Integrated Care Matters Webinar
Integrated, Local and Personal

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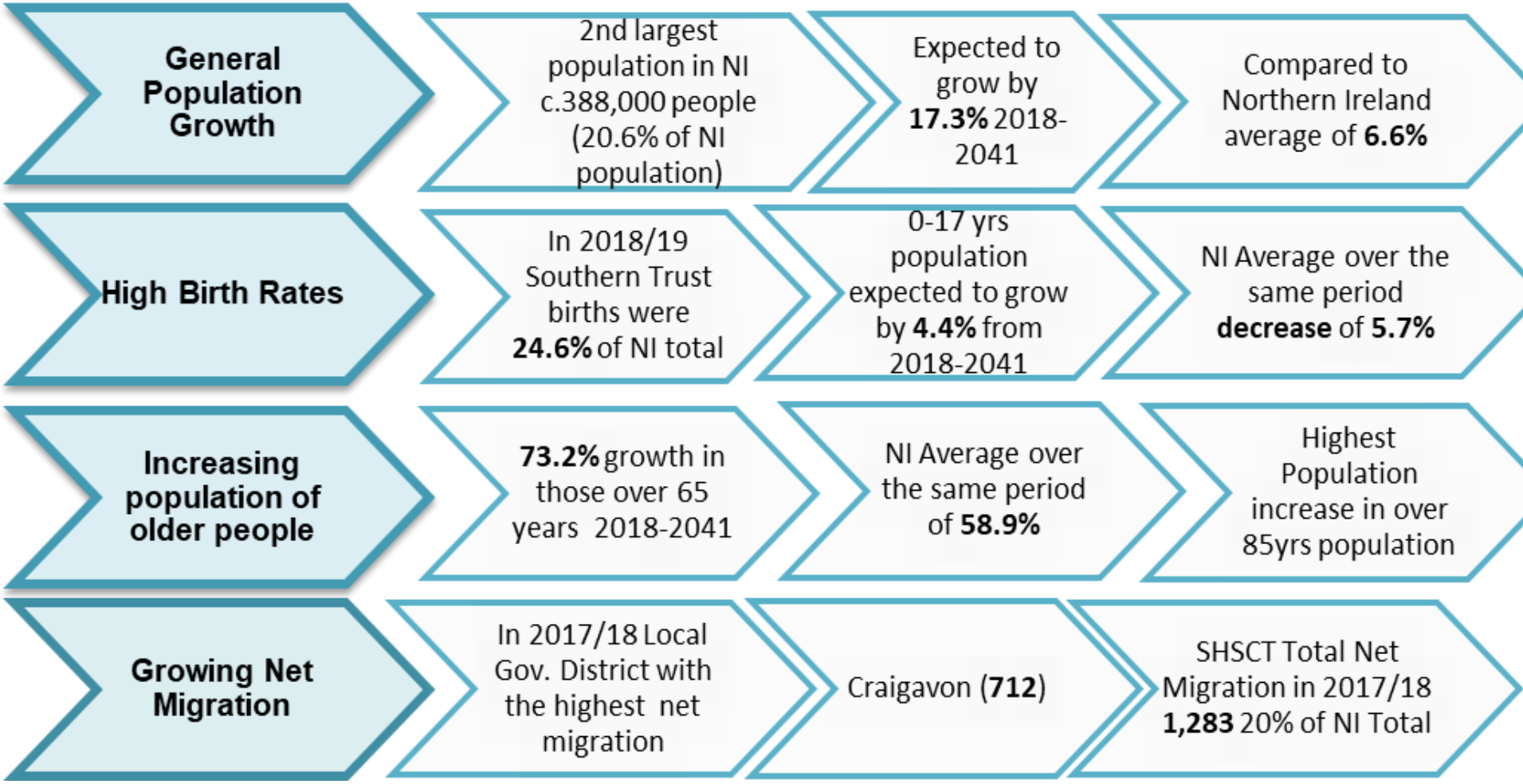
Acute Care at Home and Intermediate Care

