



Intermediate Care across Haringey & Islington

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What is Intermediate Care?

- Intermediate care services are provided to people, usually vulnerable people, after leaving hospital or when they are at risk of being sent to hospital.
- The services offer a link between hospital and home, and between different areas of the health and social care system – community services, hospitals, GPs and social care.



What is the case for change?

- Separate reviews of our local services took place, which found intermediate care in both Haringey & Islington was:
 - Complex
 - Confusing
 - Slow to respond
 - Doesn't offer preventative care but instead only responds when there is a problem



Our Ambition

- Our ambition is to align and coordinate intermediate care services across Haringey & Islington.
- By doing so we can:
 - Meet current and future need for rehabilitation and reablement
 - Reduce people's dependence on hospital, residential and domiciliary care
 - Improve access to services, particularly for those with complex needs
 - Improve value for money across the system



Our Vision

Our vision for Intermediate Care is to provide residents with direct access to services provided by health and social care staff.

We will work together as a single team to respond to residents' changing priorities and needs.

We will work flexibly to coordinate and maintain residents' long term health & wellbeing and will always support people to return to, or remain in, their usual place of residence.



Our Aim

Our team of health & social care staff aim to help people to be as independent as possible and support people to remain in, or return to, their usual place of residence.

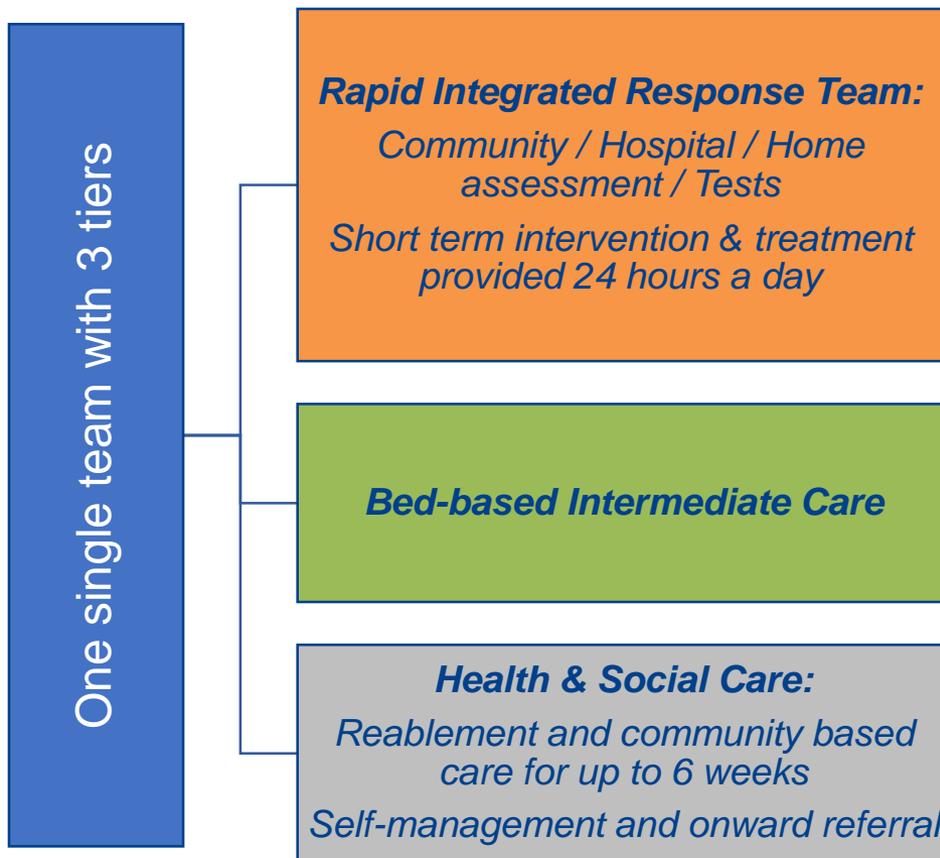
We provide support and rehabilitation to people at risk of hospital admission or who have been in hospital.

Our aim is to ensure residents transfer from hospital to the community in a timely way and prevent unnecessary admissions to hospitals and long-term care.





Proposed New Model



Proposed services to make up the new model

Haringey Services

Rapid Response
Reablement
Bed Based Intermediate Care (30) at Protheroe House, Priscilla Wakefield and Bridges
Community based NHS Therapy input
Discharge to Assess

Islington Services

Admission Avoidance
Reablement
Bed based Intermediate Care – (43) at St Pancras, St Annes and Mildmay
Community based NHS Therapy input
Discharge to Assess
Enhanced Virtual Ward

Operational leads are keen to create a consistent language for the services across Haringey & Islington.



Patient Outcomes

- Remain as independent as possible.
- Feel supported throughout the intermediate care pathway.
- Experience their care as coordinated and focused around their needs and aspirations.



Example of similar working

Epsom Health and Care @home service

Physicians, community matrons, nurses, social workers and others work together in a single team

Intensive, multi-disciplinary care packages help people stay at home

Single patient care plan and shared records facilitate integration between services and mean patients only need to tell their story once



@home currently provides integrated care

@home co-ordinated assessment and diagnostics service

Enhanced @home (rapid response service and supported discharge service)

@home hub (coordinated care up to 12 weeks)



Questions

1. Do you have experience of using intermediate care services or caring for someone who has?
 - a. If so, what was your experience of this service?
 - b. How could the service have been improved?



Questions

2. What's important to you when thinking about the speed of the service against the location?

a. Is this different when thinking about bed based services, and why?



Questions

3. What would be most important to you, or someone you care for, if they needed Intermediate Care?

