

CARDIFF HEALTH SOCIAL CARE AND WELL BEING STRATEGY

NEEDS ASSESSMENT

COMMUNITY SERVICES/INTERMEDIATE CARE (6.6.2)

COMMUNITY SERVICES

Cardiff and Vale NHS Trust, with its partners is reviewing Community Services as part of the third phase of the Trust's Clinical Services Strategy "Changing For The Better". The Project is due to be completed towards the end of the summer of 2003 and its outcomes will therefore be included within the final needs assessment. A high level description of the current services are included within this overview.

Community Nursing Services

District Nursing

The District Nursing service within Cardiff and Vale Trust is provided by 50 discrete District Nursing teams. The service that the Trust offers is unique throughout Wales as it offers a 24 hour service through the day teams described above and 11 evening and night teams. This has allowed the support of a more dependent case mix as the service can truly support patients over a 24 period. The dependency of the casemix has anecdotally been reported to have increased significantly in recent years and in attempt to compare the workloads of individual caseloads the review has incorporated the use of a dependency scoring tool.

All teams are attached to GP surgeries, many based in the surgery within practice based teams. Visits are primarily made to patients' homes but teams do also input to leg ulcer clinics and treatment room settings. Out of Hours services are provided from Splott Clinic.

The Acute Response Team comprises of a multidisciplinary team involving nursing, therapy and social work support. The Team covers the Cardiff and Vale Trust geographical area and offers packages of care of up to 10 days. The Team functions to facilitate early discharge and prevent hospital admission. The team can work independently or with existing service i.e. district nursing services or social services. If existing services cannot meet the needs of the patient, ART can provide additional support in conjunction with existing services to maintain those patients at home.

Health Visiting

Treatment Room

There is a variation in Treatment Room services provided across Cardiff. Dedicated Treatment Room staff are in post in Riverside, Llanederyn and Canton/ Parkview Clinics. These clinics serve the population and are not GP specific. Other services are provided by attached District Nursing staff in the East of Cardiff. This service runs alongside 5 Primary Care Leg Ulcer Clinics run by the Tissue Viability Team and District Nurses (some of which cover the Vale)

Practice Nursing hours are allocated to GP practices to reflect practice population size and the number of GP partners. Practice Nurses are employed by the practice and undertake a range of roles to reflect the requirements of the practice.

Specialist Services

Continence Services

Prior to 2000 Cardiff & Vale NHS Trust had 1.0 WTE nurse continence advisor in post who mainly concentrated on issuing continence products in the community. In 2001 a Director of Continence Services was appointed, and the Trust's Strategy was to develop an Integrated Continence Service. A nurse continence team has been established with two other specialist nurses, and close links are maintained with the physiotherapy service.

Accident Prevention and Injury Control

The Trust has one (0.6 WTE) nurse specialist whose remit consists of project and awareness work aimed at reducing ill health, disability and deaths caused by accidents including the co-ordination of agencies to work together to share resources and achieve common objectives. The main area of work is advisory and until recently linked in with research from within Child Health that has now come to a natural conclusion. Projects and campaigns are maximised in the Trust but are limited by capacity.

Multi-Cultural Health Resource Centre

Cardiff and Vale NHS Trust currently provides a service for ethnic minority populations within the whole city. This is the Multi-Cultural Health Resource and Information centre (MHIRC). There is a service coordinator for the project and a team of 8 part time linkworkers. The aims of the service are:

- To assist members of minority ethnic groups who have not acquired sufficient command of English or are not confident in their use of health services to make appropriate use of health services in the city of Cardiff.
- To assist members of minority ethnic groups in developing skills necessary for them to use health services unaided.
- To contribute to an objective that applies to recent government policy:
i.e.” that equal opportunity of access to all parts of the health service must be available to all sections of the community “ (Welsh Office 1998).

Sickle Cell and Thalassaemia Services

On average the Cardiff Sickle Cell & Thalassaemia Centre can review up to 2,500 haemoglobinopathy results annually and follow up approximately 250 primary laboratory referrals per year as well as dealing with around 500 patient referral enquiries from other sources. Currently there are 37 people with a haemoglobin disorder supported by the centre.

Cardiff Sickle Cell & Thalassaemia Centre was established in 1990 and provides services to the populations of Cardiff and the Vale of Glamorgan. The centre is one of more than 50 centres in the UK but is the only one of its kind in Wales. It has 3 (not all WTE) members of staff.

