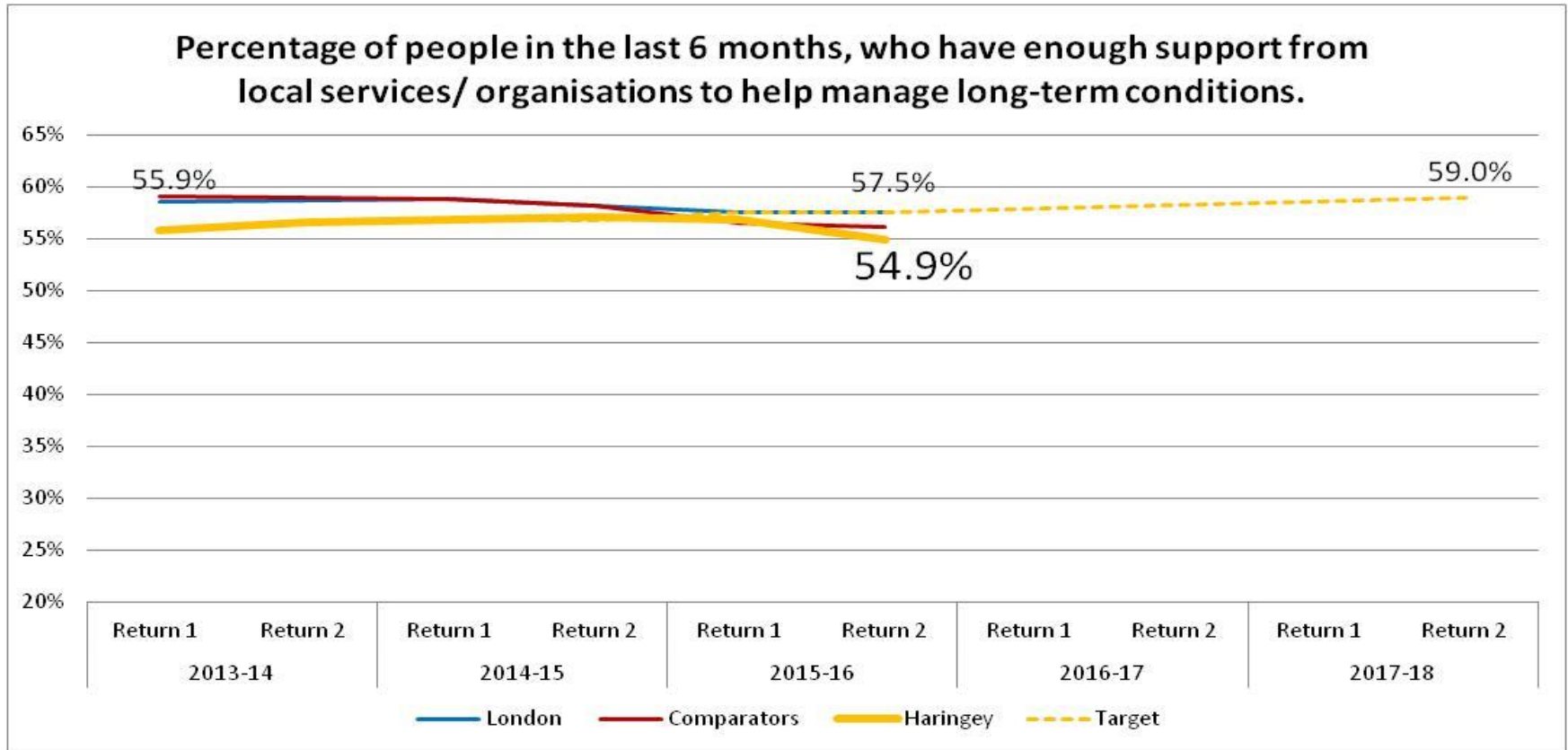


Intermediate Care: A case study of integrated care in Haringey

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Health and Wellbeing Strategy ambition & target

This presentation topic is linked to ambition 6: “More people will do more to look after themselves”



Source: GP patient survey

Overview

1. Background and context
2. What is intermediate care
3. The evidence base for intermediate care
4. Reviewing intermediate care in Haringey
5. Next steps
6. Discussion points

Context: Population health need

Ageing population

- 11,000 Haringey residents over 75
- Projected to rise to 15,000 in 10 years and 19,000 in 20 years

