Enabling Intermediate Care

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Bed based Intermediate Care (BBIC)

- **Review of BBIC provision** – snapshot audit
- **Evidence base** – Intermediate Care NICE guidance; NAIC - benchmarking
- **Options appraisal** – Apply principal's of Intermediate care to community hospitals
- **Business Case submitted** – Integrated Better Care Fund (ibcf) business case
- **Successful bid** for ibcf
- **Commenced project** Oct 2018 at Tiverton, Sidmouth and Exmouth Community Hospitals in Devon

Intermediate Care - What are the main deliverables?

- **Recruitment/workforce**
- **Equipment** – Community equipment
- **Training and competency development**– enabling approach – principals of Intermediate care– observe and encourage; promoting independence, functional rehab skills; sharing skills
- **Comm Cells/Scrums (Tiverton)**
- **Establishing new daily routines:**
  - Daily MDT board rounds and huddles instead of MDT meetings
  - Personalised MDT goal setting and outcome measures from admission
  - Safety briefing plan at handover
  - Activity away from bed, moving to day room

State of Readiness for the Future – AHPs into Action (2016)

New ways of working…

- **Strengths based approach** – training and application to practice
- **Collaborative leadership** – OT/Nurse
- **Enabling at every contact** – MDT approach to enabling/goal setting
- Preventing functional decline and optimising independence
- No more ‘’**physio not on the ward so no rehab**’’
- **Increase in functional outcomes** for patients
- **Increase awareness of roles and contribution** of whole MDT – board rounds
- **Increased focus on what’s important to the person** and MDT goals
- **Social care assessor opportunity**– proactive approach to social care; carer support; Strengths based approach; advice and support for self funders; reduce need for statutory support voluntary/connecting people back to the community navigation/orientation to new processes/ systems/working up referrals for Social care when required.

Tiverton Hospital

- **Scrums** – Team coming up with their own ideas to achieve the aims of IC in community hospital and taking action - Plug in sinks, shower curtains, grab rails in showers; piloting early shifts for therapists etc
- **Weekend/shift working** for Therapists and rehab support workers
- **Increase in Groups and Activities** inc activity coordinator and trolleys
- **Comm cell** introduction
- **Patient and carer information** pack
- **Practice coaches** to sign off

competencies

Challenges

- **Therapy takeover?**
- **Implementing** all the changes over a short period of time to optimise sustainability
- **Traditional approaches to care challenged** - new ways of working
- **Traditional ward routine changed** – day room activity – understanding the benefits v time; no MDT, board round
- **Setting up outcome measures** from the start e.g. barthel, GAS
- **Understanding roles and responsibilities** for unregistered staff

Looking back - March 2018

18% back to the acute

18% of referrals

Waited 5 days

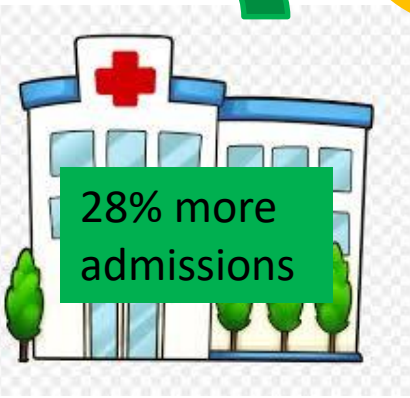
Stayed for 20 days

55% went ‘home’

Poor Therapy resource limited rehab offer, variable patient cohort – high mental health needs, delays, low morale

March 2019

~~18%~~ 12% back to the acute



28% more admissions

Readmissions to acute unchanged <16%

~~18%~~ 22% of referrals

Waited ~~5~~ 2-3 days

Stayed for ~~20~~ 14 days

~~55%~~ 69% went 'home'

30 responses collated each month across three sites.
>90% for recommendations to friends and family, treated with dignity and respect and knowing the next step

Improved resource, shared skills within MDT, able to support people to maximise independence, educating as team triage admissions

Outcomes - Bed Based Intermediate care

- Increase number of people returning home from 55 -69%
- Achieving better outcomes for people, quicker
  - Reduction in Length of Stay from 20 to 14 days
  - Increase in functional independence for 95% of people – Modified Barthel/GAS light
- Reduction of people readmitted to acute hospital
- Increase in staff morale and reduction in sickness absence
- Feedback from patients – patient experience survey monkey and person stories
- Closer MDT working between nursing and therapy and health and social care
- Nurses feel like they go home with less back ache!

Devon County Council

NHS
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Person Stories

"When I arrived I had no confidence in my abilities. There wasn't much time for sitting around was really surprised how much I was encouraged to do for myself..I am more hopeful for the future and looking forward to walking for my sons wedding" **Denise.**

"I couldn't lift my arm before, I had a job getting up and wasn't walking – it was chaos! I still have hip pain but I have changed…Now I've got the determination to do it and I am going much more for myself". **David Ireland**

Recognition from NICE – NICE into Action – Enabling Intermediate Care

- Enabling intermediate care, RDE NICE website- https://www.nice.org.uk/sharedlearning/enabling-intermediate-care

"The nomination demonstrated AHPs pushing boundaries of multi-professional, strategic leadership and having an impact at a system-wide level". Suzanne Rastrick (Chief AHP Officer, NHS England).

- **Sharing success** /Sharing outcomes wider – inc @ahpsindevon
- **More activities focused** on supporting patients with dementia in cohorted bays
- **Increase working** with wider partners
- **Uniforms** for unregistered staff
- **More development** in wider competencies e.g. nursing focused(Sharing skills)
- **Continue to develop**…using patient, carer, staff and partner feedback

Thank you!

Any questions?

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