Vulnerable Groups

In 2001 Cardiff Local Health Group, under the auspices of the Cardiff and Vale NHS Trust commissioned a report to examine the health needs of three disparate vulnerable client groups within Cardiff, homeless people, Gypsy Travellers and Asylum Seekers/Refugees. (A Level Playing Field 2001).

‘The report identified a number of gaps in service to these groups and suggested that commissioning a team of health professionals to work specifically with these groups would not only provide some of the direct care which is currently lacking but would also empower and enable vulnerable groups to achieve a more ‘level playing field’ in regard to their health, accessing health services and promoting health gain.’

'A level Playing Field 2001'

Cardiff Health Access Team (CHAT) is a newly developing team led by a Nurse Consultant (1.0 WTE funded for 2 years) providing services for vulnerable groups, and breaking down structural and personal barriers to health. The aim is to empower the groups to access holistic healthcare on an equitable level with the local population.

Primary Care Services for Asylum Seekers

The service was developed in May 2001 following the difficulties experienced in implementing the Local Development Scheme developed to provide General Medical Services to Asylum Seekers via Primary Care Contractors. Public Health Screening is offered to all Asylum Seekers via a dedicated Public Health Nurse and the Trust Asylum Seeker Team carries out a health needs assessment of all children registered with its service.

Homeless Groups

A specialist nurse for the homeless provides clinical assessment and treatment and health promotion services to homeless people sleeping rough or resident in emergency hostels throughout the city as well as assisting patients to register with General Practitioners and referring on to other appropriate health services. The specialist nurse is co-located and works closely with the Local Authority City Centre Team and receives clinical supervision from a local GP.

A specialist Health Visitor provides core Health Visiting Services to the Welcare assessment hostel for vulnerable families in Ely as well as two homeless hostels and four women's refuges across the city. Liaison and expert advice is also provided to other health professionals.

Community Dental Service

A mobile drop in dentistry service is provided at one of the emergency hostels in the Butetown area on an approximately 3 weekly basis

Podiatry

A podiatrist provides a fortnightly drop in service at one of the emergency hostels

Gypsy Travellers

There is no specialist provision for Gypsy/Travellers and patients registered with General Practitioners receive Community Nursing Services via the traditional route. A detailed needs assessment is currently being undertaken by the nurse consultant and generic health visitors on both the official Traveller sites.

Wound healing/Tissue Viability Service

In Cardiff and the Vale an audit was undertaken in December 2000 within District Nursing to ascertain the number of patients suffering with a leg ulcer and the treatment they had received. The results of this audit revealed that: -

- Almost 700 patients that have had a leg ulcer have never had a Doppler ultrasound to ascertain the cause of the ulcer.
- No formal researched assessment was undertaken.
- Wide variation of treatment
- Lack of treatment direction and focus
- Lack of recognised local training available

The Primary Care Tissue Viability Service was established in May 2001 with the appointment of a Clinical Nurse Specialist [1.0 WTE] whose initial remit was to set up primary care leg ulcer clinics within the geographical area of Cardiff and the Vale. The aim of the clinics are such that all patients referred to the service will receive a high standard of evidence based care through a standardised assessment, management and review in order to optimise healing and prevent recurrence.

The findings from the audit undertaken within the Trust in December 2000 has enabled the community leg ulcer service to commence and allowed for five D.N. sisters to attend specialist training in leg ulcer management. In addition, delivery of the service was enhanced in February 2003 by the appointment of an associate specialist nurse on a two-year contract. The role of this associate specialist nurse has been crucial in meeting patient demand for the service.

Therapy Services

The Therapy service (Dietetics, Occupational Therapy (OT), Podiatry, Physiotherapy and Speech and Language Therapy) interface with many of the areas referred to previously and also in the provision of intermediate care, outlined in the next section.

Therapy services are focussed fundamentally across three specific areas, these being:

1. Discreet uniprofessional, focussed community services
2. Therapies that are integrated within multi disciplinary community teams
3. Health Promotion/community development

General Therapy Services

Adult services are delivered within many settings across the community. It is important to note that some outpatient's community services are delivered within an acute and community hospital setting, e.g., physiotherapy outpatients and podiatry ulcer clinics. This is by design and is essential, as a result of the need to work closely with consultant colleagues, e.g., A&E, fracture clinic, diabetics, etc. In addition, for some local communities, these hospitals being their local health service provider.