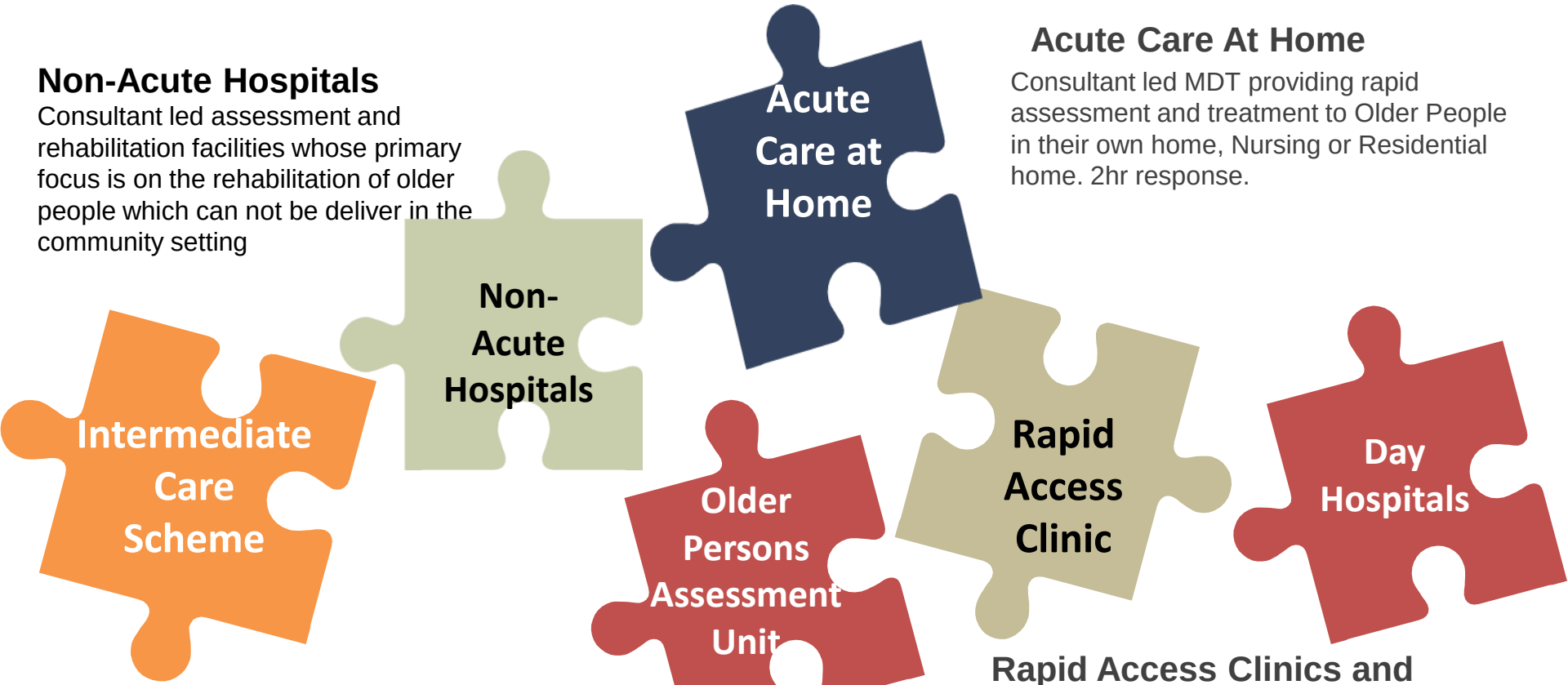
Map of NI showing the Southern Health and Social Care Trust

Southern Health

Integrated health and social care Trust providing services across hospital and community services and also in people's own homes.



Older Persons Services



Non-Acute Hospitals

Consultant led assessment and rehabilitation facilities whose primary focus is on the rehabilitation of older people which can not be deliver in the community setting

Acute Care At Home

Consultant led MDT providing rapid assessment and treatment to Older People in their own home, Nursing or Residential home. 2hr response.

Intermediate Care

Intermediate Care is a rehabilitation service consisting of OT and Physio staff who can provide up to 6 weeks input for patients who have suffered a deterioration in their functional ability. Response 24-48hours.

Rapid Access Clinics and Day Hospitals

RAC- Consultant led MDT providing assessment and treatment to Older People who suffer a sudden deterioration in their health. One stop assessment in clinic setting. 24-48hour response.

