

Intermediate Care Team Orkney Health and Care

The First Year

September 2009 - October 2010

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Care Team

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OIC

Introduction

- Background
- Guidance for evaluation of Intermediate Care services
- Why in 2 six month blocks

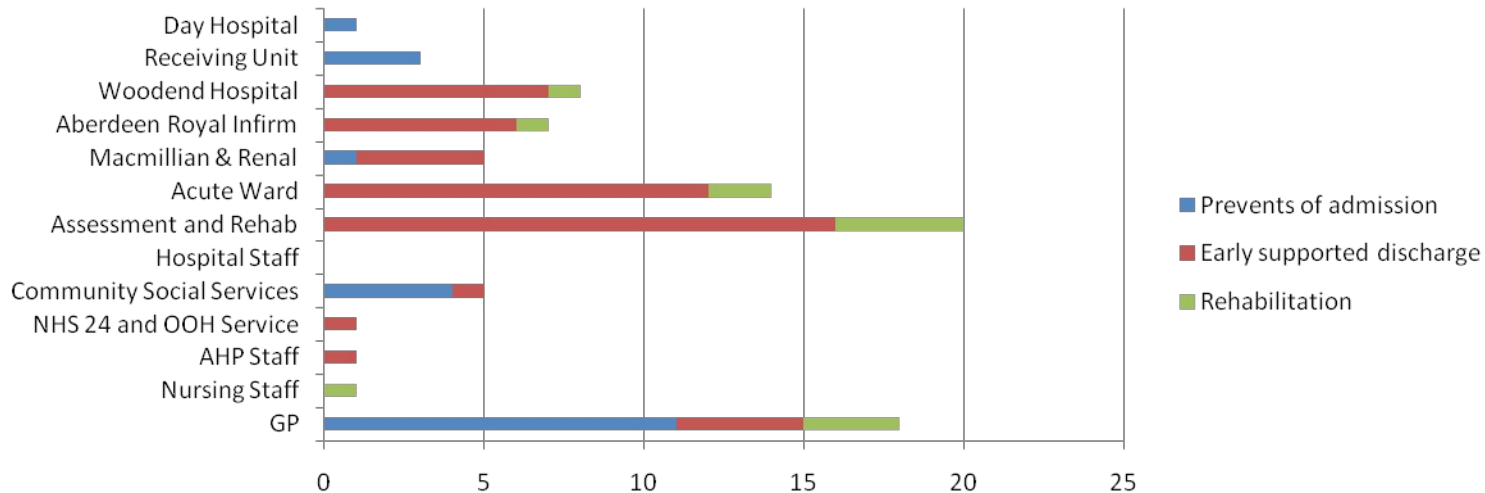
What we have included

- The Service
- Team Workshop
- Partners & Referrers
- Patients / Services Users
- Financial Data
- Conclusions
- The Way Forward