High prevalence of long-term conditions

- 3 in 4 people over 70 have at least one LTC
- Over 1400 over 65s with dementia

Context: Pressure on health and care services

- Over 7000 emergency hospital admissions in people over 65 each year in Haringey
 - Account for more than 1 in 4 of all admissions
 - Admissions cost over £15 million
 - Majority of health spend is in acute hospitals
 - Slight decline in admissions in over 65s in last 12 months
- Around 150 permanent residential home admissions in over 65s per year
- Current system of health and care for older people is unsustainable

Context: Integrated care in Haringey

- Integrated, person-centred care seen as a way of improving quality of care and reducing demand on acute services in older people with long-term conditions
- The Better Care Fund as a vehicle for delivering integrated services
 - Overseen by Haringey Health and Care Integration Board
- Haringey's Better Care Fund Vision
 - The Haringey Better Care Fund is developing a health & social care system in which all adults are supported to live healthy, long and fulfilling lives. Haringey Clinical Commissioning Group and the London Borough of Haringey want everyone to have more control over the health and social care they receive, for it to be centred on their needs, supporting their independence and provided locally wherever possible.
 - This will be achieved by a reorientation of health and social care provision from reactive and fragmented care (mainly provided in acute and institutional settings) to proactive and integrated care (mainly provided in people's homes and by primary, community and social care).

Better Care Fund: Areas of focus

Admission Avoidance

Named Care Co-ordinator
Health and Social Care Plan
Referral for bereavement counselling

Effective Hospital Discharge

Less time in hospital
Support to return home
Regain confidence to prevent falls



Promoting Independence

Identification
Link to an 'expert patient' group
Link to a local gardening group

Integration Enablers

All relevant professionals know important information
Services in the evening
Support for Harry's daughter

What is intermediate care?

- Provided to people (usually older people), after leaving hospital or when they are at risk of being sent to hospital or having an escalation of care need
- Always focused on rehabilitation and re-learning of skills to get people as independent as possible
- Can be provided in people's own homes, in settings like cottage hospitals and care homes or in purpose-built accommodation.
- Usually delivered by a multi-disciplinary team, normally for a maximum of 6 weeks at a time

Types of intermediate care services

1. Rapid response services
 - Provide extra nursing and therapy support in people's own homes to prevent hospital admission or allow people to be discharged early from hospital
2. Home-based re-ablement services
 - An approach to social care that focuses on people re-learning how to do things for themselves (e.g. cooking, washing) rather than doing these things for them.
3. Step-down and step-up beds
 - Provide multi-disciplinary support in community-based beds for people to re-gain independence after a worsening of ill health or following a hospital admission

How does intermediate care complement Haringey's integrated locality teams?

- Haringey is piloting and scaling up **integrated locality teams**
 - Involves identification, care planning and care co-ordination of people with high levels of health and care needs.
 - Support is offered over a long period by a multi-disciplinary team
- Intermediate care services differ in that:
 - They are focused around crisis or admission to hospital
 - They have to respond quickly
 - They are focused on providing support and rehabilitation for up to 6 weeks rather than on long-term needs.
- Both intermediate care and locality teams are key components of Haringey's Better Care Fund Plans
- Potential for clients to receive ongoing support from locality teams after a period of intermediate care.

Why is intermediate care important?

- Supports independence in people with health and care needs
- Provides a **return on investment**
 - Prevention of hospital admissions
 - Reduced length of hospital stay and prevention of re-admission to hospital
 - Prevention of escalation of social care need and residential care admissions
- Gives a positive experience for service users

The evidence base for intermediate care

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- Good evidence that **re-ablement**:
 - improves independence and quality of life
 - reduces long-term social care costs.
- **Rapid response** type services can improve outcomes for patients and save overall healthcare costs.
- Enhanced hospital discharge processes, which include early identification of complex discharges and links to support in the community can:
 - prevent hospital re-admissions, reduce length of stay and improve outcomes for patients.

Case study: Richmond Rehabilitation and Response team

- Managed by Hounslow and Richmond Community Healthcare Trust (HRCH) with council staff seconded to the trust. It provides three core functions:
 - support to allow early discharge from hospital
 - crisis and rapid response
 - community rehabilitation support
- The service has 6 intermediate care beds in the local hospital, and 50 beds in the community.
- It also has a re-ablement service which has a 50% success rate in helping people get to the point that they no longer need a service.
- They report their admissions to hospital rate has fallen from 100 per 10,000 to 80 per 10,000 and contributed £2.1million pounds in savings over a 3 year period.

