Appendix 1

Intermediate Care Strategy

SECTION 1 : SUMMARY

Brent Council and NHS Brent are currently planning a new integrated Intermediate Care Service in Brent. This new integrated service will provide a seamless health and social care service to keep people out of hospital and /or help people recover after a hospital stay.

This paper explains the reason for developing a new integrated service, what the service will look like and the expected benefits for Brent residents.

SECTION 2 : BACKGROUND

2.1 Case for change

Intermediate Care Services are provided in Brent in a disjointed way with health and social care doing things differently. To address the following challenges there is a recognition and commitment to take a joint strategic approach in developing these services.

- Between 2005 & 2007 there was a significant increase in the number of older people living in Brent & this is predicted to continue.
- Cardiovascular disease is the biggest killer in Brent & disproportionately affects the most deprived areas.
- Successful implementation of the Healthcare for London Stroke Pathway will significantly improve mortality & reduce morbidity.
- North West London Hospitals averaged 78 delayed bed days per week with Brent patients (equivalent to 11 beds).
- Main cause of delays in hospital people are waiting for a community/ intermediate care bed.

- *Source: NHS Brent Commissioning Strategic Plan 2008 to 2013*.

2.2 Current issues

- There is a mixed picture of variety and availability of Rehabilitation and Intermediate Care (IC) services across Brent.
- There are opportunities to realign services to reflect the needs of patients
- Current investment need to be targeted in a more structured way
- Services are not integrated, or aligned, with Social Services & locally there is no identity for IC services in a way that there is in other boroughs/ localities.
- There is a need for a fundamental change in the way that services are commissioned & provided, requiring health & social care services to engage in a different approach to better serve the patient. To accomplish this there is a need to invest to develop community health & social care IC services to support people outside residential and nursing care, ideally in their own homes.
- In terms of Stroke care there are currently very few services in Brent and a lot of

people are being discharged from hospital with no support at all

- Patient experience varies and we need to create an equitable service for all

Source: NHS Brent Commissioning Strategic Plan 2008 to 2013.

SECTION 3: INTERMEDIATE CARE INITIATIVE

3.1 Objectives

- Establish transformed integrated intermediate care pathways which bridge services across care settings & make personalised care closer to home a reality;
- Commission a range of cost-effective, outcome focused, intermediate care services in line with the integrated pathways;
- Integrate the Healthcare for London (HfL) stroke pathway -Early Supported Discharge element into the overall pathway;
- Fully integrate with improvements in the management of long-term conditions (LTC) planned within primary & community services initiative.

3.2 Timescale

The Intermediate Care Services initiative has been split into two phases:

- Phase 1 (Nov 2008-Mar 2009); Development of an Intermediate Care Strategy
- Phase 2 (Apr 2009 onwards); Agreement on strategy and plans for phased implementation

3.3 Stakeholder engagement

There are three main types of stakeholder engagement being followed.

- Programme Board meetings: These regularly review progress reports, risks & key outputs.
- Large-scale stakeholder events: This includes both individuals as well as organisations to help publicise the Intermediate Care initiative, communicate the overall objectives & help obtain stakeholder views.
- Design workshops: These have been used to help define the service requirements, new model of care & overall patient pathways.

SECTION 4: NEW MODEL OF CARE

4.1 Vision

The vision for a new Brent Intermediate Care service is:

“readily accessible and easily navigated by patients and staff, which provide ‘time-bound’ care designed to keep patients out of hospital and accelerate a patient’s return from hospital to more appropriate care closer to home.”

The new Intermediate Care service proposal also aims to address current variations which exist in stroke care and to provide a local community based service that is accessible to all ages, but based on their health care needs. The new model will

follow principles set out by the Healthcare for London Stroke Model Pathway and will be based on the principle of equality of access to all ages for stroke patients after discharge from the hospital, as well as long-term follow up of their health and social care needs, including support to their carers in line with the National Stroke Strategy.

4.2 Objectives of the New Service

In summary, the new model of care for Brent Intermediate Care aims to:

- Enable the PCT to commission a broad range of Intermediate Care & Rehabilitation interventions which are effective & appropriate, including management of stroke rehab care pathway for adults & older people who are residents of Brent, or registered with a Brent GP;
- Provide services that are targeted at people who would otherwise face unnecessarily prolonged hospital stays, or inappropriate admission to acute inpatient care, long-term residential care, or continuing NHS inpatient care;
- Support individuals to achieve effective & timely reablement, where possible.