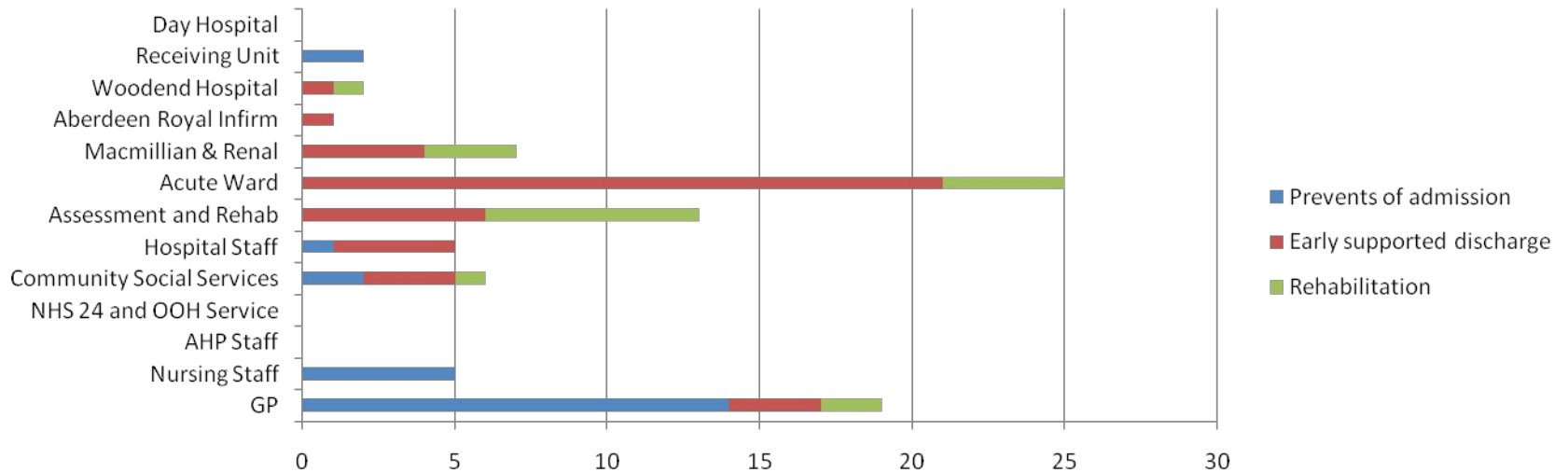
The Service

Referral Type By Referrer

Sept 09 - Mar 10



Apr - Sept 10

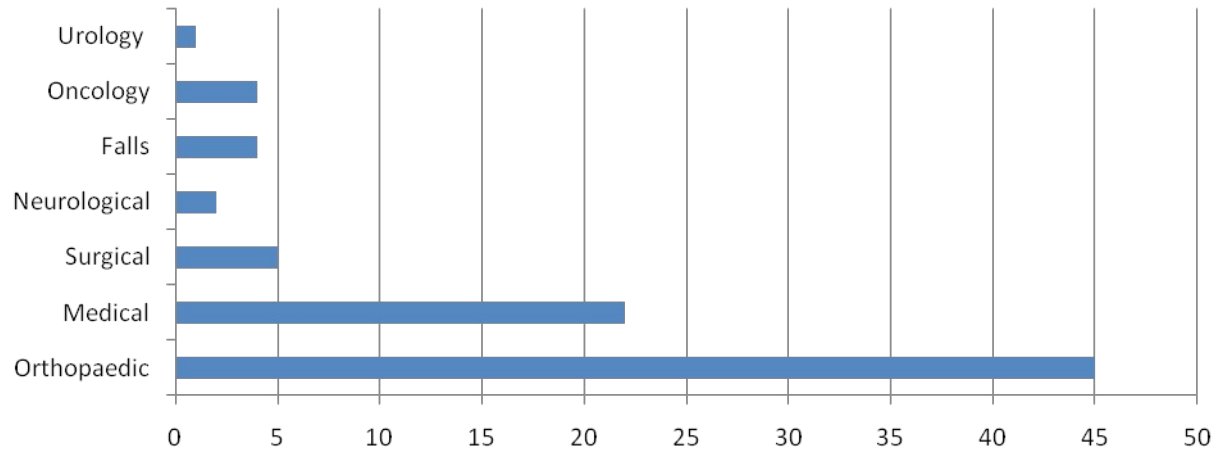


Orthopaedic Referral Pilot from Aberdeen

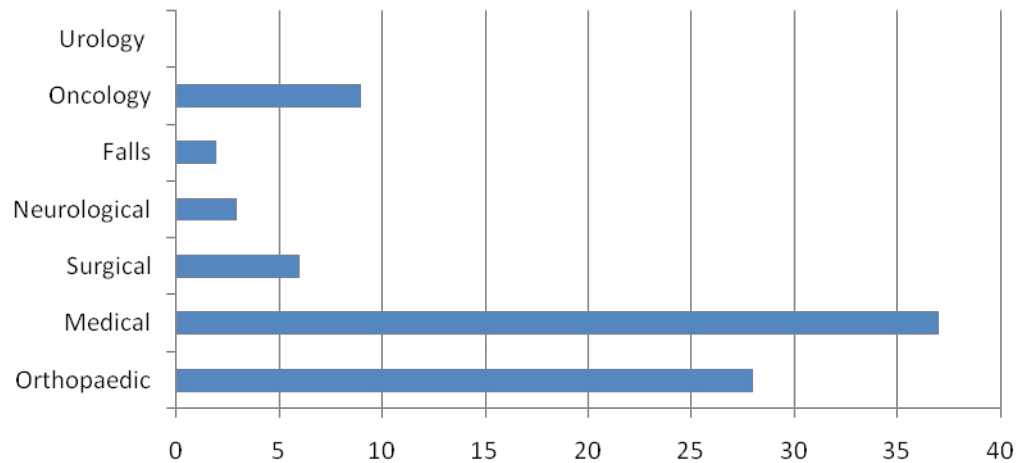
- Number of people come back into the Balfour who were medically stable from Aberdeen but need multi disciplinary rehab before they went home
- Chance to focus the referrals and manage patient journey through ICT referral
- First 6 months worked directly with the discharge liaison nurse from Aberdeen
- Outcomes
 - Reduced care packages, which would start and stay with the individuals