Dietetics

The service includes:

- Paediatric and adult clinical work (in community clinics and patients' own homes)
- Working as part of wider multidisciplinary team (in intermediate care services, children's feeding clinics and special needs services)
- Education, training and support for other primary health care professionals
- Community development work with 'sure start' and health living programmes

Occupational Therapy

The community services are currently based within the multidisciplinary teams (MDT), e.g., Acute Response Team (ART), Community Rehabilitation Team (CRT), Elderly Care Assessment Service (ECAS), etc. Outpatient's services are linked to secondary care only, e.g., hand therapy

Physiotherapy

The community physiotherapy service can be categorised into three discreet core areas:

1. Outpatients' services – providing treatment and rehabilitation (as first line conservative treatment and following surgery/injury) predominantly to patients with musculoskeletal disorders, but also for specialist services. All of these are based in specific departments across the Trust and provided to both GPs and consultants in a locality community context.

2. The community physiotherapy team is a discreet uniprofessional service across Cardiff and Vale. It offers a service for GPs and consultants alike for a uniprofessional physiotherapy service. This limited service however, can only offer assessment and advice with limited treatment only.
3. Physiotherapists work within multi-disciplinary teams, e.g., ART, CRT, ECAS, etc. The core component of the service is to provide ongoing rehabilitation in conjunction with the teams.

Podiatry

These services are provided predominantly within the community for Cardiff & Vale NHS Trust and offer a range of speculation to maintain and promote foot health, mobility and tissue viability. This includes the diagnosis treatment of lower limb musculoskeletal gait abnormalities in medical device accredited laboratory, where orthotic products are issued. Out-patients services involved in diabetic intermediate and high risk screening and foot ulcer management

Speech and Language Therapy

This service provides intervention for clients with a range of acquired communications and/or swallowing problem. Patients are seen in out-patient clinics by the speech and language domiciliary service, as part of multi-disciplinary teams, e.g., CRT, ECAS

Future Service Models

All of the professions outlined above have highlighted issues in relation to their specific area, which need to be considered as part of the Community Services Review. The outcomes of this work will be included within the Needs Assessment once the Review is complete

INTERMEDIATE CARE

Introduction

Cardiff & Vale NHS Trust, Cardiff Local Health Group and partner agencies undertook a review of current intermediate care and rehabilitation services provided by the Trust to Cardiff and the Eastern Vale of Glamorgan in 2002. The full report is contained within "Closer to Home: Findings of the Intermediate Care and Rehabilitation Review", November 2002.

Current Service Provision

There are a number of Intermediate Care Services currently serving Cardiff and the Eastern Vale of Glamorgan (see below table 1).

Table 1: Current Intermediate Care Services

Service	Area Served/Base
Day Hospital Services	Cardiff & Eastern Vale/Rookwood, Llandough, Barry
Elderly Care Assessment Service (ECAS)	Cardiff/Rookwood
Acute Response Team (ART)	Cardiff & Eastern Vale/Lansdowne
Community Respiratory Resource Unit (CRRU)	Eastern Vale, West Cardiff/Llandough
Community-Based Therapy Services	Cardiff & Eastern Vale/St David's
Community Brain Injury Team (CBIT)	Bro Taf Region/Rookwood
Vale Community Rehabilitation Team (CRT)	Eastern Vale/Llandough
Vale Short-Term Intervention Service (STIS)	Eastern Vale/Llandough
Cardiff Rapid Response and Reablement Team (CRRRT)	Cardiff/Rookwood

These services constitute a solid foundation. Universal coverage of the catchment area is not provided by some services, for example ECAS and CRRU (it should be noted that Vale SIS and CRT are equivalent to CRRRT). Furthermore, Intermediate Care Services are not currently co-ordinated centrally. The pathway of care through services is dependent upon the source of referral (i.e. General Practitioner, Social Services, Trust) and whether the patient/client is in the community or requiring support following a period of hospitalisation.

General Rehabilitation Services

The Trust provides for a range of in-patient rehabilitation need that can be categorised using Audit Commission (2000) specifications into:

- acute - treatment of acute illness and the medical stabilisation of patients
- medium/intensive - concentrated, focused rehabilitation with specialist medical and nursing support in the hospital setting
- low technological - meeting a range of needs for the medically stable with a focus of 'confidence building' (slower stream rehabilitation, transitional care)

The model of rehabilitation care across Cardiff and the Vale of Glamorgan varies due to a number of factors including current organisation of medical teams and access to services.

