NHS Rotherham Clinical Commissioning

Governing Body 3 July 2019

Intermediate Care and Reablement Outline Business Case

Lead Executive:	Ian Atkinson, Deputy Chief Officer
Lead Officer:	Claire Smith, Head of Adult Commissioning (Joint Commissioning CCG/RMBC)
Lead GP:	Dr David Clitherow

Purpose:

The purpose of the report is to provide a brief summary for Rotherham CCG Governing Body that should be read in conjunction with the full report at Appendix 1, on the development of an outline Business Case for the provision of Intermediate Care and Reablement The full report (Appendix 1) provides a comprehensive account of the current state across identified community services in health and social care and the proposed future integrated model with a clear rationale for the transformation.

Background:

Partners across Rotherham are committed to developing current services and pathways to create an integrated model for Intermediate Care and Reablement with a 'Home First' ethos. A review of current services in 2018 identified a large number of fragmented services, delivered by different teams across organisations and an over-reliance on a large community bed base to provide Intermediate Care and Reablement. Current services are focused on physical health and social care needs, which mainly support people over the age of 80.

The document (Appendix 1) proposes a new integrated service across health and social care which will rationalise the current seven pathways into Intermediate Care and Reablement support services, to three core integrated pathways:

- Home-based urgent response
- Home-based rehabilitation and reablement
- Bed-based rehabilitation and reablement

The proposal outlines a high-level model in which we will:

- Increase workforce capacity for supporting people in their own homes
- Reduce Intermediate Care bed base ('community beds') over a phased period
- Embed a recovery-focused approach supporting a range of needs for anyone over the age of 18
- Align and integrate provision to reduce duplication and improve outcomes for people and the system as a whole
- Provide the ability to both 'step up' people into one of the three integrated pathways from their usual home support and 'step down' people into the three pathways following a

hospital stay

- Provide a borough-wide service which will enable the deployment of resources flexibly across the core integrated pathways to meet the needs of the people of Rotherham
- Support the aspirations of each of the partner organisations and align with wider transformational priorities.

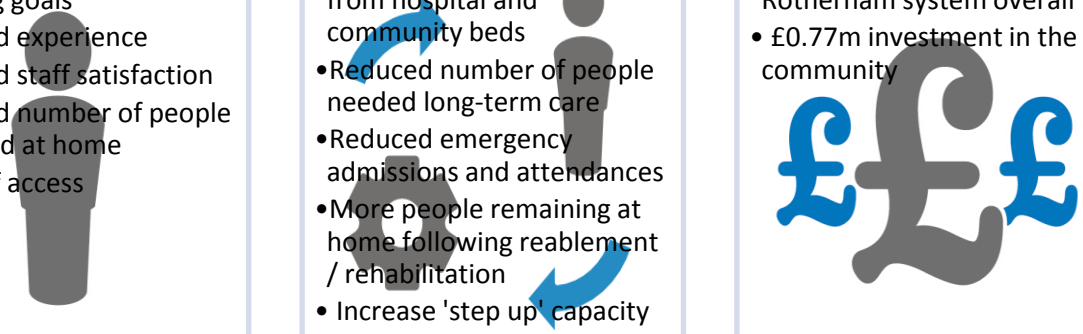
The model is premised on a reduction in the current community bed-base which audits identify is under-utilised and over-established in comparison to other areas, which in turn will support an increase in community capacity in the long-term to enable a Home First approach for more people in Rotherham. This shift is outlined in figure 1 below.

Figure 1

Current model			Future model		
	Community	**Bed-base**		**Community**	**Bed-base**
Workforce	92.6 WTE	54.49 WTE	**Workforce**	106.68 WTE	48.08 WTE
Pathways / teams	Four pathways (not integrated across health and social care)	Three pathways into 79 community beds	**Pathways / teams**	Two integrated pathways	One pathway into 54 community beds
Coordination and triage	Multiple entry points, referral mechanisms and duplication of triage		**Coordination and triage**	Reduced entry points and single multi-disciplinary triage to ensure people get the right support, first time	

As a result of these changes, it is anticipated that the following benefits will be achieved:

People	System	Financial
•Increased number of people achieving goals •Improved experience •Increased staff satisfaction •Increased number of people supported at home •Equity of access	•Reduced delayed discharges from hospital and community beds •Reduced number of people needed long-term care •Reduced emergency admissions and attendances •More people remaining at home following reablement / rehabilitation • Increase 'step up' capacity	• £0.5m saving to the Rotherham system overall • £0.77m investment in the community



This will be a significant programme of work implemented over an 18-month period in a phased and managed approach.

Analysis of key issues and of risks

1. Analysis of Current Issues

The Rotherham Integrated Care Partnership identified a number of key issues with the current intermediate care and reablement service offer for the population and outlined a vision to create a model centred on a 'Home First' approach. This was outlined in the *Discussion Paper: Reablement and Intermediate Care; Current State and Future Vision (April 2018)* which was accepted by the CCG in October 2018 (a copy of this report is included within the appendices of the business case).

In considering the case for change for the proposals outlined in this case, there are a number of key factors:

- There are currently a number of different services, split into multiple teams, providing Intermediate Care and Reablement support to the Rotherham population
- Access, capacity and understanding of the referral criteria to these services is inconsistent and not well understood
- There is significant duplication of assessment and activity as people move through the different services within Intermediate Care and Reablement
- There are still significant numbers of people who could be supported in their own home or usual place of residence but instead are moved to a community bed due to either lack of capacity in community to support them, or a lack of knowledge from the professional making the judgement. Local clinical audits of referrals to intermediate care beds have highlighted that 40% of people who went to an intermediate care bed would have been suitable for home-based rehabilitation and support. This is in-line with national research findings including the Newton Europe research paper 'Why not Home? Why not Today?'

(December 2017) which found in a study of three systems across the country, 60% of assessments could have taken place out of hospital.

- Rotherham has a large community bed-base. Including its specialist provision, Rotherham has 51.6 community beds per 100,000 weighted population (Intermediate Care Audit 2018) compared to the national average of 20.9 per 100,000 weighted population. The provision of intermediate care beds at RMBC's residential homes and spot purchase beds in the independent sector already offers 24.1 beds per 100,000 weighted population, which is higher than the England average of 22.1 beds. Whilst caution should be exercised in this figure because of the scale of specialist provision (and therefore not directly comparable), it is clear that Rotherham has a comparative over-reliance on a community bed-based offer as opposed to home-based services
- Bed-based provision is not currently equitable in terms of the intensity and availability of therapy input and the type and frequency of medical cover
- Spending time in bed-based provision can often lead to individuals moving into residential care rather than returning to their own home. Rotherham has higher than average rates of admission to residential care, it is believed that the over-reliance on bed-based intermediate care is a factor in this.
- The current provision, whilst an 18+ service in principle, supports very few people under the age of 65 and predominantly supports people over the age of 80.
- There is limited reablement and rehabilitation support for those with learning disabilities, physical disabilities and mental health conditions to recover their independence.