 - Majority would have come through Assessment and Rehab ward at the Balfour
 - Improved clinical outcome measure using Clinical Outcome Measures
 - Outcome focus, service user centred
 - Could not be continued in this format due to resource implications, and therefore information was disseminated directly to the wards, GP/community nurse practices and bed manager

Broad Category

Sept 09 - Mar 10

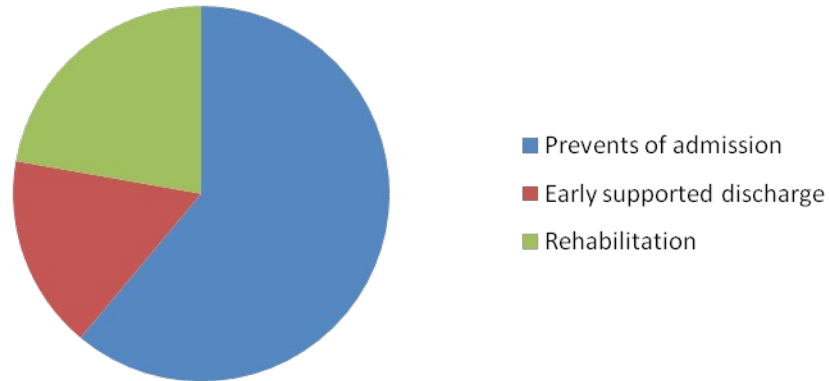


Apr - Sept 10

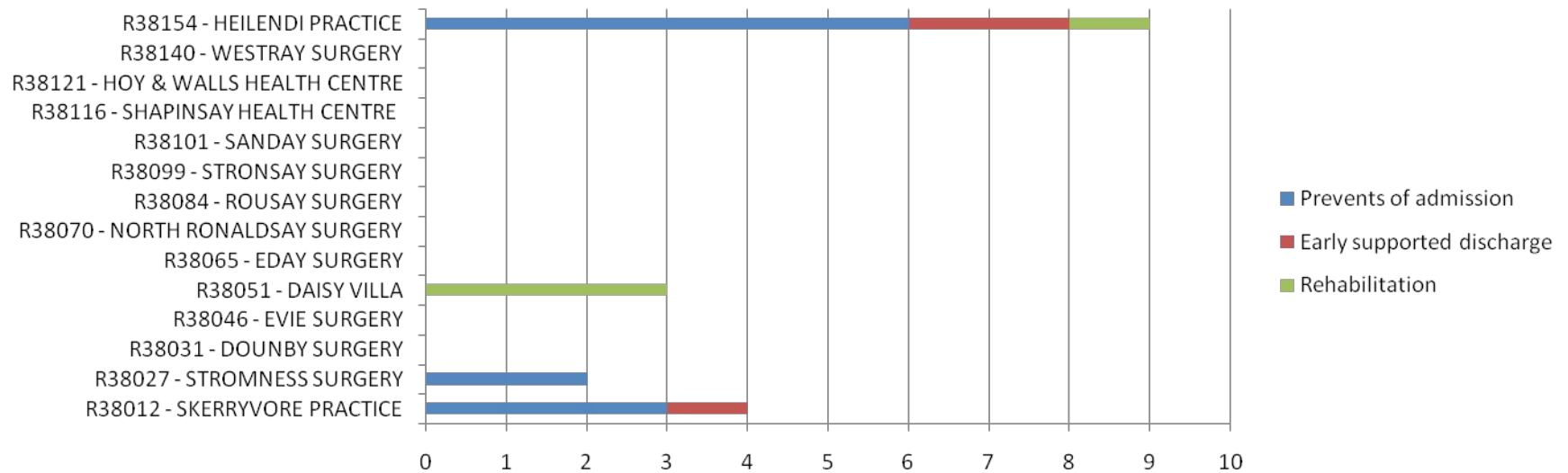


NB Falls & Orthopaedic

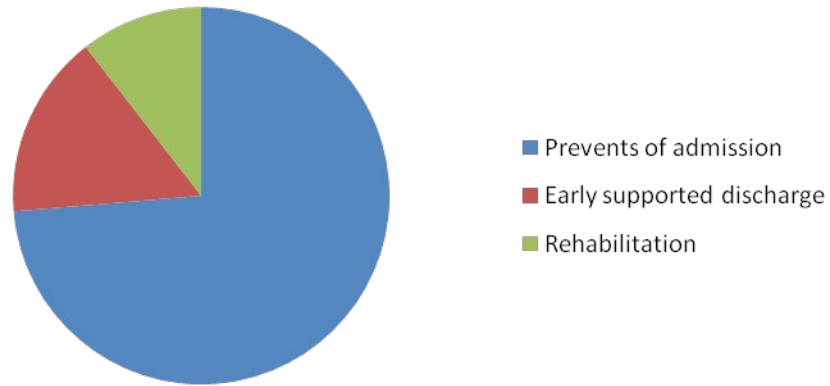
Referrals from GPs Sept 09 – Mar 10



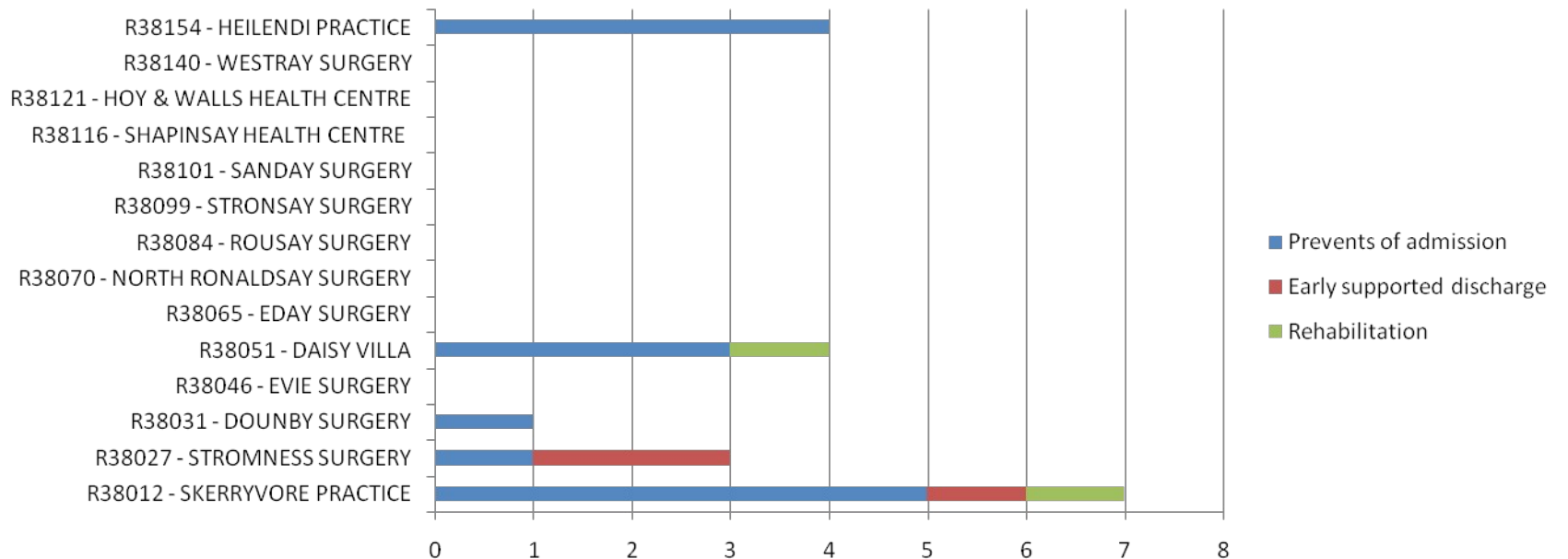
Referral Type by Practice Sept 09 - Mar 10



