also takes the lead in provision of case management and therapeutic intervention for patients with MND. Another element to the service is management of respiratory disorders encouraging self –management and coping strategies.

Speech and Language Team (SALT) - The SALT provide services to the Community this would include residential and nursing homes. Assessment, diagnosis and management of swallowing impairment and advice on the management of these conditions. The team work on communication impairment and provide alternative strategies for patient to communicate, the team also work on voice control and management of conditions such as stammering. The team have close working links with Community Dietetics, Community Physiotherapy and Occupational Therapy and the Community Neuro Rehabilitation Team.

Community Dietetics - The Community Dietetics team see patients for a range of conditions where diet and nutrition is part of the long term treatment e.g. Neurological, Oncology, GI conditions, Chronic Obstructive Pulmonary Disease, Diabetes and Home Enteral Tube Feeding the service is provided in a number of ways these being; Home visits, Clinics, Nursing and Residential Homes. The Team also work closely with GP's and provide advice on the appropriate prescribing of Nutritional Supplements.

Community Neuro Rehabilitation Team CNRT - The CNRT assess and treat patients who have an acquired neurological diagnosis from patient who have a registered Tameside & Glossop GP. The team is a multi-disciplinary, holistic, goal led service consisting of; Physiotherapy, Occupational Therapy, Speech and Language Therapy, Specialist Rehabilitation Nurse's, Parkinson's Specialist Nurse, Psychology, Technical Instructors and Team support staff. The Early Supported Discharge Team (ESDT) which is part of the CNRT support patients to live independently as possible in their home after a period of hospitalisation following a Stroke.

Community Podiatry - The podiatry service provides assessment, diagnosis, treatment and advice to improve tissue viability, mobility, to reduce pain and promote foot health. The key roles of the podiatry team are to work as a multi-disciplinary clinical teams e.g. specialist diabetes teams, vascular and diabetes clinics, physiotherapy musculoskeletal teams and District Nursing teams. The team provide assessment, diagnosis and treatment of foot health problems, provision of preventative interventions and foot health education, provide Screening of diabetes patients within their GP practice and are involved in providing training to carers, health care and social care professionals.

Glossop Community Paramedic

Glossop neighbourhood is the only neighbourhood within Tameside and Glossop that has a dedicated community paramedic who is part of the integrated community team and supports Glossop GP's, care homes and the community teams providing first response and specialist paramedic advice, assessment and treatment for patients in Glossop who might otherwise need emergency admission to hospital, including intermediate care patients.

Neighbourhood Pharmacy

The neighbourhood pharmacy service will be one of the key services within the integrated neighbourhood model of care. Pharmacists will work as part of the neighbourhood team to help identify patients at risk and intervene to reduce the need for patients to need to access hospital based services. The neighbourhood pharmacy service will support patients to self-manage their well-being and long term conditions through optimises medicines, as well as improving communication between GPs and other health care professionals.

Single Point of Contact

It is important that people have a single point of contact for all their care needs as we begin to provide a holistic approach to care. Patients will have one telephone number to contact health and social care professionals across the range of services. The SPOC will be based in one place, co-locating health and social care staff, and will operate 7 days a week. The SPOC will provide a 7 day phone line to help and guide people and professionals.

What out of Hospital Integrated Intermediate Care could look like for Patients?

When Mrs Smith slipped and fell in her own home she pulled her alarm cord. The community response team visited Mrs Smith and contacted the digital health centre through their 4G tablet device. The digital health nurses could see Mrs Smith to assess her and were able to rule out any obvious serious injury, the team provided advice and guidance and made a referral to the community Integrated Urgent Care Team to help Mrs Smith to mobilise following her fall. A Nurse from IUCT team assessed Mrs Smith and as a trusted assessor provided some equipment to help Mrs Smith's mobilise around her house and asked for one of the team's carers to visit in the evening to assist Mrs Smith to make her evening meals. The teams Physio provided Mrs Smith with some exercises she could do to increase the movement in her leg. After two days of support from the IUCT service Mrs Smith was able to manage independently in her own home but said that she would miss the company of the team. The IUCT team provided contact numbers for Action Together to provide Mrs Smith with the details of community voluntary services that she can get involved with.