2. Options and Recommendation

In reviewing intermediate care and reablement services for the population of Rotherham, a number of options were considered:

- **Option 1: Do nothing**

Rotherham can continue to provide its current intermediate care and reablement services, however, this option does not meet the aims of the Rotherham Place Plan in terms of embedding a 'home first' approach, does not address the overuse of beds in Rotherham, and will lead to continued gaps in delivery of care and support. There is also increasing evidence of the underutilisation of community bed-based provision, due to local integration and improvements in pathways.

The services will continue to operate in isolation, leading to people's needs not being met within the most appropriate and cost-effective environment and potentially causing further deterioration, extending their requirements for longer term services.

Not recommended: Will not provide the best outcomes to Rotherham people, will continue a reliance on bed-based support which does not maximise good outcomes or offer a cost-effective provision for Rotherham, which is increasingly becoming underutilised. Continuing to work in siloed teams will allow continued duplication and gaps for people and their carers.

- **Option 2: Generate efficiency through changing ways of working**

To reshape current service provision in order to realise efficiencies and enable a reduction in resources within bed-based intermediate care services. The services will operate in a more integrated way and ensure improvements in productivity and performance are achieved in line with comparative health economies.

Not recommended: The services have already made considerable efficiency gains through new ways of working, for example the establishment of the integrated discharge team (see Appendix 2). Whilst there are further opportunities for efficiency gains through changes in processes and working practices, these alone will not deliver the overarching vision to provide more community-based rehabilitation and reablement support to an all age population (adult) which is recovery-led and will not serve to reduce the over-reliance on community beds.

- **Option 3: Develop an integrated model for intermediate care and reablement across Rotherham**

The proposal is to build on and further develop services to form a single service that is more proactive and driven by people's needs, based on a holistic recovery model, rather than the individual services currently in place. The focus of the model will be a 'Home First' approach, reducing reliance on bed-based care to allow far more people to remain at home, or go straight home from hospital. Through the creation of a single service, this will improve individuals' outcomes and experience, reduce duplication in the system, and utilise the time of professionals more efficiently and effectively.

The integrated model will embody the following characteristics:

- Offer an urgent short-term response
- Offer home-based rehabilitation and reablement
- Offer bed-based therapy-led rehabilitation and reablement
- Provide support for discharge to assess pathways in people's own homes or in a community bed
- Multidisciplinary and cross-organisational
- Staff will have the skills to work flexibly across the core pathways within the model
- Provide a service to all adults (18+)
- Access to equipment, assistive technology and other services quickly

Recommended: Consolidates the collective resource within the system to meet the home first vision, and to deliver the best outcomes for the population within the available resources. This model will provide a significant next stage in the efficiency gains already made through changing ways of working.

3. Key principles for a future model

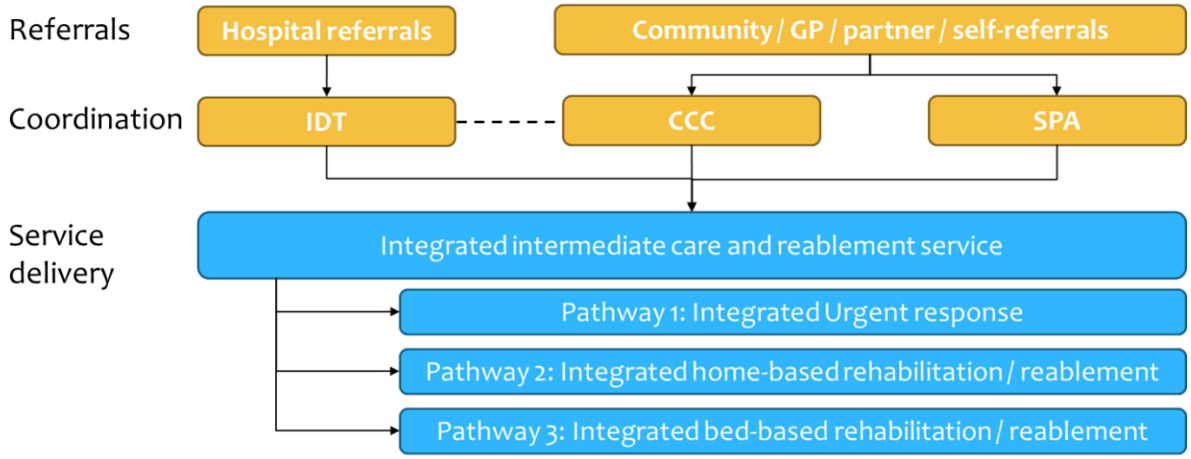
The model proposed has been built on some key principles, derived from engagement and previous work to develop a vision for intermediate care and reablement:

- Home First will be the default – we will work to get people home first time, wherever possible
- Digital and technology solutions will be a default option in terms of enabling support in people's own homes
- The model will be a flexible offer to meet the needs of the individual – not bound to a narrowly specified duration of support. Intermediate Care and Reablement will work up to six weeks free of charge, with a further six weeks available as a commissioned package of care, subject to the needs of the individual
- The model will be all age (18+) and will break down the cultural barriers which prevent people under 65 accessing the service
- Trusted Assessor model will be embedded
- Model will support people in both a 'step up' capacity from the community or 'step down' following treatment in hospital to provide re-enablement support. There will be a rebalance of the service to ensure that there is equitable step-up and step-down capacity available (currently step-down support takes precedence)
- Skilled qualified staff will be focused on assessment, planning and evaluation of support, as well as training, development and supervision of wider staff groups as well as delivery of complex support
- Non-qualified staff will deliver the majority of rehabilitation and reablement support, working to the support plans and training directed and supervised by qualified staff
- Bed-based provision will be therapy led with nursing and medical cover available as required to support people with more complex needs
- Access will be equitable for people across Rotherham
- The service will closely link to voluntary and community sector and social prescribing services to ensure people can get the right support across the full spectrum of wellbeing.

4. Outline Operating Model

The proposed operating model brings together the current range of disparate services to offer a cohesive and integrated approach to delivery of intermediate care and reablement services, consolidating seven current pathways into three integrated pathways. Figure 2 below identifies a high-level overview of this model which will be further developed during the next phase of work to provide detailed pathways of care. The operating model has been developed as a borough-wide service to give the flexibility of resource across the pathways in order to respond to demand.

Figure 2 – Proposed future model



Patient, Public and Stakeholder Involvement:

See Section 17 of the Outline Business Case for full details of the engagement to date and future engagement plans with both users of the service, their carers and staff.

These proposals build on engagement work undertaken to date in Rotherham with individuals and carers on a range of services. In addition to this, we have commenced early engagement on the development of this case through surveys, the Rotherham Patient and Public Participation Group (PPG) and through engagement with each of the partner organisations (clinical and managerial staff).

Initial engagement through the Rotherham PPG highlighted:

- A need for better coordination across services and health and social care working better together
- People being supported at home is the right offer
- Good care planning is central to this
- Concern that there needed to be more resources in the community to support people at home if there were to be less community beds available
- Each person and their carer needed to be seen as individuals and an individual-based approach taken to reflect their needs
- Concern about the ethos of 'medically fit' and this not meaning people were 'home fit'
- People want more information about the services supporting them.