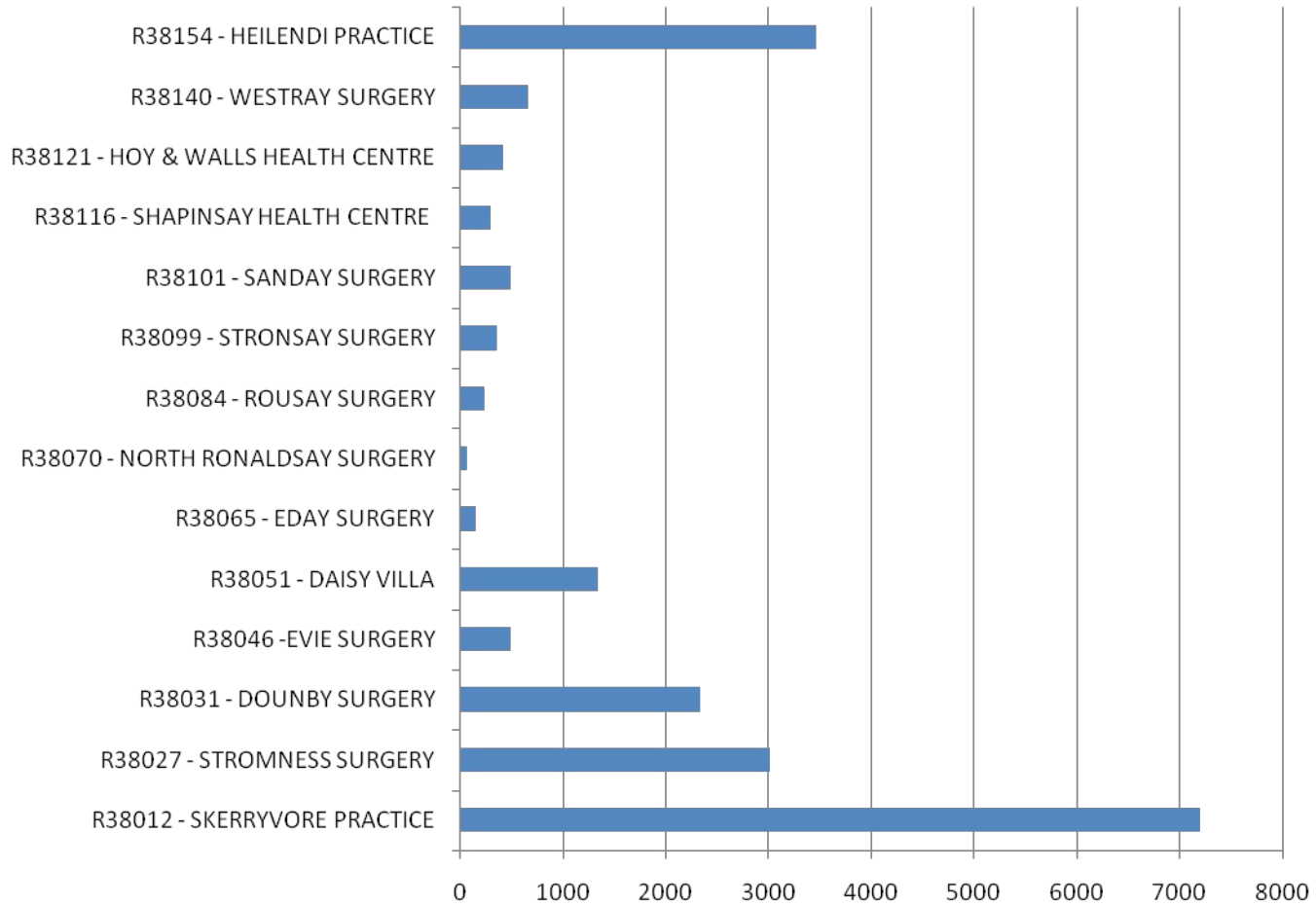
Referrals from GPs Apr -Sept 10



Referral type by practice Apr- Sept 10

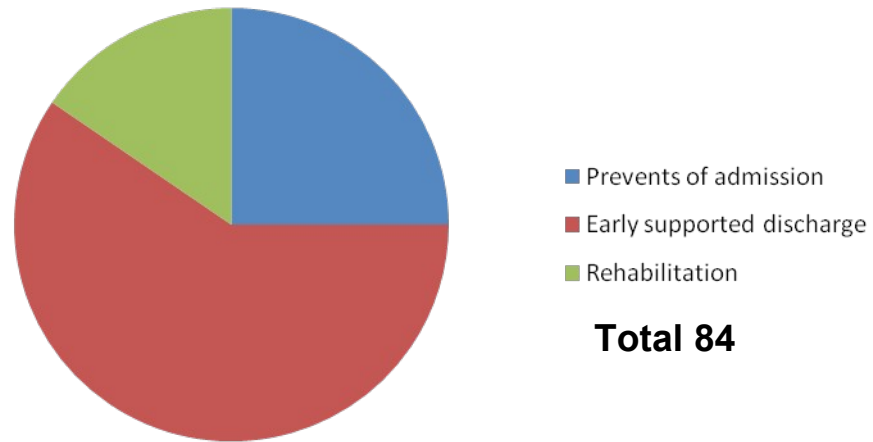


Practice Statistics

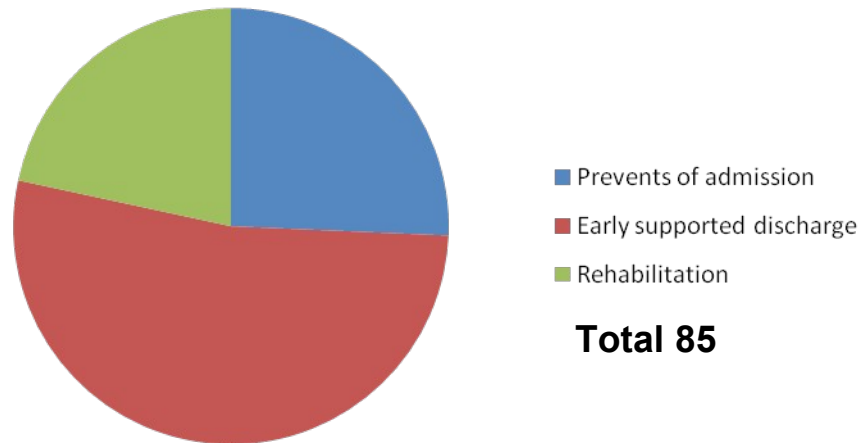


Type of Referral

Sept 09 – Mar10

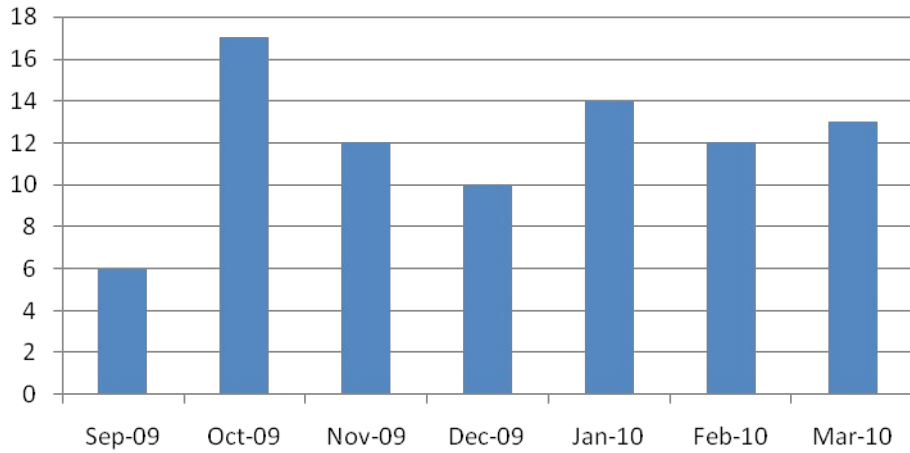


Apr-Sept 10

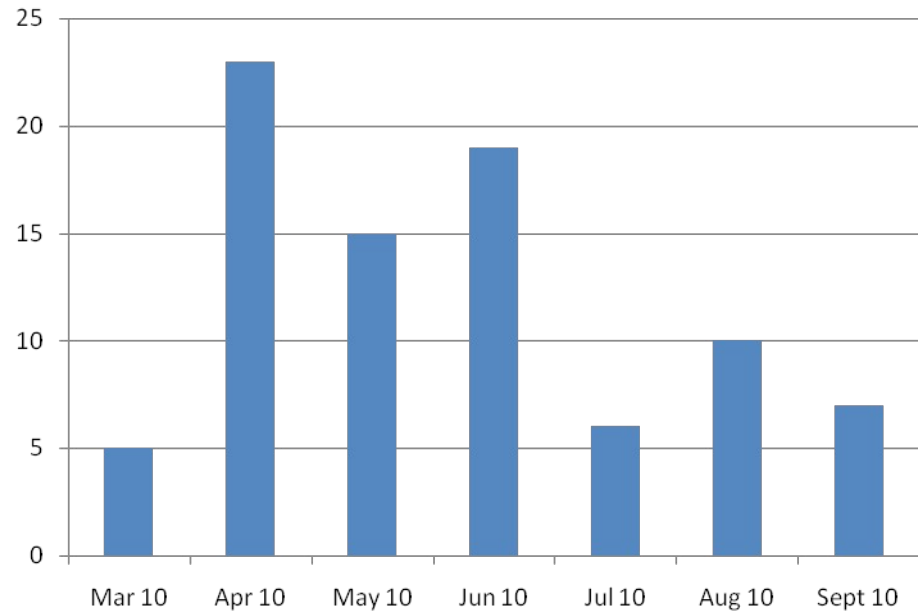


Referrals

Sept 09 - Mar 10

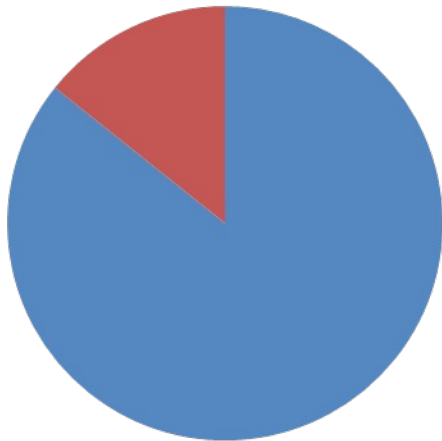


April 10 - Sept 10



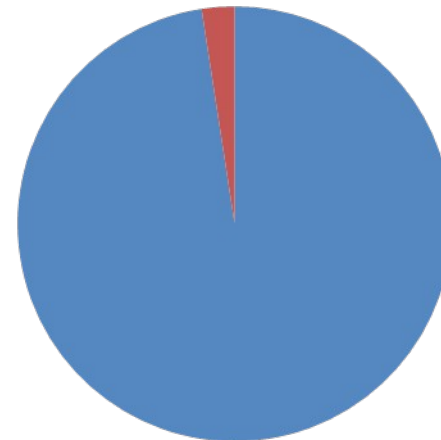
Where First Visited

Sept 09 - Mar 10



■ Home
■ Hospital

Apr 10 - Sept 10

