Reviewing patient journeys through Intermediate Care and Reablement

Overview

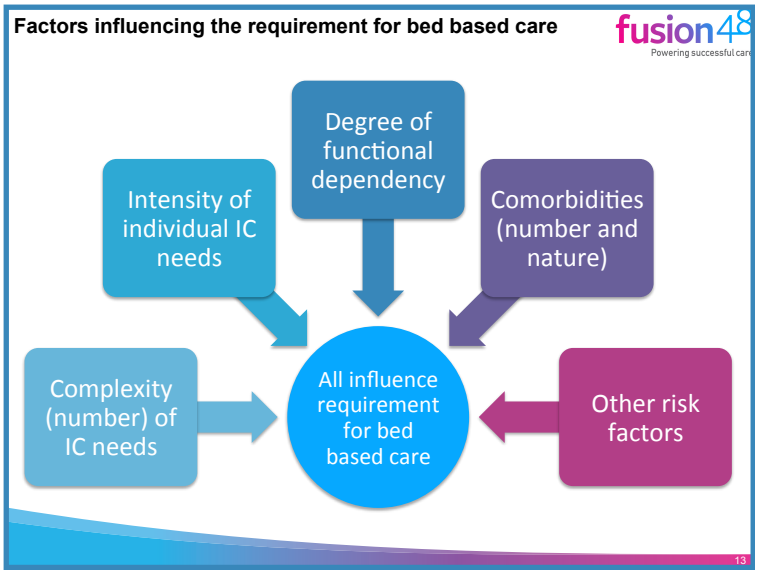
Older people, particularly those with frailty and complex needs, require integrated and responsive systems of care[1]. Intermediate care is an important transitional phase in many older people's journeys of care and represents both unique opportunities and unique challenges in this respect.

The National Audit of Intermediate Care 2014 highlighted that overall the outcomes for patients using these services are good. The report also emphasised that considerable expansion of intermediate care capacity is required to meet the needs of our ageing population, but did not make specific recommendations regarding service configuration.

A vital question therefore remains to be answered for both commissioners and providers, namely: *"Which combination of bed-based and home-based intermediate care and reablement services will be most effective in supporting older people's functional ability and thus maximising their independence and quality of life?"*

This project aimed to answer this important question for one CCG and thus inform the design of a key component of a developing 'integrated older people's pathway' in their area.

A clinical and analytical audit of a cohort of patients transitioning through intermediate care and reablement services was carried out. This audit took a patient-centred, needs-based approach, using a specifically-designed audit tool, in order to identify and analyse the key factors currently influencing these journeys of care. This enabled the description and evaluation of the effectiveness, benefits and constraints of the current service model.

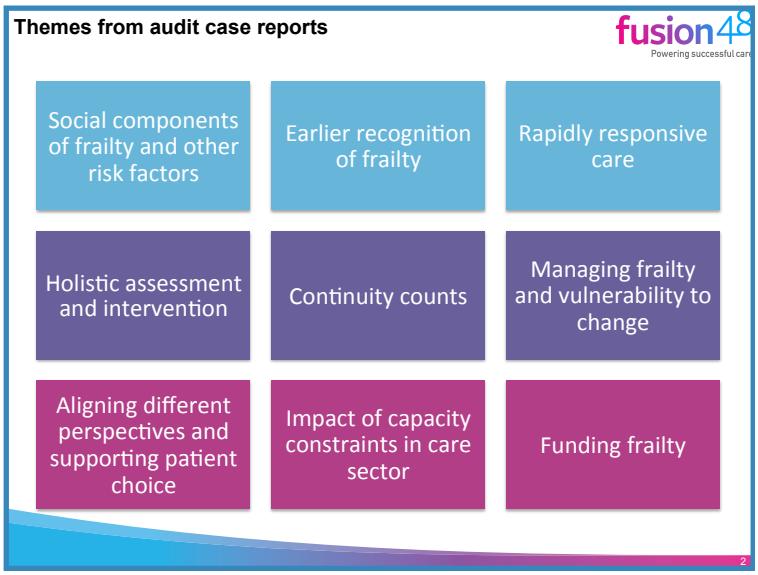


[1] British Geriatrics Society "Fit for Frailty", January 2015;
Kings Fund report "Making our health and care systems fit for an ageing population"

Key findings

- A quantitative and thematic understanding of the key factors currently determining the requirement for bed-based as opposed to home-based intermediate care services was gained. This helped to identify evidence-based opportunities for strategic service development and redesign.

- A number of frailty themes were identified and shown to be both individually and collectively having a very strong influence upon patients' current journeys of care. This helped to raise awareness of the importance of frailty amongst a wide range of stakeholders from across the local health and care economy and to initiate the concept of making local health and care systems 'Fit for Frailty'.



A vibrant workshop then took place, involving a wide range of enthusiastic frontline clinical staff, managers and commissioners, from both health and social care, and representatives of patients and third sector organisations.

The participants worked together in multi-professional, cross organisational groups, using all the evidence gathered during the course of the review, to inform and help define what will surely be an exciting shared pathway ahead.

Case Example: The Impact of Rapidly Responsive Care

90+ years old lady with frailty and multiple long-term conditions, who lived with her daughter and had no outside care support. She became confused and fell due to a Urinary Tract Infection.

This type of scenario frequently results in an A&E attendance and unscheduled admission. However, in this case she was referred to Intermediate Care (IC) by the out of hours GP and IC at home was rapidly arranged.

On the day of the audit the length of stay in IC at home was 5 days and she was doing very well. The longer-term plan was to arrange a package of care to supplement the care given by her daughter.

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