Reflection on this early engagement is that there is broad support for the 'Home First' approach, an integrated health and social care model with better MDT working, and for more resources working in the community.

Concern in relation to risk of reducing community beds has been considered as part of the phased approach to change proposed in the implementation of the service model and in assessment of risk in Section 18 of this report.

This early work has informed the development of our engagement plans for the next stage of developing more detailed proposals and pathways.

Equality Impact:
Appropriate impact assessment has been completed and attached as Appendix 4 (appendices of the main report)
Financial Implications:
A full financial appraisal forms part of the full outline business case in Section 14. See Appendix 1.
Human Resource Implications:
There will be the requirement for formal consultation with staff across The Rotherham Foundation Trust (TRFT) and Rotherham Borough Council (RMBC) of up to 45 days. Full details of the impact are found in Section 11 of the outline business case (Appendix 1). The timeframes for this consultation are detailed in the implementation plan attached as Appendix 3 of the main appendices to the outline business case.
Procurement:
The current proposal has been developed as a partnership approach with RMBC and TRFT. The preferred option for all partners, in order to closely integrate pathways and services, is for the provision of bed-based intermediate care with nursing by TRFT, as described in section 10.2 of the business case. This is not a re-provision of the bed base proposed for decommissioning from the current RMBC provision, but a re-provision of the services with nursing support, currently commissioned from TRFT and the independent sector. The business case highlighted the risk that TRFT will be unable to provide the required bed-base and nursing support in the medium-term given some of the other estate and workforce priorities within the organisation. The Trust has undertaken a detailed review of its acute bed capacity requirements for Winter 2019/20 and beyond and identified that there is a need to seek alternative bed-based provision during Winter 2019/20 and into 2020/21. Annex 1 to the business case describes the transitional arrangements required in which nursing beds will be commissioned in the independent sector, which for the purposes of this proposal, impacts on the first six months of 2020/21. On this basis, an assessment of the current independent sector nursing home capacity to provide a similar service has been undertaken through an update of the current capacity in the independent sector based on the report 'Review of Residential and Nursing Care Homes Independent Sector (Older People)' initially conducted by RMBC and RCCG in January 2019. There has been consolidated effort from commissioners to stimulate the provision of nursing beds in the independent sector and while vacancies in nursing beds current stand at 32 across Rotherham, there will be over 60 beds available when a provider in Greasborough re-opens (planned for Summer 2019, subject to registration requirements being met). The successful commissioning of winter beds from independent sector nursing homes has also been indicative of the market responding to short/medium-term needs. There is a good level of confidence therefore that the market could respond to this requirement. In this model, the therapeutic input and Advanced Nurse Practitioner would continue to be provided by TRFT as an in-reach model and the Trust would maintain oversight of the whole pathway, with admissions to this provision only via the Integrated Discharge Team (IDT) for step-down admissions from hospital and via the Care Coordination Centre (CCC) for step-up admissions from primary care. This transitional service will be delivered within the prescribed financial envelope. It is anticipated that this transitional provision will yield additional financial efficiencies. The CCG as the responsible commissioner, will determine how these efficiencies are distributed.

Approval history:
N/A.
Recommendations:
Governing Body is asked to note: **(i) note the content of the report and the detailed report Appendix 1** **(ii) approve progression to the next phase of work to undertake detailed pathway redesign, involving appropriate CCG workforce** **(iii) approval of the recommendations within the report and specifically approval of the proposed changes to commissioning of intermediate care services.**

Discussion Paper; Reablement & Intermediate Care; Current State and Future Vision

April 9

2018

Version	Date	Status
V1	23rd January 2018	Draft
V2	9th February 2018	Draft
V3	5th March 2018	Draft
V4	9th April	Draft

1. Executive Summary:

The purpose of this report is to generate discussion amongst the Rotherham Accountable Care Partnership (now known as the Integrated Care Partnership) on the future models for intermediate care and reablement. It provides an overview of the current state (noting that not all services are in scope of this review) and the future vision for reablement/rehabilitation provision in Rotherham. This is a Rotherham Place strategy through the Acute and Community Transformation Group aimed at addressing health and social care objectives through integration and service redesign of existing reablement and intermediate care services.

Defining what is meant be Intermediate Care can be challenging as local systems interpret this provision differently. Intermediate care does not define a single service; it is a term that incorporates elements of reablement, rehabilitation and recovery. The NICE Guidelines, Intermediate Care including Reablement (September 2017) provide a clear vision of the model which corresponds with our local aspirations. The guidelines state that local areas should offer all 4 types of intermediate care:

- Crisis response – to prevent an avoidable admission to hospital, offering an assessment and possibly short-term care (typically up to 48 hours but up to around 7 days) if there is an urgent increase in your health or social care needs that can be safely managed at home.
- Home-based intermediate care – services are provided at home, by a team with different specialities (therapists, nurses, equipment, and social care), that support rehabilitation and recovery and can assess for any ongoing needs including CHC.
- Bed-based intermediate care – services are delivered in a community hospital or care home, for people who do not need 24 hour consultant led medical care but need a short period of therapy and rehabilitation.
- Reablement – services are provided at home, mainly by social care professionals and specially trained social care staff. Enabling the re-learning of skills and promoting recovery to build confidence to live at home.

The majority of Rotherham's provision both home and bed based is currently focused on frail elderly with limited reablement/rehabilitation support for those with learning disabilities, physical disabilities and mental health conditions to recover their independence. This is not how we see the future model; our vision is for a whole life journey approach for the adult population.

Rotherham has a strong record on joint working across health and social care, particularly within the field of reablement. There are a number of jointly commissioned services in existence through the Better Care Fund including the Rotherham Intermediate Care Service (residential bed base provision), Rotherham Intermediate Care Centre (day rehabilitation centre), the Integrated Rapid Response Service, the Integrated Community Equipment and Wheelchair Service, the Community Occupational Therapy (COT) service and more recently the introduction of an Occupational Therapist(s) into the Reablement service and the Council's Single Point of Access. There is evidence that these services have contributed to positive outcomes for service users and carers, including reduced length of stay in hospital (Rotherham's length of stay is 3.4 days for older people over 65 years, in comparison to the national rate of 3.6 days)[1], reduced the number of admissions to 24 hour residential care (the % of long term admissions has reduced by c.30 since 2015/16 from 401 to a predicted 280 by 2017/18 year end).

However, the percentage of patients >65yrs old discharge home after a Length of Stay (LOS) <7 days is 68.5%, in comparison to the national rate of 70.6% and regional rate of 69.0%[1].

[1] Secondary Uses Services (SUS) data

Data on emergency admissions shows that there were 10,627 admissions from >65 year old in the 12 months of 2016/17, of these c.77% (8,255) were >75. It is important to note that a number of these admission are repeats, 6,140 people were admitted in 2016/17 and of these 4,646 were >75[1].