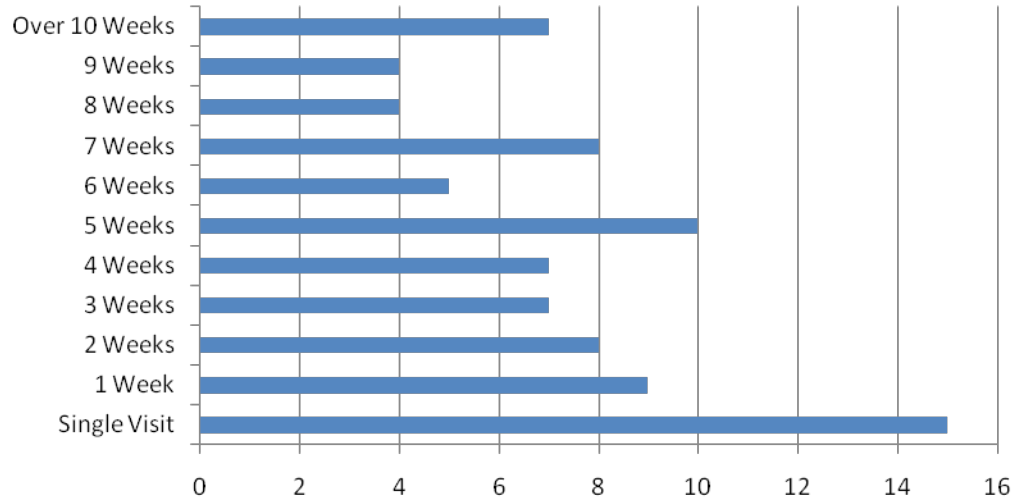


■ Home
■ Hospital

**Change in practice going forward
More visits before leaving hospital**

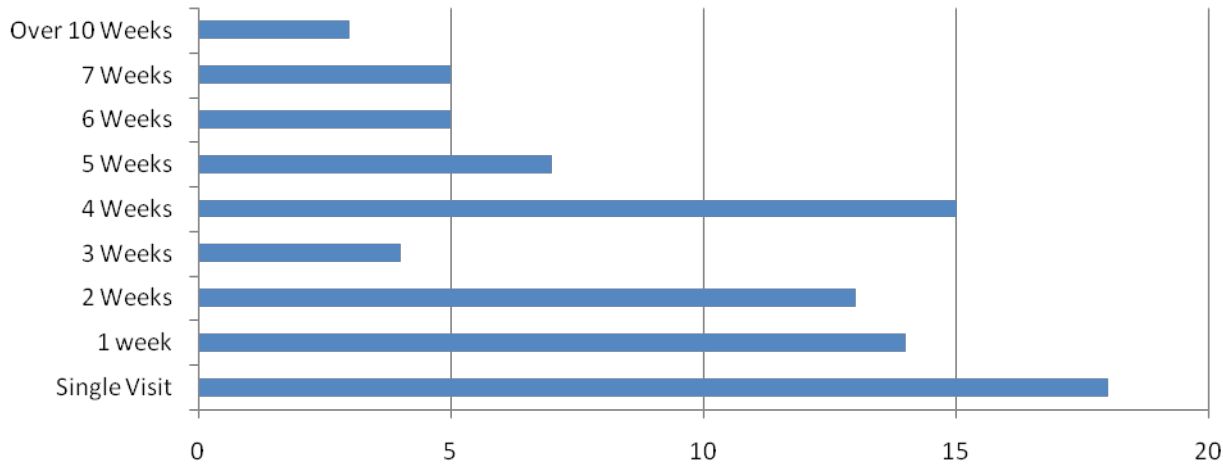
Duration

Sept 09 - Mar 10



**Average Duration
28 days**

Apr 10 - Sept 10

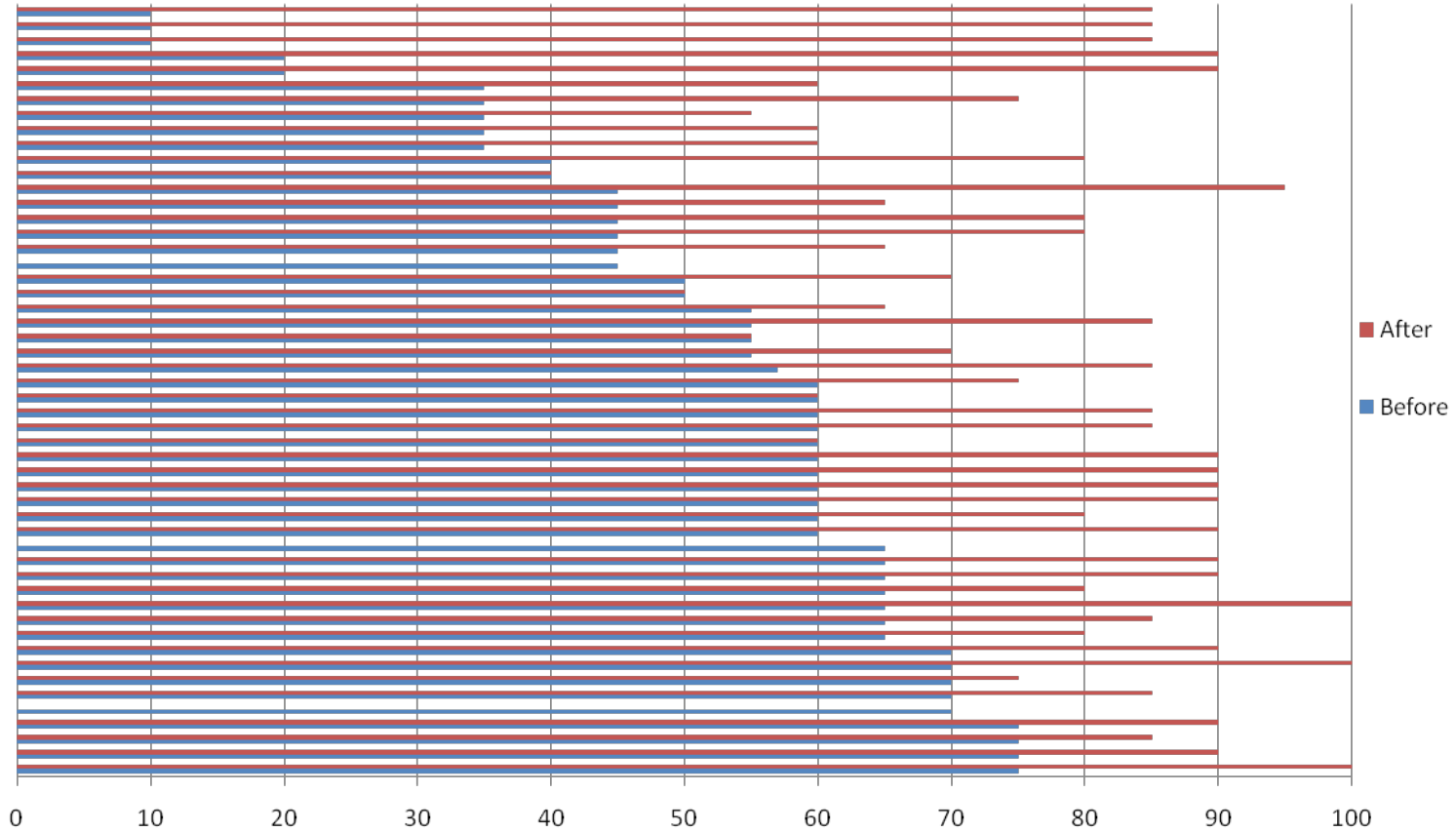


**Average Duration
19 days**

Comments on single visit cases and non accepted

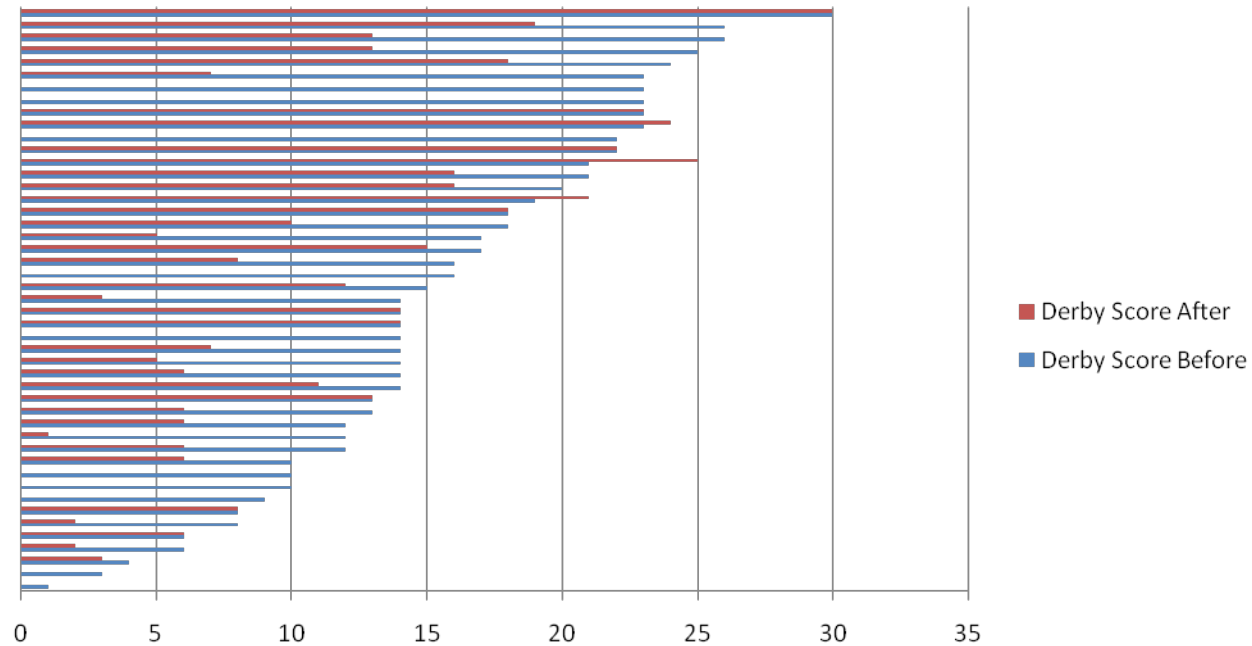
- Equipment and adaptations
- No real need, already independent and able
- Not clinically stable so need admitting
- Existing Service(s) sufficient for need
- Service refused
- (No capacity)

