Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation
Drivers for Change

- Keeping people at home or a homely environment
- Personal person centred choice
- Improved medications and treatments
- Increased older population living longer with more chronic conditions
- Pressure on the acute sector
- Benefits of Technology Enabled Care
- Desire to work differently and to the full extent of professional abilities
- Financial pressures for NHS and local authorities
New Models of Care for Older People and People with Complex Care Needs

Your Community
- Community Connectors
- Carer support
- Lunch Clubs
- Befriending
- Local Activities
- Third Sector
- Independent Sector

Support for end of life or palliative care
Dementia friendly

Locality Team
- District Nurses
- CPNs
- Pharmacists
- Community Connectors
- Social Workers

Complex Care Team
- Care at Home
- ICT
- Community Ward
- Hospital at Home
- AHPs
- Advanced Nurse Practitioners
- Care of Elderly Physicians
- Old Age Psychiatrists
- Palliative / End of life care

Families
Home
Carers
Practice Team
Locality Team
Technology Enabled Care
Rehab and Intermediate Care
Community Hospitals
Combined Assessment Unit
Hospital
Care Home
Liaison
New Models of Care for Older People and People with Complex Care Needs

Version 0.11
Pan-Ayrshire Tec-Enabled Model for Intermediate Care and Rehabilitation

**East, South and North Partnership Hubs**
Centralised number(s)
Clinical Triage
Care Homes/
Very Sheltered Housing
Intermediate Care Team
Hospital at Home
Pre-conveyance

**Community Rehab**
- Community Rehab* Day Hospitals
- Health & Therapy Teams

**Enhanced Intermediate Care**
Intermediate Care Team
Hospital at Home
Pre-conveyance

**Reablement Home Care**
For ICT Clients

**Residents**
Home or Homely Environment

**Hubs**
Intermediate Care and Rehabilitation Hub
East, South and North Partnership Hubs
Centralised number(s)
Clinical Triage

**Community Hospitals**
In-patient Rehabilitation
Stroke/Neuro Rehab

**Step Up/Step Down**
Care Homes/ Very Sheltered Housing

**Support at Home**
Community Rehab*
- Domiciliary physiotherapy
- Community rehabilitation occupational therapy
- Community adult speech and language therapy
- Community dietetics
- Enablement podiatry

**Support in an Acute Hospital**
Combined Assessment Unit
ACE Practitioners
Acute Hospital
Discharge Interface
ACE Practitioners

**Support in a Step up/Step down facility**
Admission Interface

Version 0.11
Enhanced Intermediate Care Teams

- Enhanced Intermediate Care Teams (7 days per week)
- Extended - sub-acute response to prevent admission
- Integrated MDT working
- Close liaison with CAU, ED
- Interface with ACE practitioners
- Reduction in admission/length of stay for Case sensitive Ambulatory Sensory Conditions e.g. COPD, Frailty, Cellulitis, UTI etc.
### ASCS Conditions Treatable in the Community

<table>
<thead>
<tr>
<th>Condition</th>
<th>Ayr Hospital</th>
<th>Crosshouse Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td>2333</td>
<td>70</td>
</tr>
<tr>
<td>COPD</td>
<td>1238</td>
<td>34</td>
</tr>
<tr>
<td>Asthma</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>303</td>
<td>21</td>
</tr>
<tr>
<td>Nausea Vomiting &amp; Abdomen Pain</td>
<td>134</td>
<td>22</td>
</tr>
<tr>
<td>Constipation, Gastritis, Gastro Nonfec</td>
<td>1570</td>
<td>42</td>
</tr>
<tr>
<td>Unintentional Injuries (Incl falls)</td>
<td>119</td>
<td>0</td>
</tr>
<tr>
<td>Diabetes</td>
<td>182</td>
<td>389</td>
</tr>
<tr>
<td>Renal &amp; Urological Disorders</td>
<td>1532</td>
<td>361</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>318</td>
<td>37</td>
</tr>
<tr>
<td>Total</td>
<td>7564</td>
<td>956</td>
</tr>
</tbody>
</table>

- Partnership Bed days total (both hospitals) 25447 28763 27648
- Population per LA Area 122080 138146 112799 6618 bed days - assuming 20% treatable in Community 9754 bed days - assuming 20% treatable in Community
- Use by 100,000 population 20847.94 20820.73 24510.86 18 beds reduced 27 beds reduced

- Bed Days for Acute Hospital Use per Partnership (2016/17 age over 65 years)
Community Rehabilitation Teams

- Community Rehabilitation Teams (5 days per week)
  - Community Occupational Therapy
  - Dietetic Service
  - Domiciliary Physiotherapy
  - Falls Service
  - Podiatry Service
  - Pulmonary Rehabilitation
  - Speech & Language Therapy Service
  - Multi-disciplinary Locality Teams
Strategic Service Change Programme

Questions