It is becoming increasing apparent that there is a need to review provision to ensure that it remains strategically relevant and cost effective. Engagement with staff groups through various stakeholder events has provided a large pool of information from which consistent themes have emerged about the current services. The themes were;

- Restrictions in the type of patients eligible for the services
- Lack of nursing provision within the Intermediate Care Service
- Fragmentation and over complexity of pathways
- Issues with communication between participating organisations
- Delays and impaired flow of pathways
- Lack of a robust pathway from hospital to home and culture of 'Home First'
- Over supply of bed base provision
- Delays to therapeutic intervention and equipment

The appraisal of the current state indicates that there is a need for a clearer more streamlined reablement pathway that starts with the ethos of 'Home First', with a smaller community bed base, comprising of nursing care for step up, step down and rehabilitation including discharge to assess for those complex customers whose needs cannot be met at home.

There has been significant work undertaken in 2017-18 through the Adult Social Care (ASC) Improvement Plan and Better Care Fund Plan to further improve services, including a focus on multi-disciplinary teams at the front door (ASC Single Point of Access SPA), review of the intermediate care bed base provisions eligibility criteria, service specification and referral/allocation criteria, occupational therapy input into reablement and improvements to COT service.

However, there are still issues with the current reablement and intermediate care model described in Section 2. Our intermediate care bed base does not provide nursing care, which can be attributed to the delays with patient flow in the acute sector;

- there has been a c26% increase in the number of care home attendances at A&E since 2014/15 (from c. 1,476 in 2014/15 to 1,548 in 2016/17, predicted 1,565 in 2017-18) (note of caution on figures as this may include some postcodes that are not residential care provision).
- there are delays in accessing reablement and rehabilitation services (although Rotherham's DTOC position has improved significantly from 5% in August 2017 to 1.8% in October and 2.4% in November 2017) and
- our services could work more effectively at targeting the right cohort of people and keeping them at home. For example in the first 9 months of 2017-18 (April-December 2017) 24% (342) of the people referred to the integrated rapid response service were not supported (indicating an inappropriate referral), a further 6% (91) were direct to a short stay residential care placements, leaving 70% (1,028) supported at home. In comparison The National Audit of Intermediate Care 2017 states that c.80% of people are supported to remain at home through home based provision.

CCG audits taken place in 2016-17 show that there are still a number of hospital admissions that could be redirected to intermediate care. For example, a sample audit carried out last year showed that 23% of Acute Medical Unit (AMU) admissions were avoidable. 14% of these patients were subsequently admitted to hospital despite the fact that they did not have an acute medical need. The audit concluded that 29% of AMU admissions could have been dealt with in an alternative

setting. The alternative settings identified included intermediate care services. The unintended consequence being that ultimately this will lead to increases in the likelihood of permanent admission to a care home or an increase in a package of care, due to the lack of reablement, triage and support.

Therefore, Rotherham Integrated Health and Social Care Place Plan have an aspirational priority to consider options for the redesign of services. The desire is to provide a more streamlined pathway of provision to prevent, reduce and delay care and support needs through a reduced reliance on community bed based provision that can create dependency on long term care.

A fully integrated reablement pathway home is required that redesigns our current community based services (delivered in the home and in community beds), integrating specialisms such as therapist, social workers, nursing, mental health and reablement support workers. There would be a 'Home First Community Team' with a single referral and assessment pathway and single leadership model. This would deliver economies of scale, broaden the range of people who can receive support and act as a vehicle for health and social care integration. This objective is likely to be delivered by 2020.

2. Current State – Pathways and Needs Analysis

In April 2013 CCG's replaced Primary Care Trusts (PCT) across the UK, in Rotherham our Foundation Trust (TRFT) became responsible for community services (as described below) and a programme of community transformation took place which involved further investment in out of hospital provision including community nursing and integrated rapid response.

Although joint commissioning is a long standing feature within the Rotherham health and social care system there has never been a joint strategy for rehabilitation and reablement. Over time and due to pressure in the system i.e. winter pressures there has been in particular an increase in the number of community beds, developed for different purposes (discharge to assess, social care assessment). As pathways have become more complex and services evolved without appropriate consultation and communication with all key partners the level of confusion and clarity has diminished.

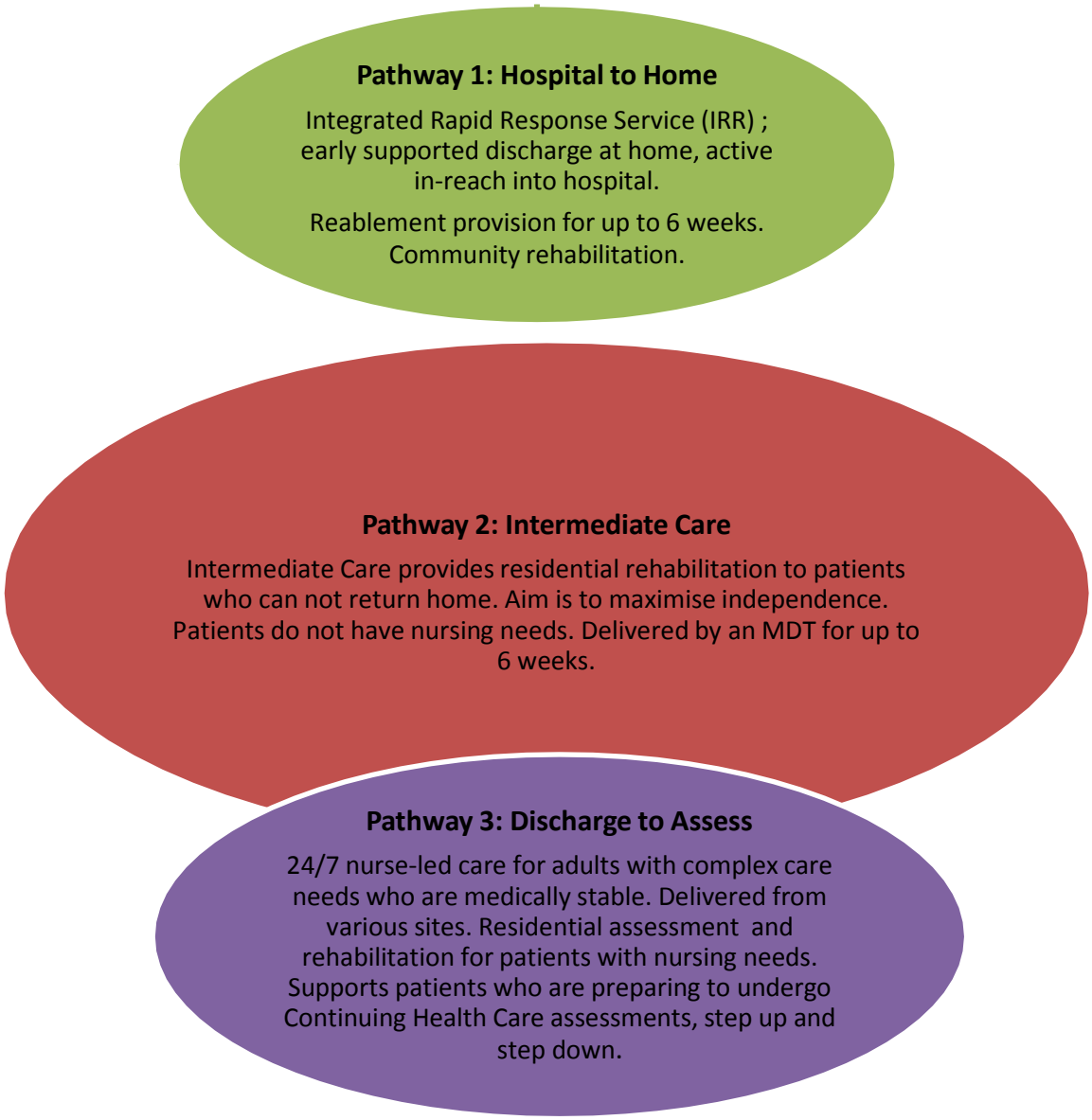
Prior to 2015 intermediate care provision (provided by RMBC in collaboration with TRFT - bed base) and Rotherham Intermediate Care Centre included a single line management structure, single pooled budget arrangement, a single point of access, additional funding for Advanced Nurse Practitioner to provide cover for minor injuries and illnesses for intermediate care units and inclusion of a specialist occupational therapist and community psychiatric nurse to help meet mental health needs and to provide specialist training to all intermediate care staff in dementia care.

