APPENDIX 2

MILTON KEYNES PCT
BRIEFING PAPER ON
ENHANCED INTERMEDIATE CARE MODEL

24TH OF JUNE 2003

Introduction

This briefing paper sets out an overview and key details (to date) on the proposed enhanced intermediate care model (EICM).

Background

The financial position of the PCT has resulted in decisions at executive level to downsize services for predominantly older people in need of in–patient rehabilitation care and therapy. The service reductions have created an opportunity to transform the range of rehabilitation services to an EICM. This new model must be developed with several givens:

- Working to achieve an average length of stay of 21 days
- No access for older people already identified as having delays in their discharge
- No respite care

An overview of intermediate care

The emphasis is on a period of active care and therapy to achieve maximum independence based on individualised care plans. Cross professional working is an essential component with the need for comprehensive assessments, single professional records and shared protocols and ways of working. The breaking down of pre-existing barriers and modernising is vital if IC services are to be effective.

To be regarded as Intermediate Care services a number of criteria in have to be met. Time limited care and rehabilitation is also key. Time limiting services usually agreed at a 6-week level gives a clear message that Intermediate Care is not about warehousing or dumping of older people. The expectation of these services is that after a period of active care and therapy the person will return to their own home.

The Department of Health (2001) state " Intermediate Care is not suitable for people with unstable acute medical conditions, this includes new acute medical problems that emerge during the course of an Intermediate Care episode." It says these patients must have access to (medical) consultant-led, hospital –based diagnostic and treatment services. This applies to those at home or already in a hospital setting. Therefore, ensuring appropriate patient selection is essential hence this is one of the reasons why services use selection or referral criteria. There is an ongoing debate about what constitutes medical stability and predictability. To be medically stable means that the patient has not needed input from a medical practitioner for at least 24 hours for assessment diagnosis or investigations. Predictability means that the patient's response

to their medical condition or current health status has been assessed and a plan for medical management has been made that is shared with the patient and the team.

The DOH say that Intermediate Care should be distinguished from:

- Those forms of transitional care that do not involve active therapy or other interventions to maximise independence i.e. for patients who are ready to leave acute in-patient care and are simply waiting for longer-term packages of care to be arranged.
- Longer-term rehabilitation or support services.
- Short term rehabilitation that forms part of acute hospital care.

In summary the proposed model within MKPCT is ambitious[1]. Achieving the average length of stay will provide a major challenge for health and social services and one that most services around the UK are not expected to achieve or work to.

Overview of the EICM

The proposed new EICM requires both a service redesign AND a transformation in service delivery to achieve interdisciplinary model of care and therapy. This means modernisation amongst all the professions to ensure that service delivery is fast and effective. It also means some taken for granted professional boundaries may need to be challenged and the role of rehabilitation assistants and nursing auxiliaries expanded

The new service will need:
Clear referral criteria (the current one will need to be reviewed)
Activity database
Patients with incomplete medical investigations and assessment or medically unstable will not be admitted
All referrals to be screened and assessed by a member of the team
Patients to be admitted under the care of a Consultant Nurse
Patients to be allocated to one of 3 primary nurses and a named therapist who will be responsible for care and therapy and discharge planning
Medical practitioner will be responsible for the patient's medical needs
1 week for multidisciplinary assessment/initiation of care and therapy plan
2 weeks for active rehabilitation and discharge planning
Weekly multi-disciplinary review
Family meetings to facilitate discharge planning
Case conferences where average length of stay is exceeded or a delay in discharge is identified after admission
All patients allocated to a primary nurse at F grade or experienced E grade level
CHAT staff to attend MDT's and support achievement of early discharge
Develop closer links and a more effective referral system to MH and Older Peoples services.[2]

[1] The average length of stay for 2002 was 29 days

Active social work involvement
Integrated records of care, therapy and social work

The expertise of the multi-disciplinary team will be developed through the emerging practice development strategy that is already building up within BCH.

The vision for this work as developed by key clinical staff is to:

> *Create a centre of excellence in multi-professional and collaborative rehabilitation that meets the health care needs of the local population now and prepares staff for the forthcoming demand in rehabilitation with older people, within predicted future demographic changes in Milton Keynes.*

The strategy aims to:

- Create a service whose clinical leaders and staff are prepared to engage in continuous development (in inter-professional practice and service organisation and delivery)
- Create a culture of practice where clinical leaders feel empowered and are accountable for practice (enhanced role performance, shared governance).
- Develop ways of working that is committed to 'getting ideas into practice' whilst at the same time critically challenging practices that do not meet patients needs/wishes or are not evidence based (clinical effectiveness clinical governance).
- Move away from a culture of 'medical dependency' among nurses and therapists to one where nurses and therapists feel able to initiate, develop and sustain creativity in practice. (Improved decision making with patient care and overall management of an episode of care).

This vision has also been converted into the following strategic objectives:

1. To develop a culture that values and responds to the experience of care from users/patient perspectives
2. To release the potential of staff to modernise their practice and services
3. To contribute to clinical effectiveness and governance within the PCT

The objectives will be achieved through an action plan based on the following cycles of action:

Action Cycle	**Theme**	**Focus**
Action cycle 1	Developing a shared vision	Agreeing a shared vision for the project, the services and nursing practice.
Action cycle 2	Maximising transformational leadership potential	Developing the leadership knowledge, skills and expertise

[2] For 2002 approximately 40% of patients in Windsor ward had cognitive impairments that required screening and further assessment for clinical depression or a dementia. This figure is consistent with national trends.

		of ward leaders.
Action cycle 3	The fundamentals of rehabilitation and care	Changes to the clinical care received by service users and to the context of care delivery.
Action cycle 4	Involvement of users/patients	Changes to the way in which users/patients experience rehabilitation and care

It is only by combining systematic practice development with service redesign that the proposed EICM can achieve its potential and older people have an opportunity to have positive experiences of hospital care whilst in the process of engaging with intensive in patient rehabilitation within a very short time frame.

Staffing and Skill Mix
Nursing & Therapists

See Appendix 1 attached
The proposed establishment is based on the targets being set for a caseload of 28 patients.
The therapy input is based on a maximum of 30mins per patient per day (direct care), this does not constitute 'intensive rehabilitation', therefore training and 'upskilling' of registered nurses and rehabilitation assistants is of paramount importance.

Job descriptions will need to be reviewed to ensure they are consistent with intermediate care service delivery (i.e.: service redesign and modernisation).

Other Issues
The workload for the Consultant Nurse will increase so this must be adjusted against other work undertaken for the PCT.
The medical practitioner role will need to be reviewed in view of reduction in beds
Social work input: dedicated provision will be required
Dedicated links with CDU to help prevent acute admissions and to access diagnostics if patients condition changes
Training needs of staff prior to and after ward opens