Joint Intermediate Care and Enablement Strategy
Implementation Update January 2013

Community Rehabilitation Stroke and Non Stroke

The Rehab team continues to work closely with the Intermediate Care and Enablement Team. The teams continue to manage people in the community enabling them to rehabilitate in their own environment and remain at home.

In the 2nd **quarter** the team supported 116 new patients for general rehabilitation and 179 people to avoid admission; in **quarter 3** they supported 140 for general rehabilitation and 203 to avoid admission.

The stroke element of the team supported 66 new referrals for rehabilitation and 10 ESD direct from HASU in **quarter 2**; in **quarter 3** they have supported 35 rehabilitation patients and 19 ESD direct from HASU more than double the target. This would account for the decline in the number rehabilitation patients as the number of patients on the case load remained constant at an average of 80.

92% of patients said they had improved after input from the team in quarter 3.

Contributes to objectives 1, 2, 3, and 5

Admission avoidance

Both North Middlesex University Hospital & Barnet & Chase Farm Hospitals now have their admission avoidance services in place with case finders working in A&E to identify patients who need not be admitted. So far NMUH have managed to avoid 64 admissions since 6th December and Chase Farm 16 since18th February. Both trusts are working to ensure patients are identified and managed prior to the four hour wait target in order to avoid a short stay. Social care is established in both services and Chase Farm are working to employ a CPN as part of the service.

Feedback from Enablement and Intermediate Care team suggests that they still have capacity and are not receiving as many referrals as they would have expected. A review of the service on both sites is to be undertaken in April and a report will be taken to the Integrated Care Group.

Contributes to objectives 1, 2, 3, and 5

The Multi Disciplinary Care Homes Team Admissions in October, November and December have shown minor reductions from the 2011 figures. Comparing just the month of December, emergency admissions are lower than in 2011 (29 v. 34).

A&E attendances were higher in December than the previous year (49 v 45) with an accompanying £164 increased cost.

Outpatients attendances are 56 lower (350 –v 406), and the cost £9.5K lower.
However, Patient deaths following emergency admission rose to 8 in December.
In addition, CHAT report that they have

- Seen >1401 patients as part of the rolling review and acute clinics;
- Have completed 110 ACPs and 116 DNRs between May 2012 and February 2013; and
- Stopped 267 medications and taken 34 patients off anti-psychotics

Tissue viability

- The project is now in 19 care homes with additional support being provided for residential homes by the District Nursing Service.
- The team is now fully staffed – a Band 7 Specialist nurse was recruited in November. A secondment for a Band 5 nurse from the DN service started in January 2013. The TVS team as a whole is responding to the needs of the Care Home Sector in relation to tissue viability education and training and clinical practice.
- Patients suffer from a variety of wound care problems however the main problems are related to pressure ulceration, not all of which have developed in the homes; a a significant number are being admitted from hospital with these wounds.
- To date:
    - Education and training has been delivered to 92 care home staff from 13 care homes;
    - Tissue viability care has been delivered to 98 residents
    - Referrals from Care homes are increasing

Contributes to objectives 1, 3, 4 and 5