However, the service has become fragmented with loss of single line management structure and loss of an MDT approach in rehabilitative services in the community. The Community Rehabilitation service also merged into the wider Domiciliary Physiotherapy service in 2015/16 to give equitable access across the whole of population in terms of waiting times for assessment. The model in place prior to this merge consisted of a multi-disciplinary team of occupational therapists, physiotherapists and home care enablers to deliver short-term rehabilitative support and optimise independence for people in their own homes, increase independent living skills, optimise physical function and improve confidence, reduce the need for high cost care packages and reduce the risk of inappropriate admission to hospital or long-term care.

The text below attempts to describe visually and inscribed the current provision in place for frail elderly (in the main). It is important to note that this does not cover all reablement and rehabilitation offered to Rotherham people as described in Section 5; Services Out of Scope.

There are currently 3 reablement/rehabilitation pathways as follows;

Figure 1: Admission Prevention and Supported Discharge Pathways



2.1. Scope of Review

The services falling into the scope of this review are detailed below. Reference is made to some services delivered at home that may not form part of the redesign in order to provide a fuller picture.

Pathway 1 – Hospital to Home

The Integrated Rapid Response (IRR) service is commissioned to provide rapid response (within 4 hours) for active in-reach into hospital (early discharge), admissions avoidance (support in a person own home). It also provides minor injuries/illnesses cover for residents in care homes. The service is delivered by an MDT and incorporates community rehabilitation from a small team of therapists, nurses and support workers over a 24/7 period. Around 2,000 referrals are received each year from

a wide range of sources including A&E, AMU, Clinical Decision Unit (CDU), ambulance, community hospital, community nursing and therapy teams, care homes, hospice, GP, social services, Rothercare, reablement services. There are also 14 residential care homes across the borough that can be used by IRR to spot purchase short term placements. (See Section 2.2 for details)

The Council provide an in house reablement service which delivers support up to 6 weeks free of charge to people who are able and willing to take part in rehabilitation, following a recent injury or illness. The Council has also commissioned an additional 500 hours per week on block (up to a maximum of 1,000 based on demand) through IBCF funding with the independent sector. This was commissioned to meet unmet demand as a result of capacity issues within the in-house service.

Independent sector domiciliary care is commissioned as a Fast Response service for up to 72 hours to facilitate hospital discharge, until the contracted provider can take over the care package. There are also 13 contracted domiciliary care providers to provide maintenance care packages in the community. The CHC team have a block contract with 6 domiciliary providers plus Rotherham Hospice Trust and 14 spot contract providers, amounting to a total of 21 providers. 10 of those providers are the same providers that the Council contracts with.

Figure 2: Map of Community Based Services in Rotherham in 2017/18 (Pathway 1)

2.2 Activity and Demand Analysis

Figure 2 shows community based services in Rotherham, (as stated this is not represent all community service – and can be argued this mainly links to frail elderly). As displayed in the diagram there is a lack of connectivity between the services with no clear pathway identifying the most appropriate route i.e. a single assessment process for reablement, rehabilitation and recovery.

Integrated Rapid Response: The IRR service currently deals with around 2,000 referrals per annum (based on data from 2016/17 and 2017/18). The service is commissioned to provide rapid assessment and response to support early discharge and prevent hospital admission. The service is commissioned to support the following cohorts of patients;

- Exacerbation of Long Term Condition (LTC) where there is a risk of admission in conjunction with the GP/Community Matron
- Frail older patients who are ill at home and unable to care for themselves
- Patients who have a fall which has affected ability to carry out activities of daily living
- Palliative care patients (The 1st point of call will be Mainstream District Nursing Services)
- Carer breakdown in own home
- Breakdown of care package in a care home/nursing home
- Minor illness and injury

The main interventions set on the service specification to be carried out by the IRR service include;

- Early identification of need
- Rapid MDT assessment and care planning
- Nursing intervention, including IV therapy if capacity allows
- Falls risk assessment
- Intensive rehabilitation services, including, physiotherapy, occupational therapy and reablement
- Respite care e.g. due to carer breakdown (support to social worker who will arrange Respite)
- Co-ordinating alternative levels of care

Although the service is commissioned to provide support for up to 7 days, indications from stakeholder discussions are that capacity is an issue which leads to inflexibility in support for people to remain at home. The increased use of spot purchase beds provides some evidence to collaborate this. Further work is required to understand the capacity of this service to deliver outcomes for health and social care.

Referrals from the community have declined since 2015/16 from 37% to 25% in 2017/18 (predicted year end). This suggests that the current model is moving towards a hospital discharge service, rather than a hospital avoidance service. A snap shot of performance data indicates that in the first 9 months of 2017-18 (April-December 2018) 24% (342) of the people referred to the integrated rapid response service were not supported (indicating an inappropriate referral), a further 6% (91) were direct to a short stay residential care placements, leaving 70% (1,028) supported at home. In comparison The National Audit of Intermediate Care 2017 states that c.80% of people are supported to remain at home through home based provision.

The IRR service has access to 8 step up beds at Lord Hardy Court or Davies Court, however, these are frequently filled by the Acute for step down (intermediate care) which is reflected in the increasing use of spot purchase independent sector beds in the community. This is detailed below under Pathway 2 bed base provision.

Reablement Provision: The in-house reablement service is currently providing support to 70 people with 737 hours as at 05/02/2018 and the independent sector reablement service, commissioned on block for 500 hours with ability to spot purchase up to 1,000 hours, is supporting 90 people with 602 hours. (RMBC Insight, January 2018). This is a snap shot in time, the number of people and the hours of support changes daily.

In 2017/18 to date (Jan 2017), 38% of referrals are from the hospital, 36% from the Council's Single Point of Access team and 26% from other sources. At this stage the outcomes for people on service are not readily available. A full review of these services is expected in 2018.

