Hull Intermediate Care Services

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Senior Operations Manager
Local Demographics Vs National picture

- 36,000 people aged 65+
- 22,000 living with a life limiting illness or disability
- Deprivation higher than England average
- Life expectancy for both men and women lower than England average
- Heavy reliance on acute hospital based care
- National outlier in respect of emergency admissions

*NHS Hull CCG (2015)*
Emergency admissions

Emergency Hospital admissions, SARs, 2008/9 to 2012/13, Selection (comparing to England average)

- Green: Significantly better than England
- Yellow: Not significantly different
- Red: Significantly worse than England

Source: Public Health England, HSCIC © Copyright 2014
www.localhealth.org.uk
Our Journey so far...

2001- 1 yr pilot- 5 beds in a local nursing home  
1.0 wte OT, 0.6 wte rehab assistant

2002- permanent funding agreed for above plus 1.0 WTE Physio

2003- Pilot evaluation increased to 15 beds  
additional 5.0 wte nursing and therapy staff

2004- pilot 1 PA geriatrician and 1 PA GPwSI

2007- increase to 25 beds  
nursing and therapy input permanent funding for medical cover

2010- New LA funding for 5 Reablement beds pilot in residential home

2012- LA permanent funding Section 256  
Total bed base to 45 + 4 PA geriatrician input
## Current provision

Community bed based rehabilitation = 45 beds  
Home based rehab = 30  
Reablement flats = 18  

TOTAL WTE = 56.0

<table>
<thead>
<tr>
<th>Workforce</th>
<th>WTE/Planned Activity per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Geriatrician</td>
<td>4.5 PA per week (for 45 beds)</td>
</tr>
<tr>
<td>GPwSI</td>
<td>2 PA per week (for 45 beds)</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>0.60</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>6.0</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>7.0</td>
</tr>
<tr>
<td>Therapy assistants</td>
<td>10.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>18.0</td>
</tr>
<tr>
<td>Health Care Assistants</td>
<td>10.0</td>
</tr>
<tr>
<td>Social Workers</td>
<td>0.2</td>
</tr>
<tr>
<td>Admin Staff</td>
<td>3.0</td>
</tr>
</tbody>
</table>
Hull Intermediate Care Service Overview

Hospital-based Rapid-response team
- Prevent admission to base wards
- Facilitate rapid transfers of care
- "Discharge to assess " model
- Input to daily patient flow meetings within integrated discharge Hub

Community facility based rehabilitation
- Access to step-up and step-down community beds and reablement sheltered accommodation flats
- Multi-disciplinary intensive rehabilitation
- Care coordination by most appropriate senior clinician

Home based rehabilitation
- Specialist care at Home
- Multidisciplinary intensive rehabilitation
- Prevention, self care and long-term support
- Collaborative working model with local authority and voluntary sector services

7 Day Services 8am-8pm 365 days a year
Intermediate Tier of Services

HOSPITAL

DISCHARGE FACILITATION

45 COMMUNITY BEDS
Includes non-weight bearers

18 REABLEMENT FLATS
Sheltered housing

MANAGED AT HOME

ADMISSION PREVENTION

COMMUNITY
Commissioning arrangements
Half funded by CCG & Half funded by LA circa £3m

Health and social care services work in partnership to ensure referral pathways are in place and are simple to understand.

The service is available for people who are:

- 18 years and above
- Registered with a Hull GP
- Medically safe to be managed in a community setting
- Require short-term rehabilitation from a multi-disciplinary team.
- Willing and able to participate in Rehabilitation.

We Welcome ???Rehab Potentials.....
National Audit of Intermediate Care (2014): “Best Practice” indicators

- Assessment by geriatrician within 72 hours of admission ✓
- Geriatrician-led multidisciplinary rehabilitation ✓
- Secondary prevention of falls ✓
- Bone health assessment ✓
- Referral to transfer time 2 days or less ✓
- Multidisciplinary care by 5 or more staff types ✓
- Average length of stay less than 21 days ❌
- I was involved in discussions and decisions about my care ✓

Young J, NAIC Conference (2014)
Medical Cover NAIC (2015)

Provision of medical cover

- Consultant geriatrician (in house)
- Consultant geriatrician (sub-contracted)
- GP and consultant geriatrician
- GP (in house)
- GP (sub contracted)
- Service users own GP
- Advanced Nurse Practitioner
- Other

NAIC 2014: 13.55
NAIC 2015: 16.28
## NAIC 2014

<table>
<thead>
<tr>
<th>Audit Area</th>
<th>Hull Intermediate Care</th>
<th>National Average</th>
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</thead>
<tbody>
<tr>
<td>Cost per Bed day</td>
<td>£118.14</td>
<td>£235.20</td>
</tr>
<tr>
<td>Cost per service user admitted</td>
<td>£4054.05</td>
<td>£5548.89</td>
</tr>
<tr>
<td>No: of referrals</td>
<td>1564</td>
<td>546.07</td>
</tr>
<tr>
<td>No: of referrals accepted</td>
<td>444</td>
<td>389.03</td>
</tr>
<tr>
<td>Bed Occupancy</td>
<td>90%</td>
<td>85.27%</td>
</tr>
<tr>
<td>Average LOS</td>
<td>34.3</td>
<td>27.95</td>
</tr>
</tbody>
</table>
NAIC 2014