Case Study: Roseberry Mansions re-ablement flats: Camden

- 10 bedded re-ablement unit
- Self-contained flats
- Multi-disciplinary team delivers intensive re-ablement and rehabilitisation
- Access to 24/7 support
- 72% of customers either returned home following the service or were re-housed in either sheltered or extra care housing.
- 28% of customers had a reduced care package after the service
- Significant health and care savings reported

Reviewing current intermediate care provision in Haringey: Examples of good practice

- Rapid response service
 - A nurse-led service that provides time-limited support in people's homes to prevent hospital admission
 - Provided by Whittington Health
- Re-ablement
 - An approach to social care that focuses on people re-learning how to do things for themselves (e.g. cooking, washing) rather than doing these things for them.
 - Provided by Haringey Council
- Home from hospital
 - Volunteers provide support to get people settled back at home after a hospital admission
 - Provided by Bridge Renewal Trust

Reviewing current intermediate care provision: evaluating our local rapid response service

- Funding for rapid response service is through the Better Care Fund
 - The service is provided by Whittington Health and provides rapid access to intensive nurse-led support at home for people who may otherwise need hospital admission.
 - Service users also have access to night-time carers
 - Service can be accessed via A and E or by direct GP referral
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- **Hospital admission is avoided in more than 8 out of 10 clients**
 - **For every £100k invested in the service it is estimated that over £260k is saved through reduced hospital activity**

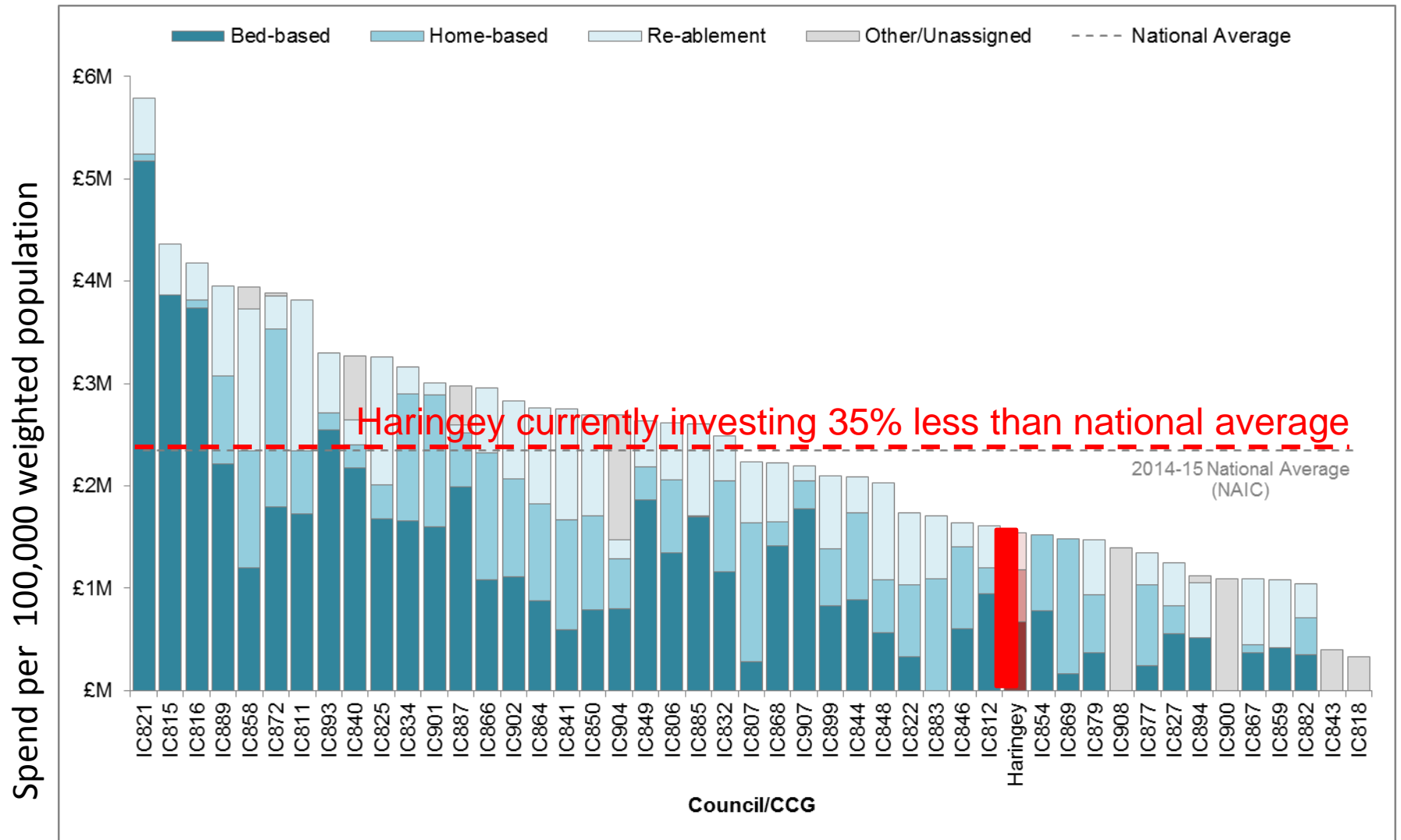
Reviewing current intermediate care provision in Haringey: ¹⁷