Date: 05/02/2018

Independent Sector reablement – HSG

No of people on service	Total Hours Being Provided	No. of people waiting in hospital	No. of people waiting in IC
90	602.3	0	0

In house reablement – RMBC

No of people on service	Hours Being Requested	No. of people waiting in hospital	No. of people waiting in IC
70	737	0	0

The Rotherham Intermediate Care Centre (RICC): RICC provides rehabilitation facilities within a day setting. There are two elements within the Day Rehabilitation Service, a physical rehabilitation service aimed at optimising physical function and a community integration service which focuses on lifestyle issues, physical activity, mental well-being and access to local community services.

Physical Rehabilitation Service (Phase 1): The physical rehabilitation service provides holistic physiotherapy and occupational therapy assessment leading to a treatment/rehabilitation plan being developed. The emphasis of this phase is to increase and optimise physical function and ability to live safely at home. This is a 6 week exercise programme.

The service is only accessible on 2 days per week, either on a Monday and Wednesday or a Tuesday and Thursday. Transport to and from RICC by the Council's transport provision is provided and there is a contribution of £5 per week (regardless of number of attendances). They also receive a cooked meal whilst they are there (contribution of £4.70 per meal paid by the customer).

Community Integration Service (Phase 2): This concentrates on the person's health and well-being and assists them to consider options available, through existing community opportunities. The aim is to enhance wellbeing with purposeful activity and access to community services to prevent social isolation and promote good mental health.

Performance Data 2016/17 and 2017/18

Year	RICC Phase 1	RICC Phase 2
2016/17	147	81
2017/18 April 2017 to January 2018	152	62

The table above provided by RMBC/TRFT shows that in the last 2 years there has been between 228 and 285 (2017/18 predicted to year end) new customers accessing the service per annum.

It is estimated that this service costs around £1,845 for an average of 5 weeks (10 days) for Phase 1 and for one day per week for up to a maximum of 19 weeks input for Phase 2. See Section 7.1 the Financial Challenge

Community Therapy: the community therapy service (at home) provided by TRFT is known as domiciliary physiotherapy provision. It currently sees approximately 1,590 people per annum (based on TRFT performance data for 2017/18 predicted yearend). 84% of these are seen as urgent (1342)

and only 83% of these patients assessed as urgent are seen within 2 working days of receipt of referral. This highlights the current issues with responsiveness of service to meet Home First principles.

Domiciliary Care: It is also useful to note that there are currently 8 contracted domiciliary care providers and 5 spot purchase providers who provide maintenance packages in the community to people in their own homes. There are currently 1,053 older people in receipt of domiciliary care and 259 older in receipt of a direct payment for this purpose. (RMBC Insight, January 2018).

N.B. a financial breakdown of services is provided in Section 7.1

Figure 3: Map of Community Beds in Rotherham in 2017/18 (Pathway 2 and 3)

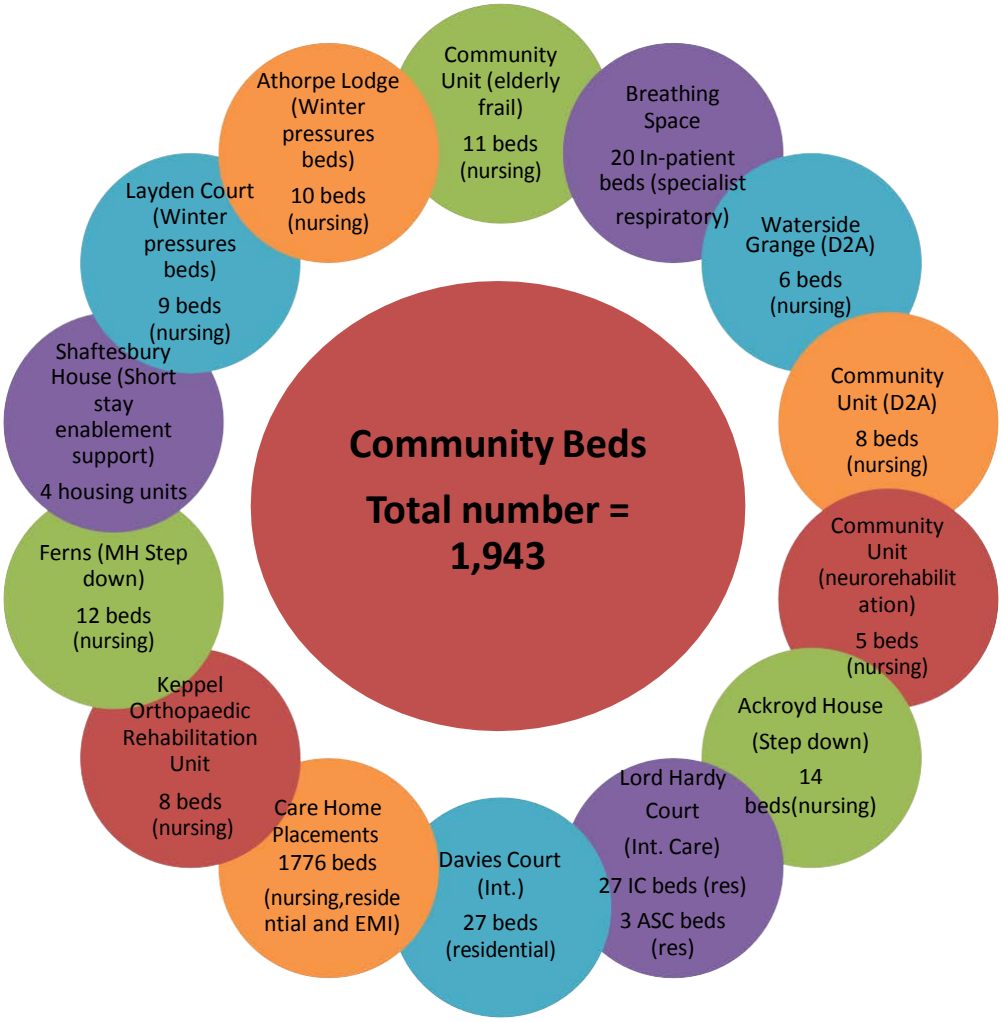


Figure 3 above shows the number of community bed provision in Rotherham in 2017/18. There are a total of 1,943 community beds, with 1,776 beds in independent sector care homes (residential and nursing care mainly long term placements).

Pathway 2: Intermediate Care

Intermediate Care/ Social Care Assessment Beds: therapy-led service delivered by the Council across several sites (currently Lord Hardy Court and Davies Court - 27 beds at each unit) for patients who are unsafe to return home until they are fully optimised. Patients who access this service should have no nursing needs as the provision does not have nurse input. The average length of stay for general and specialist (Stroke) rehabilitation is 31 days in 2017/18; this is slightly higher than the average of 27 days found in the National Intermediate Care Audit 2017 report. Hospital, GP, community nursing, therapy, IRR and social work staff refer into the service. Around 650 patients are admitted to the service each year, with around 85% returning to live in the community and 2% admitted to 24 hour residential care according to the service provider.