Source: NHS Brent Commissioning Strategic Plan 2008 to 2013.

4.2 The STARRS concept

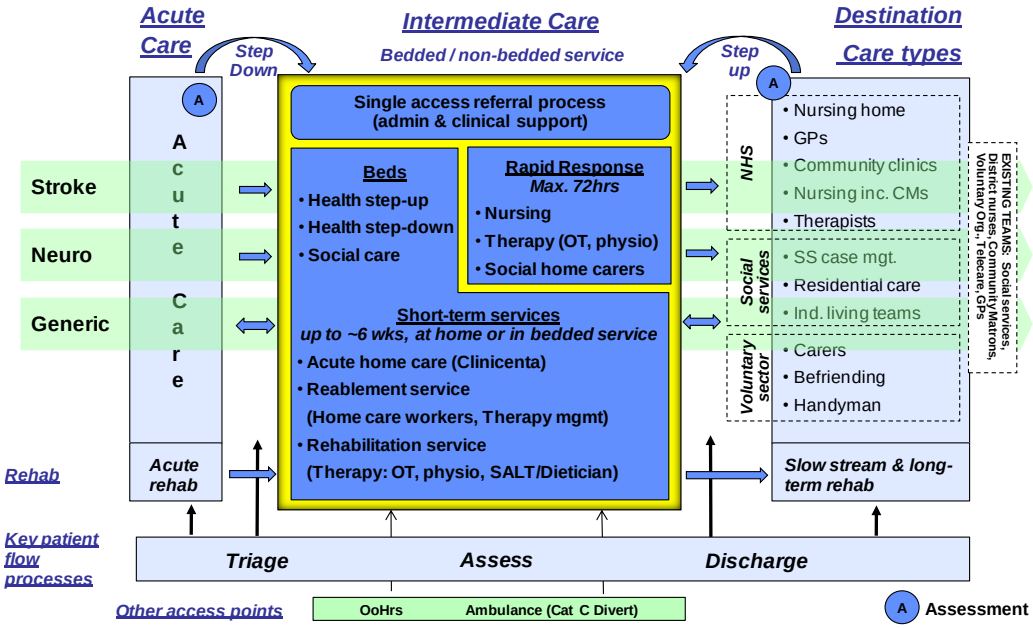
The name for the new Intermediate Care service is 'STARRS' (Short-Term Assessment, Rehabilitation & Reablement Service). This can be defined as a short-term, intensive intervention of health and/ or social care which enables people to reach their rehabilitation potential before moving on to their ultimate care destination. This includes rehabilitation and reablement for up to a maximum of six weeks.

There are two key entry points for individuals:

- Those at risk of acute hospital admission;
- Those who are medically fit for discharge from an acute hospital.

4.3 Components of STARRS

Figure 1: Key components of the New Intermediate Care Service (STARRS)



STARRS has a number of different services, with the main aim of providing care closer to home, and in the patient's place of residence where at all possible.

4.4 The key operational parts are:

- The Rapid Response team (i.e. urgent assessment & intervention to stabilise a patient for a maximum of 72 hours, as an alternative to A&E attendance);
- The Short-Term service, comprising of one, or a combination of;
  - Temporary beds (health step-up & step-down beds & social care beds).
  - Time-bound Reablement service (i.e. social home care, with therapy management);
  - Time-bound Rehabilitation service (e.g. therapy);
  - Acute home care (via Clinicenta);
- Access to both is co-ordinated by a Single point of access (referral & triage).

A summary of the services and care settings within STARRS is in Appendix 1.

Who will this service be for?

- Over the age of 18 years.
- A resident of Brent & registered with a Brent GP.
- Individual experiencing a short-term crisis (immediate/ imminent need for health intervention, or need for support during a breakdown of care), but is not expected to require treatment in an acute hospital, treatment able to be met safely within the patient's own home & with their consent
- Individual in an acute hospital bed who is medically fit for discharge & has been assessed as having rehabilitation potential who would benefit from time-bound packages of rehabilitation/ reablement support.