Day Hosp- Provide rehabilitation services for older patients with or without medical review as required.

Focus today

How has SHSCT Intermediate Care service focused on providing integrated, local and personal care?

Background – Intermediate Care in Southern Trust

- Intermediate Care is has been operational in SHSCT since 1998

- Trustwide multidisciplinary rehabilitation service to provide short term intervention to promote the independence of people following a hospital admission or where there has been a deterioration in functional ability due to an acute/exacerbation of their medical condition.

- Funding allocated from 2016/17 to 2019/2020 for additional staff required due to increase in referrals and then for further additional staff to facilitate service developments e.g discharge to assess and Older Persons Assessment Units

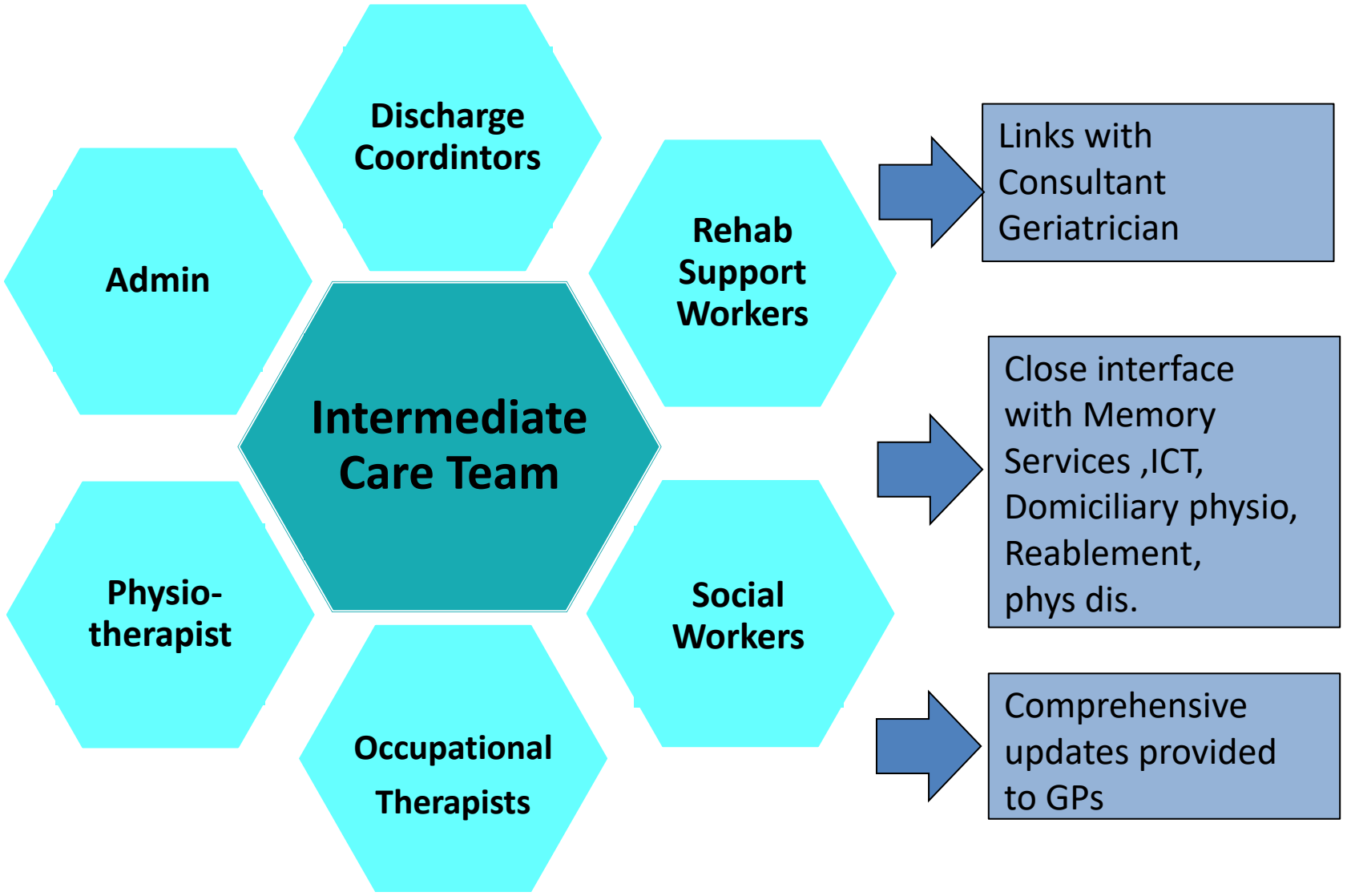
Intermediate Care Scheme can:

- Prevent hospital admission and enable clients to leave hospital when they are medically fit
- Respond rapidly – response time for assessment of 0.8 days on average – within 2 hours if necessary
- Arrange short term placement in residential/ nursing home if client is unable to remain in own home (for > 65s)
- Multi- disciplinary, short term rehabilitation and focus on client remaining / returning to own home.
- Reduce the need for long term help at home or long term care
- Delay/ reduce the affects of frailty

Guidelines for referral to service

- Resident of Southern Trust
- Recent decline in function/ ability
- Requiring OT &Physio input
- Patient consent to referral/ input from ICS
- clients will normally but not exclusively be over 65

Intermediate Care Team



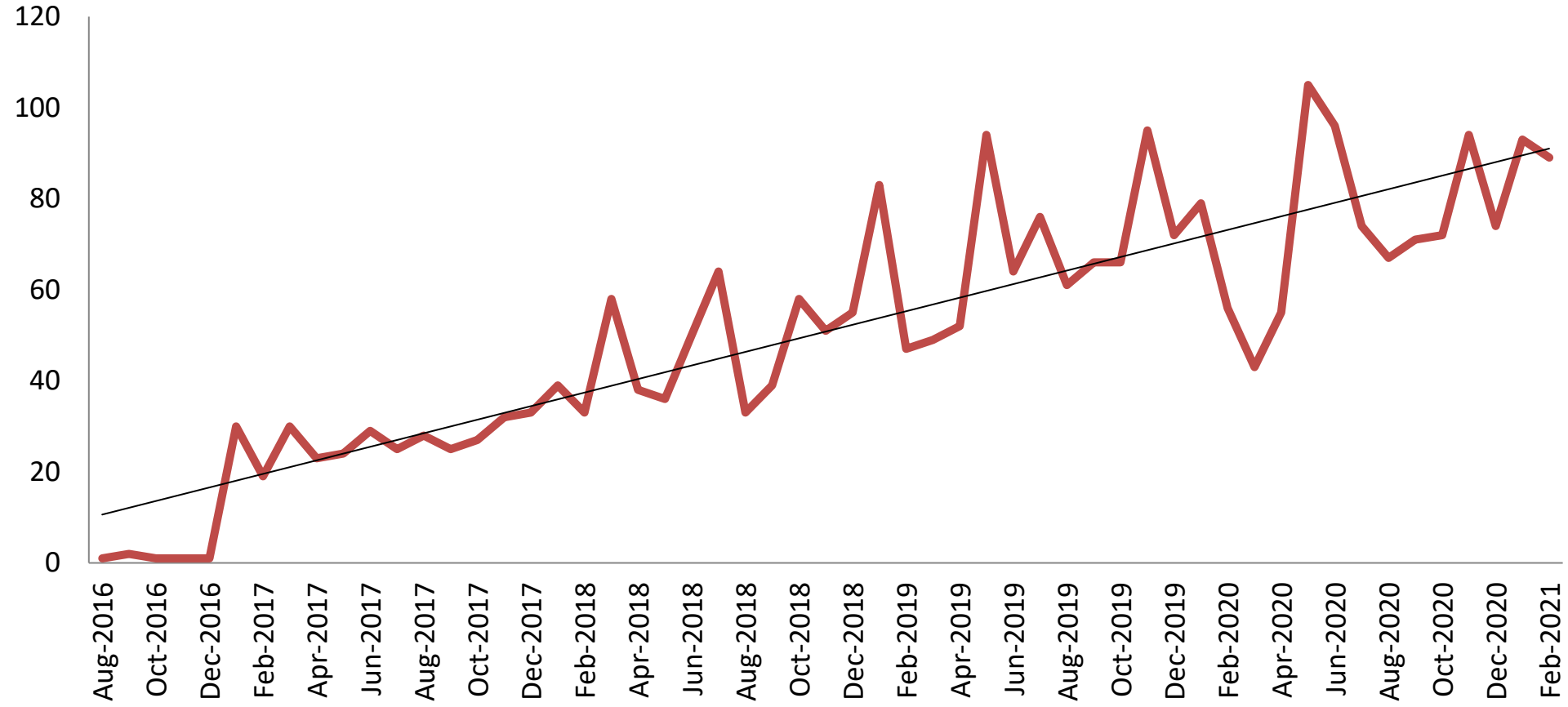
Step up Intermediate Care

- Prevention of hospital admission
- Support to community colleagues to provide rapid, wrap around service in own home
- Short term placement in care home if unable to remain in own home
- Same day response to prevent crisis
- Close working with GP and community services

Step up Intermediate Care

- Historical emphasis on hospital discharge (step down)
- Engagement with GPs and community teams to promote step up pathways
- Referral to assessment – same day

Step up referrals to service 2017-2021



Case Study

- Contacted GP following a fall- difficulty in/ out bed/ on /off chair
- Baseline : Independent but “less able” in past few months
- Step up referral via A&I – seen same day- 3 hour response time.
- Struggling with transfers, gradually stopped cooking since partner passed away 1 year ago, not remembering to take medications, reduced social connections
- ICS outcome-following 16 days on ICS- independent with transfers, set up routine and technique for daily medications, resuming light meal prep and delivery of meals arranged, planning to join Men’s shed

Step down Intermediate Care

- Unique role of **Discharge co-ordinators** and **Inreach managers**
- provide community expertise and focus on discharge pathways to support acute hospitals
- Early escalation of issues and agreed action plans to address same
- **Home first-** default pathway- less reliance on step down beds
- Discharge to Assess

Home Vs Placement

With Rehab	2017/18	2018/19	2019/20	2020/21 (to date)
Referrals to home	1417	1685	2068	2424
Referrals to placement	691	714	949	512
Total referrals with rehab	2108	2399	3017	2936
% home at starting pathway	67%	70%	69%	83%
No. D/C home from placement	533	569	718	414
% D/C home from placement	77%	80%	76%	81%

Home First Ethos

- 2020/21 to date:

- Total referrals with rehab **2936**
- Referrals to home **2424**

- Referrals to placement **512**
- Discharged home **414**
  from placement (ICS)

