Intermediate Care Model for Tameside and Glossop

Vision for New Model of Care for Tameside and Glossop

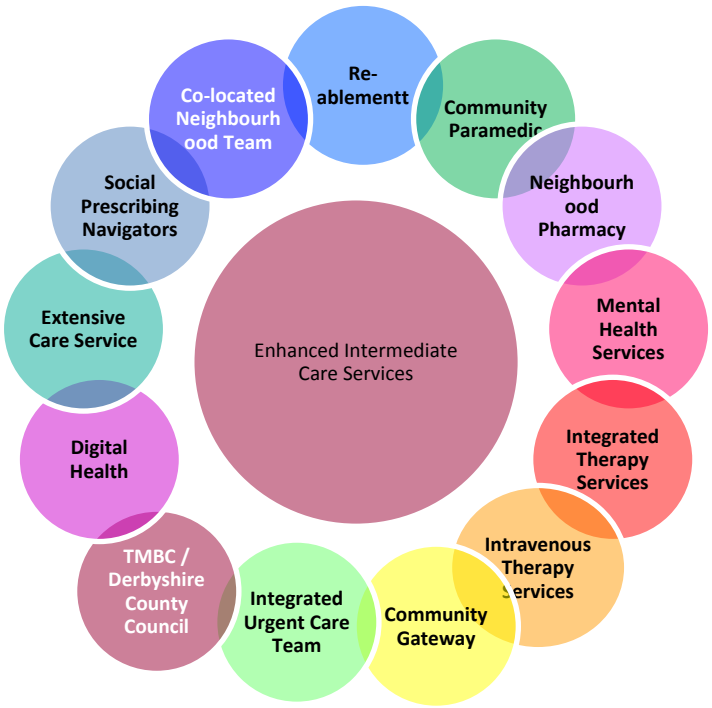
Tameside and Glossop health and care system has recognised that it needs to develop new models of health and social care to meet the changing needs of is population, including an aging population with more complex and long term health and care needs and the need to provide high quality and effective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

Proposed Intermediate Care Model

There are four nationally defined categories of intermediate care;

Crisis Response:
(NICE definition) - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home Based Rehabilitation:
(NICE definition) - Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Bed Based Intermediate Care:
(NICE definition) Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Re-ablement:
(NICE definition) Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

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.

Crisis Response

The urgent element of the Intermediate Care model for Tameside and Glossop is through the Integrated Urgent Care Team (IUCT) which is made up of health and social care services for Tameside patients and healthcare services for Glossop patients (with interface with Derbyshire County Council social care services). IUCT will provide the urgent response to the crisis health and/or social care need for patients. The IUCT service to ensure patients are supported through the most appropriate pathway into and out of acute hospital or care services with “home” always being the goal.

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 upto 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.

Home/ Community Based Services

IUCT, community and specialist intermediate care services are in place (and new services being implemented as part of the Integrated Neighbourhoods) which are provided in the community setting to deliver the home based 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;

Community Integrated Urgent Care Team (IUCT)

The Integrated Urgent Care Team (IUCT) also provide the short term community based social care services and/or placements (for Tameside population) for a period of upto 6 week which sit alongside the intermediate tier health care services to provide a full home based intermediate care service.

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. This service has commenced in Willow Bank and Pendlebury Court care homes in Glossop and will be in place in Oakford Manor by the end of August.

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 musculo-skeletal 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 neighbourhood also 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 an 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 home based Integrated Intermediate Care looks 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.

Integrated Neighbourhoods

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. 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.

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 Tameside Metropolitan Borough Council for Tameside and Derbyshire County Council for Glossop. 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.

Bed Based Intermediate Care

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 from acute care for patients who are awaiting assessment for ongoing care services (including complex assessments) or have an non-medical ongoing care/rehabilitation need before they are able to return to their place of residence
- Step up from community to avoid acute admission or long term care placement
- Intermediate Care Services (step up or step down)

The ICFT is the provider of all intermediate care beds for Tameside and Glossop. Following the implementation of the home based intermediate care model which ensures delivery of robust intermediate care services in the home setting, the Trust proposes that all the community beds should be located in the 96 bedded 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 (with some additional provision in Glossop to meet the needs of the population).

What Bed based Intermediate Care looks 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.