Service descriptions:

Once a referral is accepted into the STARRS the person can benefit from either the:

1. Rapid Response Service

2. Short-Term Service

The patient need descriptions for the elements within the Short-Term Service are:

- **Rehabilitation:** The individual has a health need & has rehabilitation potential.
- **Reablement:** The individual has a dominant social need, with some therapy requirement.
- **Acute care at home:** The individual requires acute nursing care, but this can be delivered in their place of residence, i.e. does not warrant a hospital bed.
- **Health step-up bed:** The individual is medically sick but does not need to be admitted as an acute inpatient, but does require 24/7 nursing care & observation, with access to diagnostics.
- **Health step-down bed**: The individual is recovering after an acute inpatient stay, needs regular nursing & therapy intervention whilst in a bed & has rehabilitation potential.
- **Social care bed**: The individual has a dominant social need requiring 24/7 reablement support in conjunction with some therapy & is unable to return to their place of residence, or planned long-term residential placement.

SECTION 5 : STROKE REHAB PATHWAY

5.1 Healthcare for London (HfL)

HfL have issued a Stroke Strategy which explains the current problems for London stroke patients and details new requirements for improving their health care.

One of the points is that around a third of all strokes could be prevented. This could be achieved through better public/ staff awareness & education & better management of medical risk factors, e.g. high blood pressure.

Source: London Stroke Strategy (HfL, Oct 2008).

5.2 Brent stroke patients

Key findings include:

- Total of 343 Brent residents are hospitalised with a stroke per year.
- Total of 303 surviving stroke patients per year.
- NWLH is the dominant acute provider (73% of stroke patients).
- Of the remainder, Imperial College accounts for 17%.
- 288 stroke patients per year (95%) require some form of community rehab.
- Wide range of dependency, which warrants a mix of care package intensities.

5.3 New Stroke Pathway

The stroke care pathway for Brent patients will change as a result of the initiatives planned, which are in accordance with HfL's Stroke Strategy.

The new stroke care pathway is more structured, is delivered by specialist stroke clinicians and provides improved continuity of care for the patient. Key changes are:

- The acute phase is presentation at a Hyper Acute Stroke Unit (HASU) (for up to 72 hours urgent medical care), followed by specialist acute care & rehabilitation in a Stroke Unit (SU).
- Implementation of a new Early Supported Discharge Service which will enable patients to receive intensive stroke rehabilitation at home.
- A seamless handover to the relevant provider for ongoing community rehabilitation, where required

5.4 Next steps

- July 2009; Service start of Early supported discharge service.
  - Each PCT commissioning this service is liaising with Clinicenta to confirm localised plans. For Brent, this is being co-ordinated through the North-West London Cardiac Network.
- Autumn 2009; Start of HASU & SU implementation.
  - The HASU & SU configuration (locations & sizes) in London is subject to public consultation & is being managed by NHS London.

SECTION 6: LINKAGE WITH OTHER INITIATIVES

The Intermediate Care Strategy needs to be viewed as part of NHS Brent's whole, end-to-end vision of delivering future health care to the people of Brent. There are many links, synergies and dependencies with other current initiatives, the most pertinent being the Primary & Community Care Strategy.

SECTION 7: PROJECTED IMPACT

The projected impact of this initiative against thye CSP outcome measure is summarised in the table below.

Figure 4: Reducing Delayed Transfers of Care target

Delayed transfers of care (NI 131) - per 100k population	2008/09	2009/10	2010/11	2011/12	2012/13
Current forecast (without initiative)	15	15	15	15	15
Target:	15	13	11	9	7
% Change versus baseline	0.0%	-13.3%	-26.7%	-40.0%	-53.3%

Current performance for year to date is 10.8 delays per 100,000 of population of 18+

Figure 5: Reducing emergency acute hospital admissions target

Reduced NEL admissions (65+ ambulatory sensitive conditions)	2008/09	2009/10	2010/11	2011/12	2012/13
Current forecast (without initiative)	22,660	23,340	24,040	24,761	25,504
Avoided admissions	500	1,000	1,500	2,000	2,500
Target:	22,160	22,340	22,540	22,761	23,004
% Change versus baseline	0.7%	1.5%	2.5%	3.5%	4.6%