- **Total number of patients home = 2424 + 414= 2838**

96%

Intermediate Care – An Integrated Approach

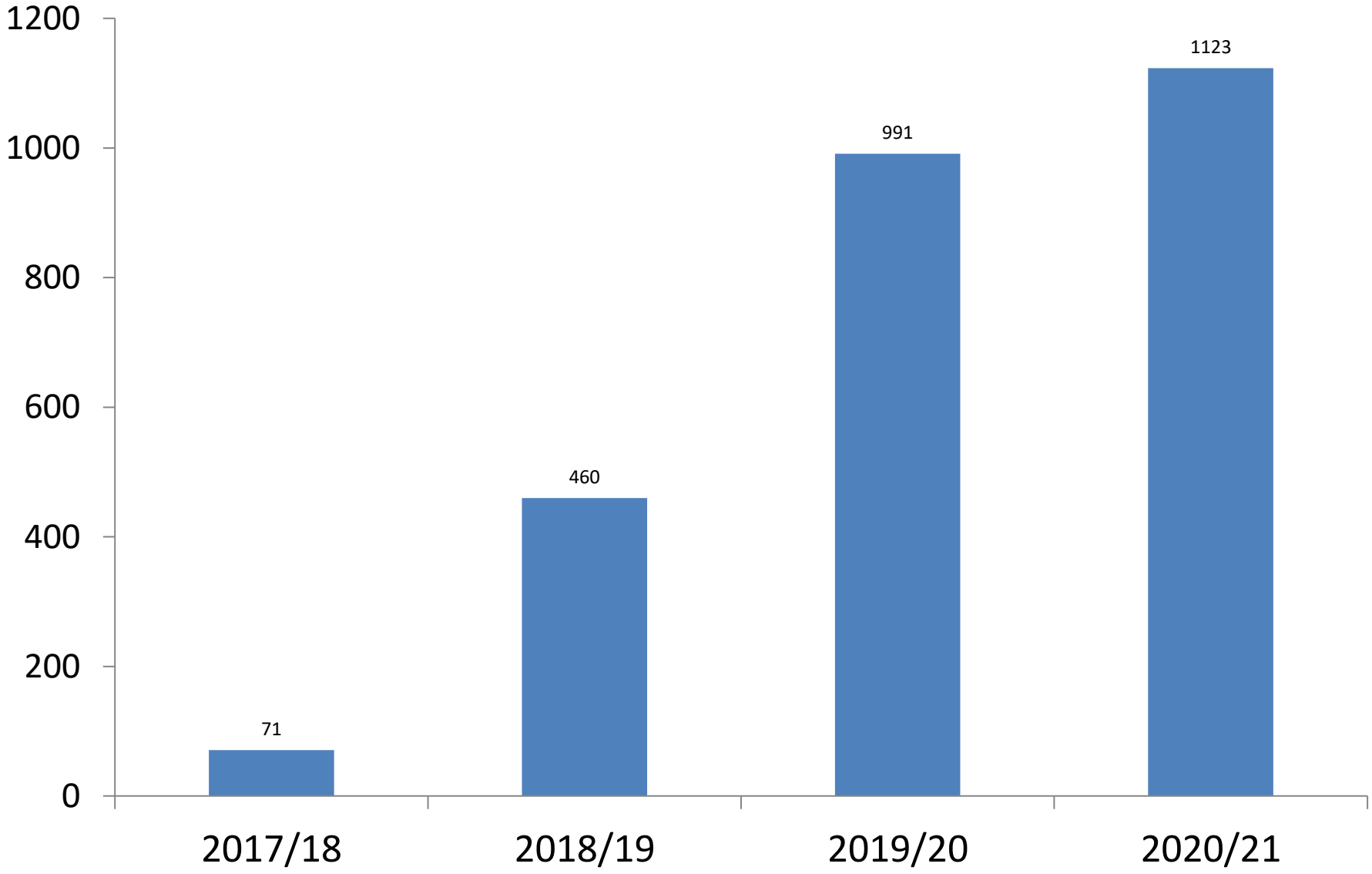
Discharge to Assess

- Collaborative working with colleagues – acute and community
- Focus on the simpler discharges initially
- Reduce duplication
- Establishing trust across Directorates
- Assured/ rapid response from Intermediate Care- same day as needed