There are also 3 social care assessment beds located at Lord Hardy Court to facilitate hospital discharge which is accessed by the hospital social work team/transfer of care team. This allows ongoing social work assessments to be completed outside the acute setting and allows further recuperation/recovery time of patient discharged from hospital.

This service has a dedicated therapy team, mental health and a social work team, although they are not currently integrated. There is also a GP LES for that covers these beds to ensure appropriate medical cover.

Pathway 3: Discharge to Assess

Discharge to Assess Beds; there are 8 beds located within Oakwood Community Unit (TRFT community base located on the acute site) and there are 6 beds at Waterside Grange (independent sector provider), amounting to a total of 14 Discharge to Assess beds.

Both services provide 24/7 nurse-led care for adults with complex care needs who are medically stable, residential assessment and rehabilitation. It also supports patients who are preparing to undergo Continuing Health Care (CHC) assessments. Referrals for these services are received from the Care Co-ordination Centre, Transfer of Care and CHC teams. There an average of 80 admissions to Waterside Grange per annum based on 2016/17 and 2017/18 data, the average length of stay is c28 days. There is an average of 96 admissions to the Community Unit D2A beds based on the same time period; the average length of stay is c28 days. However, there is evidence from multi-agency discussions that some people remain delayed in these beds for long periods of time.

Therapy is provided to both services but from different community teams, this is also the same arrangement for social care. There is a different social work team that deals with customers who require CHC funded care to those that have screened out and only require social care support. Medical input to the community unit is via the community physician, waterside grange is part of the GP LES.

Oakwood Community Unit: alongside the 8 Discharge to Assess beds there are 11 step-up and step-down nurse-led community beds. This equates to a total of 19, it is important to note that the service is commissioned by the CCG to provide 20 beds on a block basis. Approximately 12 months ago reconfiguration of the unit to appropriately accommodate neuro rehabilitation patients led to a reduction in capacity by one bed.

The service supports patients who are medically stable but unable to return home due to, for example, ongoing nursing needs. Full medical cover is provided by TRFT. Therapy is provided into the service to support reablement and rehabilitation goals, and there is dedicated social work support, from the hospital team. Again there are complicated arrangements which determine which social work team will support.

The average length of stay at the Community Unit is 16 days in step up/step down and 33 days in discharge to assess. Approximately 9% (24) of patients are discharged into the hospital. Note this data was captured by TRFT in 2016/17, the CCG no longer receive information on these KPIs.

Breathing Space and Neuro Rehabilitation: There are 20 specialist beds at Breathing Space ran by TRFT for respiratory (COPD, Asthma). This is the largest respiratory rehabilitation programme in the country, providing individually tailored pulmonary rehabilitation for 40 people each day with overnight accommodation for 20 patients.

Breathing Space was opened in 2007 and is funded through a partnership between RCCG and the Coalfields Regeneration Trust (CRT) to deliver a specialist model of care for patients with chronic respiratory disease. The service should focus on enabling choice and self-management, promoting a better quality of life for those with respiratory disease, their families and carers, a significant reduction in the cycle of admission and re admission to hospital and the slowing or even halting of the decline into state dependency typified by this condition.

In 2007, 24% of the population of Rotherham smoked and 5,600 people were identified as having COPD on GP databases. Rotherham had higher than average incidence of smoking related diseases such as COPD. However, the prevalence of adult smoking is in decline (18% of the population in 2015) and is now similar to the England average, but differences remain between Rotherham's most and least deprived communities.

Turnover is much higher here, with an average length of stay of 5 days (based on data from 2016/17, 2017/18) with c. 1,000 patients accessing the service per annum. There are 5 Neuro Rehabilitation beds at Oakwood Community Unit; unfortunately there is no data for this provision. Both pathways are provided by TRFT.

There Physiotherapy, and Occupational Therapy support dedicated to this provision, with social care support arranged through their physiotherapy team. The community physician (specialist in respiratory conditions) provides a ward round to the in-patient unit once a week and the current intermediate care GP cover contract also provides medico-legal cover for Breathing Space.

Ackroyd (TRFT Commissioned) and Ferns (RDaSH with TRFT input): Over the past 18 months there have been up to 14 beds commissioned with the independent sector (Ackroyd), with approximately 160 patients per annum accessing the service. These beds are commissioned by TRFT to reduce length of stay in hospital for those who are medically fit/ended their consultant led care from hospital, but are awaiting non-acute health and social care support. Support is provided by community teams as required including:

- Therapies
- District Nursing
- Community Matrons
- Community Physician
- Transfer of care team

From the data supplied by TRFT for the period January 2017 to January 2018 the average length of stay is 22 days, with on average 46% of patients returning home.

Ferns RDaSH: There are also 12 beds commissioned on the hospital site provided by RDaSH (Ferns) for people with Complex Needs (Dementia). Data from RDaSH indicates that to date (2017/18) approximately 74% returned home, 9% were readmitted to TRFT and the remainder (17%) either ended up in long term residential care.

Winter Pressures: The Council and CCG have also recently commissioned 19 winter pressure beds – 10 beds at Athorpe Lodge and 9 beds at Layden Court to reduce delayed transfers of care and alleviate winter pressures. There have been 87 admissions into the service during January and February 2018, with an average length of stay of 9 days. 42 have been discharged into the community (home) (58%), 16 into a permanent care placement (22%), 8 re-admitted to hospital (11%) and 6 went into respite care (9%). The initial pilot was established for a 2 month period to the end of February 2018. It has now been agreed that the pilot for 10 beds at Athorpe Lodge will be extended until March 2018 to meet expectations within the winter plan and is financed through the Improved Better Care (IBC) funding.

Figure 4; shows the differential in terms of outcomes from the bed base provision. Note not all services have been able to provide outcomes for comparison, and services deliver to different specifications which may impact on outcomes.

Shaftsbury House: The Council funded short stay home project became operational in October 2016 which included 4 self-contained adapted properties which is overseen by the in-house reablement service. The purpose is to provide short-term housing support for people unable to return to their own home because of housing needs (no heating, cluttered, risk to health and safety), safeguarding concerns (on a case by case basis), existing home requires adaptations, requires assistive technology before returning home, unable to access a home care package within their area and to facilitate reablement when it cannot happen in their own home. The scheme has supported 14 people; average length of stay is 8 weeks for people returning to community and 6 weeks for the person going into residential care. The cost of the scheme so far is £57,509 and 89% bed occupancy rates have been achieved.

Keppel Ward (Acute beds): Keppel Orthopaedic Rehabilitation Unit (KORU) utilises 8 beds (6 bedded bay and 2 cubicles) for orthopaedic trauma patients who require rehabilitation prior to discharge. It has been developed in order to facilitate the need for an orthopaedic step down facility as currently the Trust does not have such an area to facilitate this pathway. This facility enables the movement, rehabilitation and discharge planning for a number of Orthopaedic trauma patients to relieve the bed pressures on Fitzwilliam Orthopaedic Trauma Ward. A high proportion of patients go from KORU to intermediate care. Data for this service is not available in terms of length of stay.