Barthel Scores



Derby

Apr 10 - Sept 10

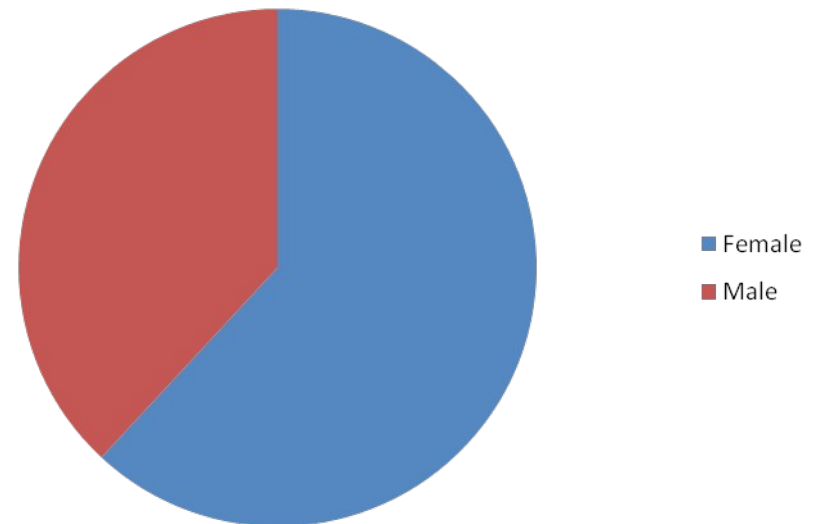
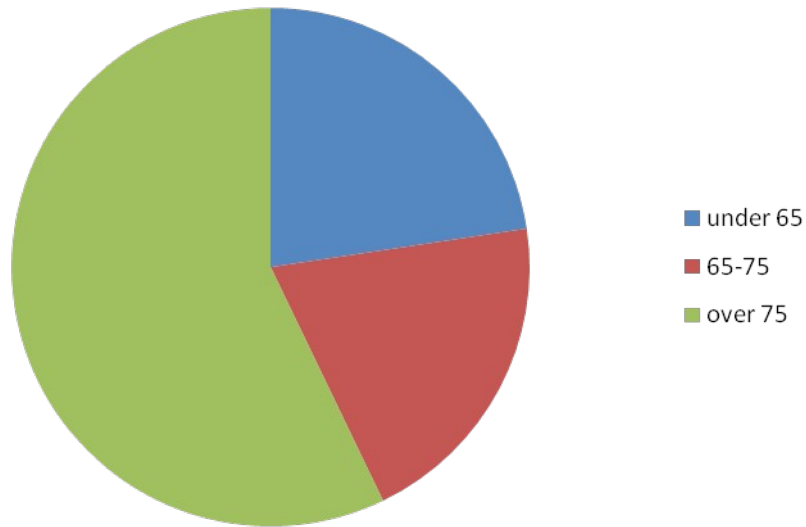


Average Before 16

Average After 11

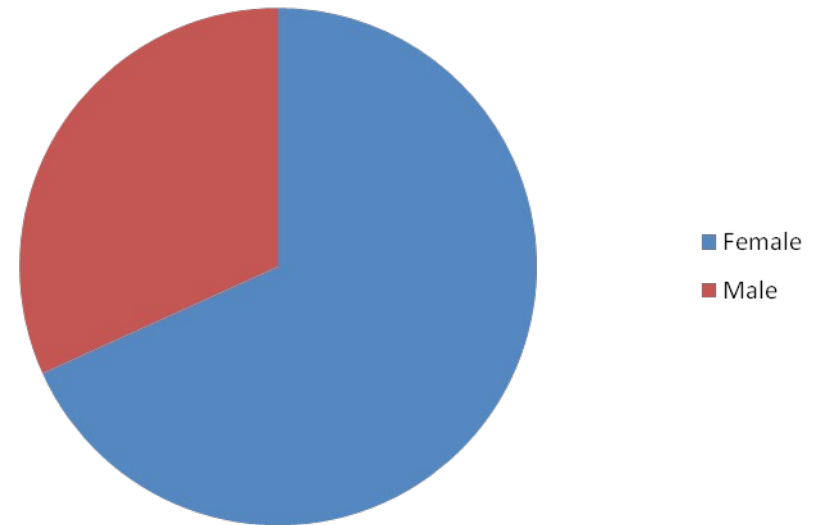
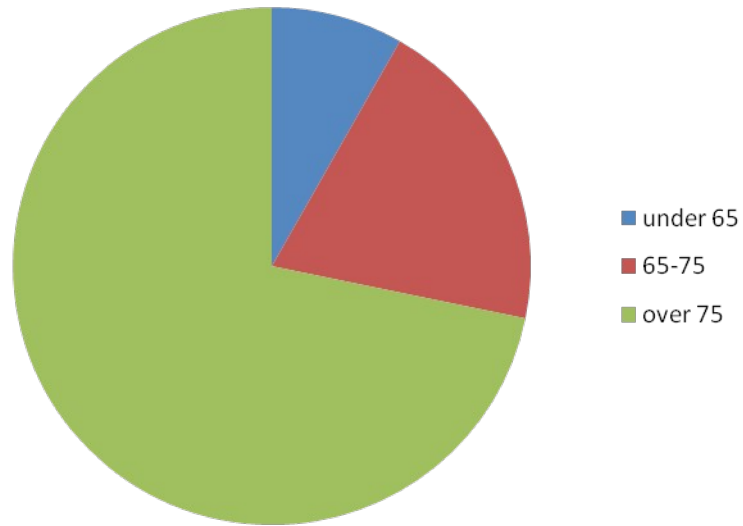
Demographics

Sept 09 – Mar 10



Demographics

Apr – Sept 10



The Team

Team input

- Team Workshop - 17th September
- Self evaluation and development day held
- Independently facilitated
- 12 team members attended
- Open and participative environment
- Reflect on past year
- Building a development/action plan

What had work well

- New ways of working - Integration
- Made a difference to patients - Independence
- Had fun
- Good team working
- Out & about – Patient's home
- Good leaders
- We have had success

Would we could develop

- Support
- Personal & Professional development of team members
- Communication
- External communication
 - Referrals
 - Promote better understanding
- Develop the team working
- Workload management
- Need to get structured patient feedback
- Should celebrate success

What we want to focus on going forward

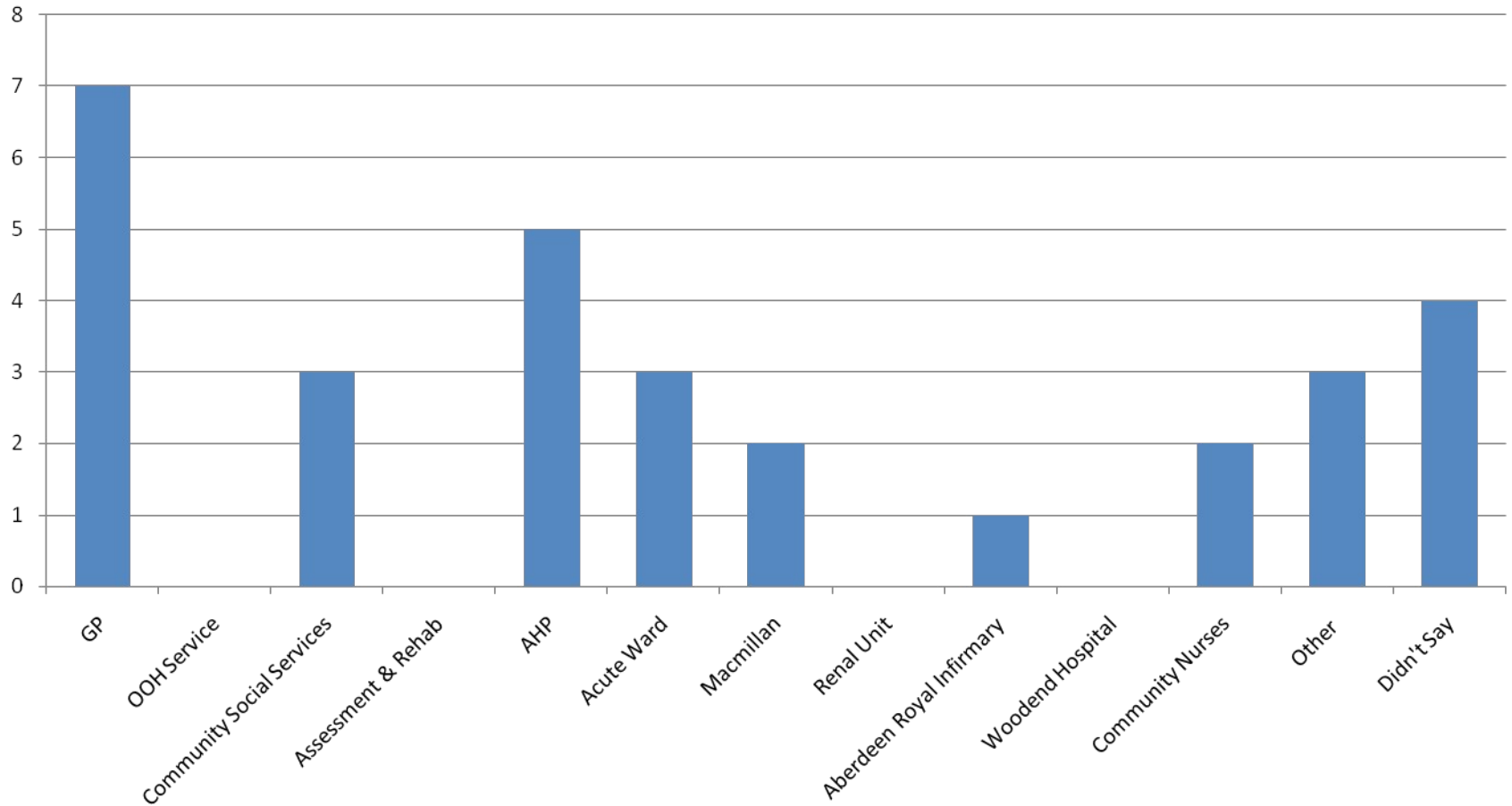
- Further development of the team
- Educate & promote service
- Clearer criteria
- Patient questionnaire and feedback
- Support and training
- Communication