- Continued promotion and encouragement of D2A- aim to make default pathway- in 20/21- 30.5% of all referrals to ICS rehab were D2A

If you had 1,000 days left to live how many would you choose to spend in hospital?

Ask-
Are they benefitting from being in a hospital bed?

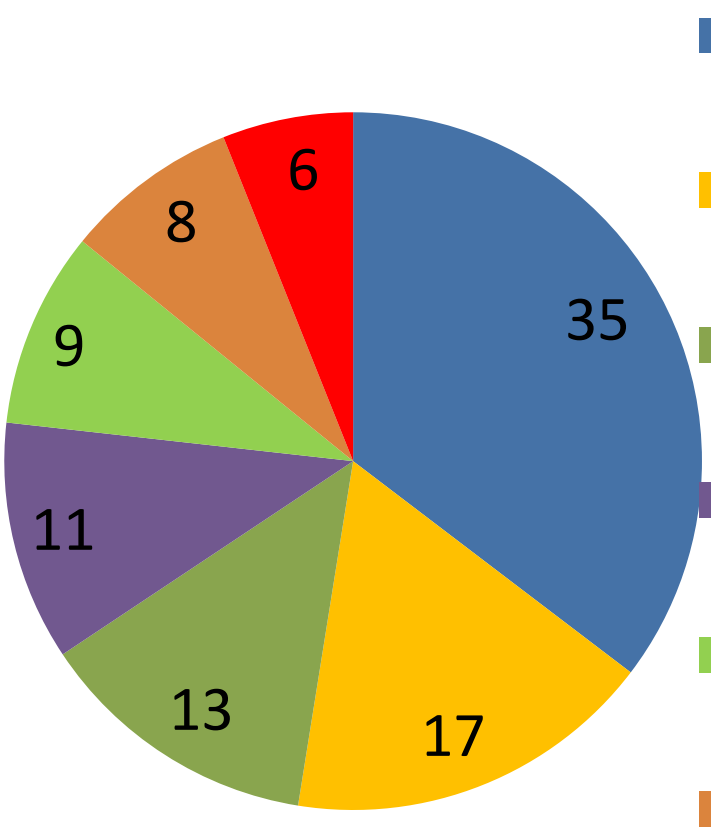
Discharge to assess referrals 2017- 2021 (to date)