APPENDIX 1 – STARRS SERVICE DESCRIPTIONS

Component	Type/ function	Timeframe	Short description/ attributes	Resource type
Rapid Response: (alternative to A&E)	Rapid assessment	max. 72hrs	Assessment of individual with urgent health need, or breakdown of care - instead of attending A&E. Includes telephone triage function. Rapid face-to-face assessment at individual's place of residence.	Nurses (Clinicenta), Therapists, Social care workers.
	Rapid intervention		At time of assessment, same resource also performs urgent medical treatment. Aim is stabilisation, so can be routed to generic services for on-going care, or further short-term care community treatment. (If not will go to acute as 999 case). Intervention may be rapid admission to 'step-up' bed to avoid acute hospital admission. Call-off to specialist teams (e.g. mental health, Continuing Care).	
Care setting:	Home	up to ~6 wks	Ideal care setting to receive intervention to address medical need & any related social need. Intensive time-bound rehabilitation by therapist(s) to achieve rehab potential. May also involve intensive time-bound package(s) of social care.	Nurses, Therapists, Social care workers.
	Step-up beds	5 to 7 days	Community health beds - accessed from the community - Nurse/ GP led. Used to avoid unnecessary acute admission for ambulatory care conditions.	GPs, Nurses.
	Step-down beds	up to ~6 wks	Community health beds. Used for post-acute rehabilitation care.	Nurses, Therapists.
	Social care beds	<3 wks	Social beds for a short-term package (different to long-term residential placements). Used as step-down after discharge from acute health care, or as step-up to prevent potential acute admission.	Nurses, Therapists, Social care workers.
Services:	Reablement	up to ~6 wks	Intensive time-bound package(s) of social care. Delivered at individual's place of residence, or in conjunction with bedded service.	Reablement workers, Therapy
	Rehabilitation	up to ~6 wks	Intensive time-bound rehabilitation by therapist(s) to achieve rehab potential. Delivered at individual's place of residence, or in conjunction with bedded service.	Physiotherapist, Occupational
	Acute home care	up to 5 days	Community nursing care (at acute intensity) to facilitate earlier discharge from acute hospital, or as alternative to acute inpatient admission. Delivered at individual's place of residence.	Nurses.

APPENDIX 2 – GLOSSARY

(Brent definitions, unless specified):

Intermediate Care

Time-bound packages of health and/ or social care which enable people to reach their maximum rehabilitation potential before moving onto their ultimate care destination, which either avoids unnecessary acute admission, or expedites acute discharge to more appropriate care closer to home.

Some other common definitions of Intermediate Care:

“…enable people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximize independent living". (NSF for Older People, DOH, June 2002).

"…those services that do not require the resources of a general hospital but are beyond the scope of the traditional primary care team." (Oxford and Anglia Intermediate care Project, 1997).

STARRS

(Short-Term Assessment, Rehabilitation & Reablement Service); the name given to Brent’s new model of care for Intermediate Care provision.

Rehabilitation

Active, goal-focussed, health intervention to restore the skills of a person (e.g. mobility) who has had an illness, or injury, so they regain maximum self-sufficiency and functioning to a level they experienced prior to the illness, or injury.

Reablement

Active, goal-focussed, social care intervention to enable a person to regain, or develop, independence in their day-to-day living, rather than depend on others.

Step-up bed

Community health bed accessed from the community which is used for medically sick patients to avoid unnecessary acute admission for ambulatory care conditions.

Step-down bed

Community health bed which is used for patients requiring post-acute rehabilitation care.

Social care bed

Short-term, residential package of social care which is used either for step-down after discharge from acute health care, or for step-up to prevent a social care issue e.g. carer breakdown

APPENDIX 2 – GLOSSARY CONTINUED

Stroke care terms (Source: London Stroke Strategy, HfL, Oct 2008).

HASU

(Hyper-acute stroke unit); which provides the immediate response to a stroke, where the patient is stabilised and receives primary intervention. The patient's length of stay is typically no longer than 72 hours.

SU

(Stroke unit); which provides multi-therapy rehabilitation and ongoing medical supervision following a patient's hyper-acute stabilisation. Length of stay varies and will last until the patient is well enough for discharge from an acute inpatient setting.

TIA

(Transient ischaemic attack) assessment and treatment services which provide rapid diagnostic assessment and access to a specialist, within 24 hours for high-risk patients and within seven days for low-risk patients.