Destination on discharge

- Own home
- Not known
- Died
- Hospice
- Mental health facility
- IC bed based unit
- Community hospital
- Acute hospital
- Sheltered housing
- Nursing home
- Residential home
- Relative's home

National Avg: 64.47%
Hull: 73.42%
NAIC 2014 Hull Intermediate Care

Mix of disciplines

- Nursing
- Therapy / AHPs (Inc MH workers)
- Social worker
- Health care support worker
- Medical
- Supporting functions
- Other

Mix of disciplines (average) — Mix of disciplines (submission)
NAIC 2014

Modified Barthel index: 2014

Service user 1
Service user 2
Service user 3
Service user 4
Service user 5
Service user 6
Service user 7
Service user 8
Service user 9
Service user 10
Service user 11
Service user 12
Service user 13
Service user 14
Service user 15
Service user 16
### NAIC 2014 PREM results

<table>
<thead>
<tr>
<th>PREM question</th>
<th>Hull Intermediate care</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information available to staff re: pt condition</td>
<td>100%</td>
<td>85.83%</td>
</tr>
<tr>
<td>Information given to pt</td>
<td>83.33%</td>
<td>85.17%</td>
</tr>
<tr>
<td>Pt awareness of goals</td>
<td>100%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Pt involvement in goal setting</td>
<td>50%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Trust &amp; confidence in staff</td>
<td>100%</td>
<td>87.21%</td>
</tr>
<tr>
<td>Pt involvement in discharge decision making</td>
<td>66.67%</td>
<td>62.24%</td>
</tr>
<tr>
<td>Pt feeling less anxious on discharge from service</td>
<td>83.33%</td>
<td>74.68%</td>
</tr>
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</table>
Innovation in Practice

- A & E liaison service – Nurse-practitioner led
- Front Door Rapid Response & joint triage in ED
- Discharge to assess for ED & Assessment units
- Proactive management of frequent callers
- Rapid response therapy, # clinic follow ups
- ED assisted discharge – voluntary sector
- Electronic patient flow management- CAYDER
- Dedicated Pt transport service for ICT
Innovation Continued....

• Rapid access to minor adaptations - dedicated joiner
• In hours dedicated GP input post discharge
• Senior pharmacist follow up from acute trust
• Twice a week geriatrician review in community along with pharmacist
• Physio Independent prescriber
• Daily information meetings/board rounds
• Access to IT systems in community
• Discharge review service
• Engaged & proactive workforce
Community bed based rehab

• 3 separate bedded facilities
  – x15 nursing bed
  – x30 residential beds
  – x18 reablement flats

• Geriatrician led MDT (4.5 PA Consultant Geriatrician per week)

• MDT of more than 5 specialities

• Rapid access to community based specialist nursing services e.g. respiratory, cardiac, end of life teams

• 7 day provision of intensive therapy and rehabilitation

• Social Worker input to MDT
Challenges

• Onward patient flow management
• Integration Vs Competition
• Multiple- agencies
• Resource- funding cuts
• Recruitment
• Health behaviour change for patients
What next

New Care Models (NHS England)

“Secondary” care reaches into general practice
Primary & Acute Care Systems

“Primary” Care reaches into the hospital
Multispecialty Community Providers

Young, J. NAIC conference (2014)
Plans for Hull in line with Five year forward view

- NHS Hull CCG strategic plan 2014-2020
- Lead provider model for community services
- Community Hubs (MCPs)
- Hull Integrated Care Centre (PACS)
- Urgent and Emergency care network
- Care Co-ordination by “expert generalists”
- RCGP primary care blue print
- BCF plan
A few tips...

• Audits, pilots, service evaluations
• Invest in resource for the above
• Early engagement with CCG
• Explore CCG strategic plans
• Encourage and nurture innovation
• ACT fast – a year is gone from Five year forward view
• Service re-design and work force planning must happen now (acute-community rotations)
DTOC Trend for the North of England over the past year

Delayed bed days for the North of England as a whole by responsible organisation by month over the past 12 months

Source – UNIFY national data collection
Aim

The aim of the medical elderly service in the community is to increase access to specialist medical care for older people delivered as part of an integrated pathway across acute, primary and community care.

Ricky Saharia (2011) Community Geriatrics provision
Service model

- Consultant led community geriatric care
- Integrated across primary, community and acute care.
- Consultant time will be split 50/50 across acute and primary/community care.
- Clinical sessions specifically for acutely ill dementia patients working across the hospital & community settings and working in partnership with older adults mental health services.
Provision

• Clinical Leadership
• Input to Intermediate Care
• Rapid access clinics
• Support for GPs managing complex patients in community - MDT
• Support for GPs managing care home patients
• Work with long term conditions / community matrons

Ricky Saharia (2011) Community Geriatrics provision
Older Person’s Pathway

Older Person → Symptom → GP / OOH → Acute illness → Admission → Early Supported Discharge

Multidisciplinary Medical Elderly Clinics → Assessment

Medical Elderly Clinics → Symptoms managed

Intermediate Care Services

Re-ablement → Home From Hospital

ICT Bed / Community Hospital

Improve quality of life
Maximize independence
Support home living

Ricky Saharia (2011) Hull medical elderly community pathway
Thank You

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