The UHW site offers limited access for acute rehabilitation intervention. The majority of intensive rehabilitation and low technological/'slow stream' rehabilitation care being provided on non-acute sites (provided on wards at West Wing and St. David's Hospital). Within Cardiff the Trust also provides a limited service for patients with transitional care needs (those being patients who have completed their programme of medical care, but who are awaiting completion of discharge arrangements). At present, ten beds from within West Wing and St. David's bed compliment are designated for this purpose.

Table 2: Current General Rehabilitation Services

Rehabilitation category	Location	Ward areas/numbers	Designated beds
Acute rehabilitation	UHW	Ward C7 - medicine*	(38)
Medium/Intensive rehabilitation	Llandough Hospital	Stroke Unit (Ward E3)	23
	West Wing Hospital	Stroke, Orthopaedic & Medical Rehabilitation Wards	79
	Rookwood Hospital	Medical Rehabilitation Ward 6	20
Low technological rehabilitation	St. David's Hospital	2 wards	50
	West Wing Hospital	1 ward	40
	Barry Hospital	1 ward	24
		Total beds	236 (274)

* beds managed by Integrated Medicine at UHW

Additionally, the service provides outpatient, day hospital and outreach services for neurodegenerative patients with movement disorders, including Parkinson's Disease, and Memory Team services for people with cognitive disorders.

Specialist Rehabilitation

All specialist rehabilitation in-patient facilities are consolidated on the Rookwood site, where there is direct access to support services including the Artificial Limb and Appliance Centre (ALAC), Clinical Engineering and Voluntary Agencies. These services work closely with the Neurosurgery, Neurology and Trauma wards in the University Hospital of Wales and the Neuro-Psychiatry ward in Whitchurch Hospital.

Table 3: Current Specialist Rehabilitation Services

Rehabilitation category	Location	Ward areas/numbers	Designated beds
Spinal Injury (including Amputee services)	Rookwood	Ward 4	19
		Ward 5	20
Neuro-Rehabilitation	Rookwood	Ward 7	17
		Ward 8	18
		Total Beds	74

Spinal injury and neuro-rehabilitation services are provided on a supra-regional and regional basis with patients accepted from across South and Mid Wales and as far afield as Devon/Cornwall. The majority of patients requiring amputee services are admitted from local areas.

Strengths of Current Services

Intermediate care, day care and community rehabilitation services

- good evidence of multi-disciplinary/professional working with close collaboration between health and social services
- Innovative service developments enabling patients to be cared for in their own homes.

General rehabilitation services

- strong multi-disciplinary working within service areas.
- Access to specialist geriatric assessment is a key strength.
- Service model has a strong evidence base.

Specialist rehabilitation services

- strengths include specialist expertise and effective multi-disciplinary working practices.
- strong communication and clinical links between key service areas.
- academic/international research profile is good.

Weaknesses of Current Services

Access and capacity

- lack of equity across Cardiff and the Eastern Vale.
- Service developments have occurred on an opportunistic basis and with short term funding.
- Access can be difficult from both primary and secondary care.
- Lack of flexibility with admission protocols means that direct access to general in-patient rehabilitation services is limited to the small number of beds at Rookwood controlled by ECAS.
- Insufficient in-patient rehabilitation capacity to meet demand.
- Difficulties in access domiciliary care services/long-term care placements affect in-patient throughput and access.
- Insufficient day-hospital and core community rehabilitation service capacity to meet demand.

Estate (Facilities and Configuration)

- No purpose built modern facilities and many of the existing facilities lack physical adaptation to meet requirements.
- Significant maintenance issues
- Dispersal of services across locations causes pathway inefficiencies and restricts the level of dependency of patients who can be transferred for rehabilitation.

Staffing Establishments

- Shortage of therapy staffing levels has been identified of over 100 WTE across the three service areas.
- Medical and nursing staff shortfalls at St. David's and Rookwood, including out of hours.
- Poor access to therapy and social work services.

Working Practices

- Opportunities for skills sharing and flexible working practices are not being fully utilised
- Therapy services are only provided on a 5-day/week basis.