Older Persons Assessment Unit

- ED diversion scheme for older frail population
- Identify appropriate pathways for older frail patients
- Continuity of care via collaborative working
- Holistic multi-disciplinary assessment. The patient receives a fully comprehensive geriatric assessment and frailty screening
- Medical and Nursing input – AC@H
- AHP input - Intermediate Care
- Knowledge of community pathways and services

OPAU Discharge Outcomes



- GP
- Acute Admission AC@H
- ICS
- NAH
- Clinic

985 referrals from 01/04/19 to 31/01/20.

83% of these referrals were not admitted to an Acute bed.

ED Follow up - Rationale

- Initial COVID-19 surge - recognised that older, frail patients who attended ED where the decision was not to admit, may have needs for follow up services and it would be beneficial to link with these patients.

- All patients over the age of 65 could be followed up with a telephone call by a therapist from Intermediate Care to ensure they were not struggling and provide them with appropriate advice and support.

- If an onward referral to another service was deemed necessary, this could be initiated immediately to the appropriate service

- The need for early intervention, advice and referral is vital in the management of Frailty and can not be overlooked in the time of COVID-19.

Who can follow up?

- Intermediate Care was operational through COVID to help ensure timely discharge from hospital and prevent unnecessary admissions.

- There were a number of staff however that were shielding or unable to take part in face to face visits who were very keen to help provide a service in any way possible.

- These staff agreed to provide a follow up service for all patients over the age of 65 that attended ED, were not admitted and not actively open to another service.

ICS In/Exclusion Criteria

Inclusion criteria

- Falls* (presentation to ED or history of)
- Continence issues*
- Polypharmacy - 5 meds or more*
- Cognitive disorder*
- Reduced mobility / ability to cope
- UTI
- Fractures
- Significant musculoskeletal injuries
- Problems impacting transfers
- General concerns from triage info
- Social isolation risk* (from any of above or clinical reasoning)

Exclusion Criteria

- Minor injuries or abrasions
- Permanent Nursing/Residential home resident

Clinical Reasoning

- In/Exclusion criteria should not be used rigidly and clinical reasoning should apply.

* Frailty warning signs

ED Follow ups
April 2020 – end January 2021

No. contacted since April 2020	Advice /Reassurance/ Exercises & contact details for Access & Information	Advice /Reassurance/ Exercises & onward referral to relevant service
3304	2786	516
		15.6%

ED Follow ups
December 2020 and January 2021

Advice /Reassurance/ Exercises & contact details for Access & Information	516
Physiotherapy	17
Occupational therapy	25
Intermediate Care	11
Falls	38
Key worker/carer assessment	3

At a time of loneliness and isolation…

Focus on Frailty

- Enhance awareness of frailty across all services/ Directorates
- Proactive identification of frailty
- Early intervention/ signposting for mild frailty
- Holistic- emphasis on self management- choice and independence, Living well with …..
- Community and voluntary engagement and support

Feedback

- In September of 2020, I fell and fractured my tibia and my knee and was placed in a leg brace for 12 weeks.
- Prior to this incident I was fully independent and still driving my car.
- I was very dependent on my carers and family to assist me with all my daily needs. My biggest fear that I was not going to be able to walk again.
- From day 1 the staff were so positive that I would be walking again (it might take some time but it would happen).

- Day by day my confidence increased and I began to believe that this would happen. I was involved in all discussions with the team and together each week we set new goals - and all my personal preferences were taken into consideration.

- It all due to the dedication, positivity and excellent care this team provide and it is carried out with a smile on their faces (even under the masks!). They constantly encouraged me, gave positive feedback, pushed me when required and made me believe that I would be walking again

THANKS