Partners and Referrers

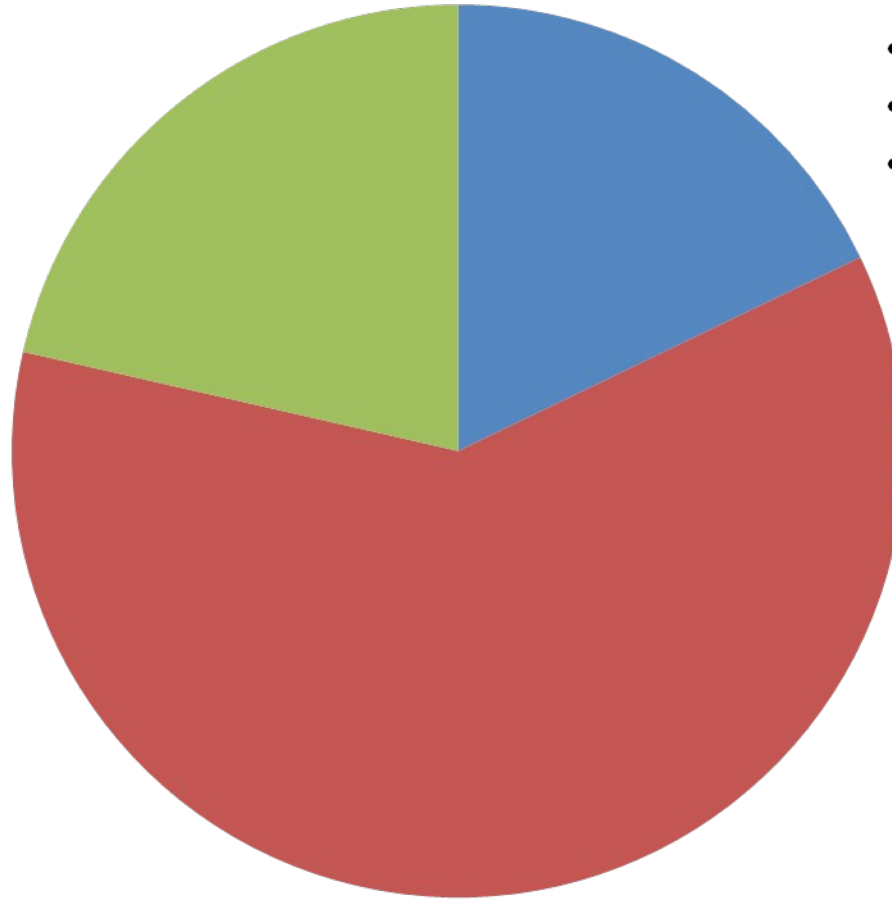
Results from Partner and Referrers questionnaire

- The survey ran Thursday 18th November 2010 to Friday 3rd December 2010.
- It was available on line via Survey Monkey.
- An email with the link to the survey was sent to the follow groups of people.
 - *GPs*
 - *Hospital wards*
 - *Aberdeen*
 - *AHPs*
 - *Community Nurses*
 - *Community Social Services*
 - *Stroke outreach*
- In total 30 people responded and took part in the survey

Who responded



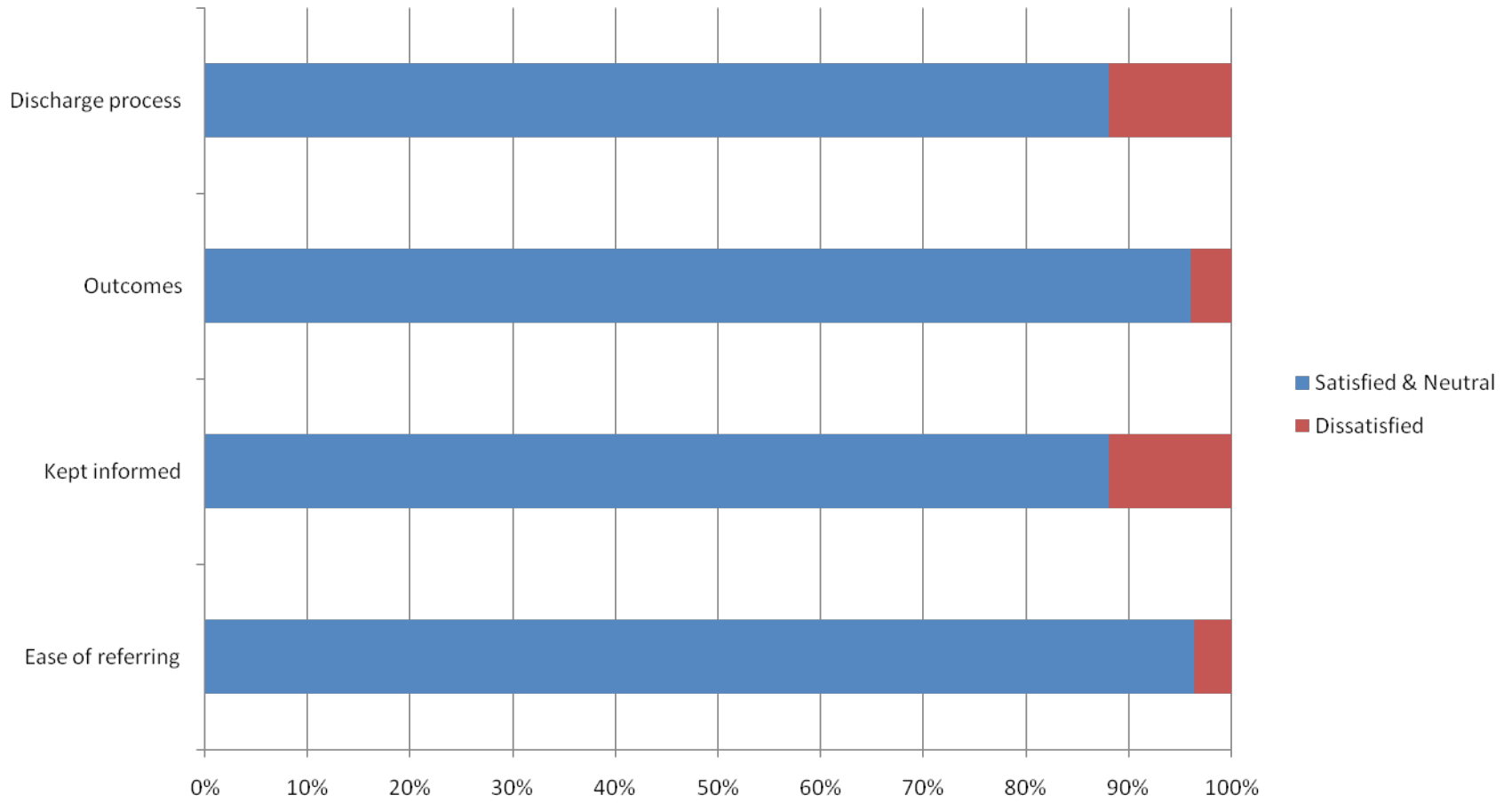
What was their understanding of the services that ICT provides?