Service activity

	Clients (new per year)	Source		Average time in service (days)	Total Bed Days (if applicable)
Service	2014-15	Hospital	Community	2014-15	
Rapid Response service	445	78%	22%	3	n/a
Homecare reablement	508	93%	7%	27	n/a
Home from Hospital	143	94%	6%	16	n/a
Social Care Step Down (Spot-purchased)	55	100%	0%	104	5,750
Winter Step Down	7	100%	0%	46	320
Cavell Ward	117	100%	0%	29	3070

Reviewing current intermediate care services in Haringey: 18

Lower than average investment in intermediate care



Review of intermediate care in Haringey: What residents are telling us

- People are not always given access to support from community services when they need it after leaving hospital
- Patients and their carers are often unsure about who is responsible for their care when they are discharged from hospital
- Patients referred to community therapists can experience long waits for the service to start
- Voluntary sector organisations could play a much greater part in supporting older people with health and care needs

Summary of gaps in intermediate care services in Haringey

- Current services are small scale
- No integrated intermediate care pathway
- Multiple organisations involved in intermediate care
 - Often not joined up
 - Different access points to different services
 - Communication to patients and GPs about what is available is patchy
- Limited bed-based intermediate care provision at present
- Hospital teams not fully linked to community teams in the hospital discharge process.

Recommendations of intermediate care review

1. Develop an integrated intermediate care pathway, including bed based and home based elements with the following features:
 - Multi-disciplinary teams including links to voluntary sector
 - A common point of access to the service
 - Access to rehabilitation and re-ablement
 - Crisis response at home as well as bedded units.
 - Duration of service up to 6 weeks.
2. Develop business cases for expansion of intermediate care services
 - Rapid response
 - Re-ablement
 - Bed based intermediate care
3. Develop an enhanced discharge pathway for complex patients in North Middlesex Hospital and Whittington Hospital, that includes the following:
 - early identification and planning of complex discharges
 - a clear link to the intermediate care pathway



Haringey

Clinical Commissioning Group



Next steps

- Recommendations of review of intermediate care in Haringey being taken forward by Health and Care Integration Board
- Initial focus is on:
 1. Increasing capacity and scope of our Rapid Response service
 2. Commissioning dedicated rehabilitation and re-ablement beds for step-down from hospital and step-up from the community
 3. Increasing re-ablement capacity
 4. Bringing together existing services into an integrated intermediate care pathway with clear links to the hospital discharge process
 - Linking to Safer, Faster, Better improvement programme at North Middlesex Hospital.

Summary

- Development of an integrated intermediate care model could help support sustainability of the local health and care system.
- Other areas of London have achieved this and have seen a return on investment.
- We have some good local services to build on, but these are small scale.
- To achieve a significant impact on demand for hospital services and long-term care we will need to scale up and integrate our current intermediate care services
- At present we are taking an incremental rather than a transformational approach, with activity still centred on the hospital rather than the community setting.

For discussion:

1. The Board is asked to support the approach being taken by Haringey Council and Haringey CCG to develop and scale up an integrated intermediate care pathway in Haringey.
2. Board members are asked to consider how their organisations can contribute to the development of an integrated intermediate care pathway in Haringey.