Joint Working With Social Services And Partner Agencies

- There is scope for closer collaboration between the Trust, Social Services and Voluntary Agencies particularly for intermediate care provision and discharge planning practices.
- Closer liaison is needed with the independent and domiciliary care sector.

Access and Funding of Community Equipment Supplies

- Current funding and supply protocols need review.

Services for Young Chronic Sick

- The needs of patients with chronic diseases, entering the transition from paediatric to adult services are not well recognised or served.

Support to Carers

- Carer support could be further improved by focusing on information, respite and skills training.

Model and Components of the Future Service

A proposed model of Intermediate Care and In-Patient Rehabilitation Services has been developed and is shown overleaf together with the key elements of the General and Specialist Rehabilitation Services Model.

Figure 1: Overview of Future Model of Intermediate Care & In-Patient Rehabilitation Services

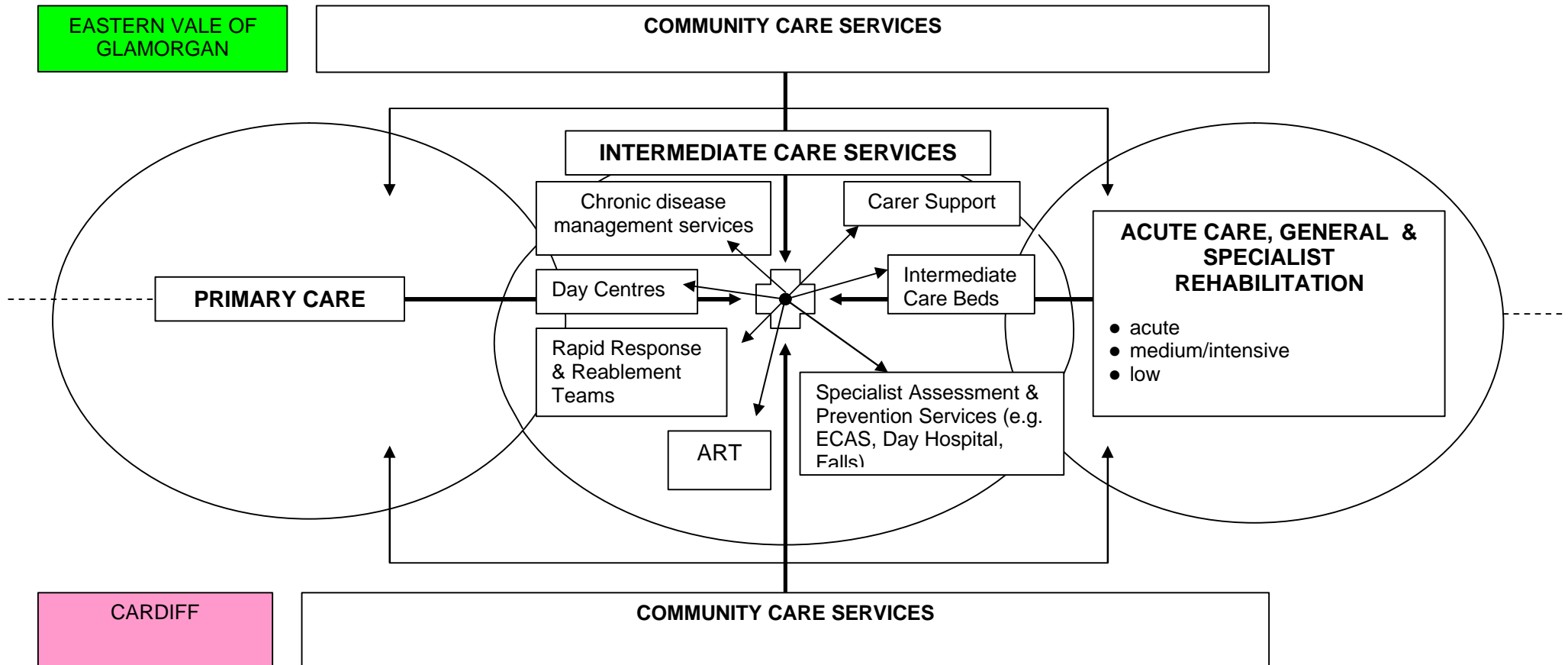


Figure 2: Key Elements of the General & Specialist Rehabilitation Service Model