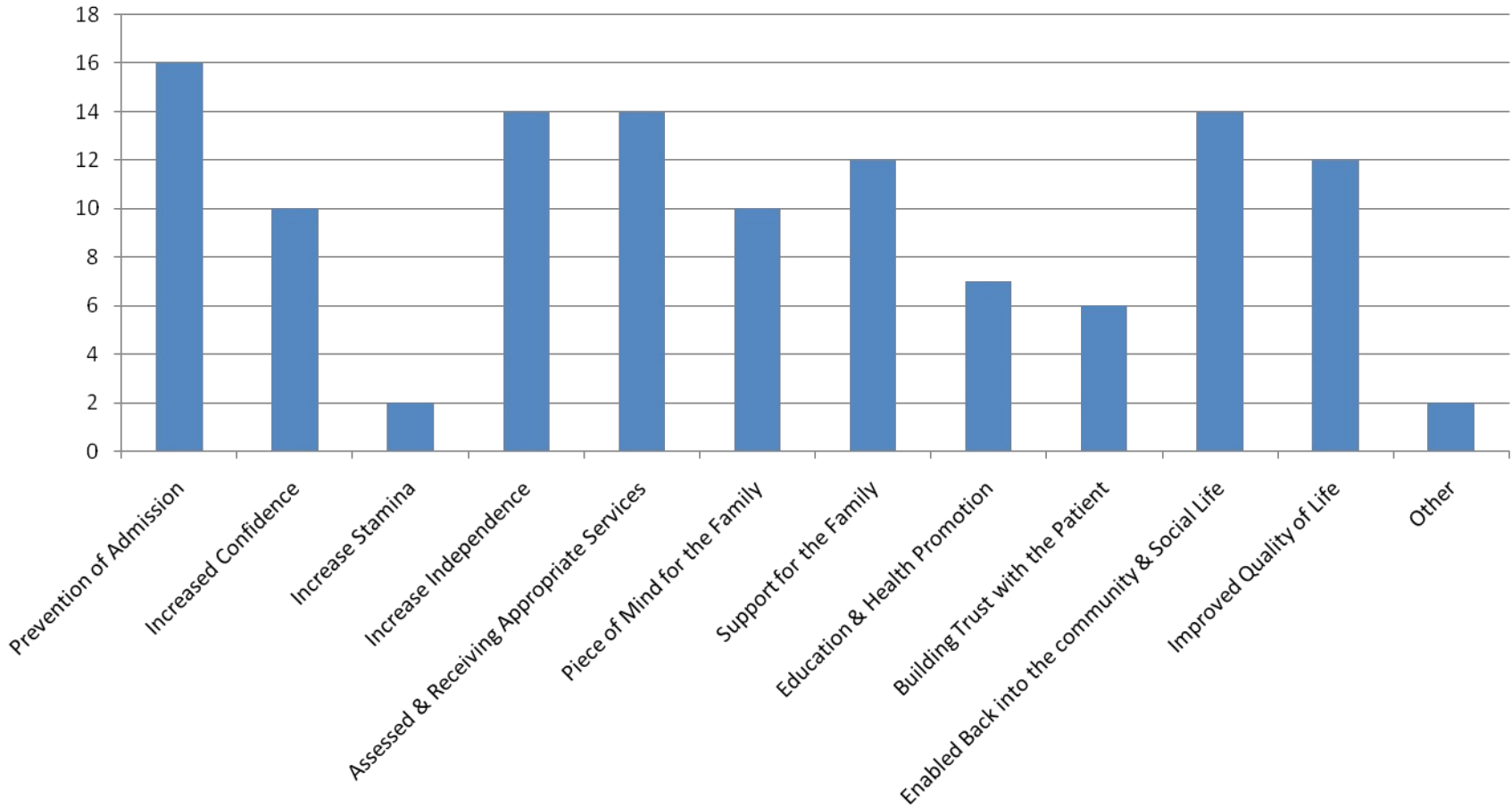
- Rehabilitation/Step Up
- Prevention of Admissions
- Early Supported Discharge

■ Listed 3
■ Listed 2
■ Listed 1

How they rated their satisfaction with the Intermediate Care Service



What benefits have their patients and service users seen



What worked well

- Generic workers/Care apprentices
- Bringing the service into the persons own home
- Multi disciplinary team
- Continuity of journey
- Quotes
 - ‘Enthusiastic RSW which patients have responded well too’
 - ‘Where referrals have been accepted then results have been very good. It has been good to watch the Team develop and become more aware of CSS community processes so that they can access services appropriately themselves.’
 - ‘I have been able to discharge patients home from the ward earlier knowing that they are receiving Nursing, Occupational Therapy and Physiotherapy services at home with the support of trained staff and rehabilitation support workers.’
 - ‘Patients have responded well to the interpersonal skills of the rehab support workers’

What has not worked as well

- Capacity
- Criteria
- Communication
- Quotes
 - ‘As time has gone by ease of time to response of the service appears to reducing and this is probably because of workload issues due to its success.’
 - ‘Communication re progress and information on discharge could perhaps be improved.’
 - ‘Unfortunately the expectations put upon (and probably the lack of resources allocated to) the ICT have been unrealistic. It is an extremely useful part of the jigsaw of services which are required but complements rather than replaces other services.’
 - ‘Feel there could be more communication to ensure that resources are being well used where community nurses and ICT are visiting the same areas.’

Suggestions/Comments

- Care Pathways
- Expand/increase capacity
- Valuable & Core Service
- Quotes
 - ‘The development of a care pathway to show how all community care services interact and how they can be accessed with the aim of developing a simple, clear, cohesive and comprehensive care service of which ICT is an integral part.’
 - ‘Well done. It has in a short time become a core service and I breathe a sigh of relief when the team arrive because I know that I can leave the patient in good hands’
 - ‘A single point of entry into the care system - to co-ordinate the various services.’

Service Users, Families and Carers

Compliment and Complaints

- These were unsolicited
- Includes cards received, comments in the press etc.
- Sept 09 – Mar 10
 - Compliments 20
 - Complaints 1 (Didn't want a male member of staff)
- Apr 10 – Sept 10
 - Compliments 17
 - Complaints 1 (Insufficient information re other service going in)

Finance Data

Budget

- Total budget £402,328
- Staff £347,632
- **9.61 WTE**
- Travel £ 54, 696

Conclusions/Recommendations and Moving Forward

Conclusions/Strengths

- Whole system approach
- Rehabilitation and enablement approach
- Integration of workforce and services
- Out of hours support
- Generic Working/Care Apprentices

Recommendations for the way forward

- Single point of referral
- Documentation and pathways of care
- Better continuity/journey for services users
- Joined up OOH/night care – further reduce length of stay
- Whole system approach
- Integration of workforce and services

Recommendations for the way forward ...cont.

- Rehab/enablement model
- Seven day a week – Discharge Policy
- Alignment to GP practices
- Increased focus in the patient / public involvement
- Generic worker / care apprentices
- Mobilise and access resources

Questions