Community Beds

A **flexible** community bed-base is key to effective intermediate care as it supports an individual's needs that cannot be met through home based intermediate care. By providing an enabling environment for further assessment; rehabilitation; completion of treatment and/or recuperation, it will prevent unnecessary admissions to hospital (through step up) or into long term care and facilitate timely discharge to assess for those people not able to be assessed at home but do not require Acute care.

When home is not the default position for the provision of care for an individual, the flexible community beds base will offer:

- Step down capacity for discharge to assess (including complex assessments)
- Step up capacity to avoid acute admission
- Intermediate Care Services

The ICFT is the provider of all intermediate care beds for Tameside and Glossop in two locations, Stamford Unit and Shire Hill. Following the implementation of home first model which ensures delivery of robust intermediate care services in the home setting, this model proposes that all the community beds should be located in the Stamford Unit facility in order to utilise the resource flexibly to meet the needs of the patients across the health economy and fully deliver the service model for intermediate care beds.

What Community Bed Intermediate Care could look like for Patients?

Mr Jones was admitted to Tameside and Glossop's flexible community bed base following a recent illness which required acute treatment in hospital. Mr Jones having COPD and diabetes had been admitted to hospital 3 times in the last year. At the IMC unit Mr Jones was assessed by the physiotherapist and provided with a list of 'goals' to be achieved during his stay and how long it was expected that this would take. After only 5 days at the unit Mr Jones had met his goals so a 'Home First' discharge to assess was arranged so that Mr Jones could continue his rehabilitation in his own home as soon as possible. Mr Jones was assessed by a physiotherapist and a social worker who were able to wrap around care and support until Mr Jones regained his confidence and independence. The IUCT team noted that Mr Jones has two long term conditions and has recently been admitted and discharged from hospital so made a referral to the Extensivist service so that Mr Jones could benefit from some enhanced medical intervention before his long term care needs could be fully met within his integrated neighbourhood.

Integrated Neighbourhood services

Tameside and Glossop Integrated Care Trust has established five Integrated Neighbourhood Teams, which will be Multi-disciplinary teams comprising Primary care (including GP services and pharmacists), community services such as district nursing and therapy services, social care, Mental Health services and the voluntary/community sector, one of which is for the Glossop neighbourhood.

The vision of these Neighbourhood Teams to deliver high quality and connected core health and care services, tailored to the neighbourhood population in order to best meet the specific needs of the population and to improve outcomes.

In respect of intermediate care model the Integrated Neighbourhoods through the GP, social care services and community teams will provide a co-ordinated care and support service to people who live in their neighbourhood area who have intermediate care needs. The team will also link with the intermediate tier/specialist and urgent care services to provide additional care input where required.

Mental Health Service

We are working to improve and integrate mental health services to better support the needs of individuals. This is being done by aligning all available resources within the locality including existing and new resources as part of our Care Together programme.

One of the key priorities is to increase mental health capacity within the Integrated Neighbourhoods through:

a) increasing access to emotional and mental health well-being workers by offering easy accessible drop-ins in GP surgeries and other community locations and a broadened mental health offer with a wider range of interventions;

b) developing a new model, integrated with the Neighbourhood Teams, to meet the needs of people with complex needs;

c) increasing dementia support in the Neighbourhoods by integrating Dementia Practitioners and Admiral nurses in the Neighbourhood Teams, as well as working with a Dementia Support Worker from the Alzheimer's Society; and

d) establishing a self-management education college to support people to develop the knowledge and skills to manage their own health.

Social Prescribing Navigators

A social prescribing service within the neighbourhood teams who provide links to non-medical services to support individuals in self-care and wellbeing.

Community Social Care

Social care services are provided by Derbyshire County Council these assess and provide care to patients to ensure they are able to remain independent for as long as possible and to delay placements into long term residential care.