Figure 3 Analysis; there are 164 short-stay beds in the community (intermediate care/step up/step down/specialist respiratory and neuro/Discharge to Assess). However, 19 of these beds are temporary over the winter period which takes the total to **145**. This equates to 51.6 per 100,000 weighted population.

Of the 164 short stay placements as at January 2017, 103 provide nursing care (63%), 57 residential care (35%) and 4 (2%) are located in housing units.

Figure 5 below provides further details around the community beds; it gives a brief overview of the number and type of beds and the occupancy levels. It also indicates the average length of stay in the bed types and indicative costs per bed. To note outcomes are collected variably across services which is why this data is only captured in the narrative above.

Figure 5: Community Bed Stock Take 2017/18

Unit	Breathing Space	Community Unit (Elderly Frail)	Community Unit (Neurorehabilitation)	Community Unit (D2A)	Waterside Grange (D2A)	Ackroyd House	Athorpe Lodge	Layden Court	Intermediate Care/ Integrated Rapid Response	Care Home (residential, nursing and EMI) available beds	Keppel Orthopaedic Rehabilitation Unit	Ferns	Shaftesbury House	Totals
No. Beds	20	11	5	8	6	14	10	9	54	1779	8	12	4	**1,943**
Bed occupancy 2016-17	86%	95%	NK	75%	87%	84%	85%	%85	89%	Residential = 90% Nursing = 95% EMI = 92%	95%	New service – not available.	75%	
Average LoS 2016-17	5.76 days	16 days	73 days	33 days	28 days	21 days	9 days	9 days	31 days	NA	NK	New service – not available.	58 days	
Provider	TRFT	TRFT	TRFT	TRFT	Horizon Care	Hermes Care (TRFT sub-contract)	Athorpe Healthcare Ltd	Four Seasons	RMBC with TRFT therapy input	Various independent sector homes (x35).	TRFT	RDaSH	Varies dependent on needs	
Cost per bed per week	£1,596	£1,365	£2,457	£1,365	£651	£750	£591	£591	£917	£463 (gross cost)	£1,050	£2,564	£378	**£16,434**
Cost per annum	£1,660,000	£781,000	£1,150,000	£568,000	£203,000	£546,000	£47,280	£42,552	£2,574,936	£26.7 million excluding funded nursing care (+£1.7m) – Total £28.4 million	£437,000	£1,600,000	£78,624	**£9,688,032 (excluding care home costs)**

This does not include costs of provision such as community therapy, social work, mental health and GP cover. See 2.1 Finance

Not only can people be referred into the commissioned beds stated above there is a long standing arrangement through BCF funding for IRR service to spot purchase additional capacity from the independent sector for emergency placements to prevent a breakdown at home that is likely to result in an admission to hospital. They should be used only when there are no vacancies within the intermediate care services step up beds. Analysis shows that in 2016/17 the number of spot purchase beds significantly increased and this remains the trend in 2017-18 to date.

- 2014/15 – 63 admissions to spot purchase beds
- 2015/16 – 39 admissions to spot purchase beds
- 2016/17 - 110 admissions to spot purchase beds
- 2017/18 – 69 admissions to spot purchase beds (April 2017 to February 2018)

The majority of admissions are residential placements, but there may be a small number that are admitted to residential EMI beds. The arrangements are historic and don't cover nursing need through placement from the independent sector. They are able to access the Community Unit (step up) when there is a bed available. The access to beds is not completed in collaboration with social care, and evidence suggests that on average 43% people go home, 32% are re-admitted to hospital, 12% are admitted to respite care and 1% transferred to a more appropriate intermediate care bed for further rehabilitation (IRRR data 2017/18).

There are a total of 35 independent sector care homes (owned by 25 Organisations) contracted to support older people in Rotherham. They provide a range of care types categorised as Residential Care, Residential Care for People who are Elderly and Mentally Infirm (EMI), Nursing Care and Nursing Care for People who are Elderly and Mentally Infirm (EMI). The independent sector care home market in Rotherham supplies 1,776 beds and accommodates around 1,558 older people. Bed occupancy rates are usually around 88% at any one time. The strategic direction is a move away from long term care; however, there is a limited number of nursing care beds available in Rotherham (around 35-40 vacant beds at any one time) which is reflected in a national shortage of nurses (Partial Review of the Shortage Occupation List, Review of Nursing, March 2016).

Care home capacity by care type: Table 1 below shows the number of Rotherham MBC contracted beds for Older People as at Quarter 3 2017 (this includes 120 Local Authority beds at Davies Court and Lord Hardy Court incorporating the intermediate care beds):

Table 1: Number of Contracted Independent Sector Beds

Care Provision	***Number of beds Q3 2017***
Residential	***522***
Nursing	***204***
Dual Registered	***189***
Residential EMI	***319***
Nursing EMI	***129***
EMI Dual Registered (Nursing/Res)	***110***
Residential/Residential EMI dual	***538***
Totals	***1776***

There has been an increase (approx. 3.5%) in the number of beds in 2017 following a number of providers increasing the overall capacity in their homes during Q4 2016/17 from a total of 1,714 to 1,776.

Whilst there is sufficient capacity to meet current need for nursing placements, the decisions that organisations undertake resulting in large scale deregistration will have immediate negative impact at a local level. A contingency plan devised jointly with health is required to ensure we are in a position to meet demand. Continued reductions on current capacity would cause concern.

Care Home Occupancy Levels: Whilst a high vacancy factor is a benefit for the purchaser and customer since there is increased capacity and choice, it raises potential for concern regards market stability in that care homes are at risk of reduced profit and possible destabilisation.

Overall vacancy factor in independent sector care homes for 2017/18 has seen a decrease from 14.81% in Q1 to 12.57% in Q2. Whether this is sustained remains to be seen.

Occupancy rates are particularly high in care homes offering:

- Dual Registered Residential and Nursing care
- Dual Registered for Residential with Dementia and Nursing with Dementia care
- Dual registered Nursing and Nursing with Dementia care
- Residential with Dementia care

The trend between 2014 and to date indicated a steady decline in the numbers of people entering permanent 24 hour care, with the exception of 2015/16 which shows a clear rise in numbers.

Table 2 – Number of People Living in Care Homes

2014-15	2015-16	2016-17	2017-18
996	**1059**	**876**	**836**

Source of information RMBC SALT returns

The number of vacant independent sector care homes (as at 5.3.18) which has been extrapolated from the Care Homes Live Bed Status which care homes regularly update on a daily/weekly basis are as follows:

Table 3 – Number of Bed Vacancies

Type of Bed	Bed Vacancies
Residential	146
Residential EMI	142
Nursing	40
Nursing EMI	21
Total	349

There is a total of 349 vacant beds in the independent sector (March 2018), although there will be some elements of double counting as some beds are dual registered. The Table above shows that there is very limited capacity within the nursing care sector – as there is only 40 vacant nursing beds in the community. This is due to several homes de-registering their nursing beds over the last 3 to 4 years. There is a higher vacancy rate in the residential/EMI care rate.

In addition to this 19 winter pressures nursing step-down beds and 14 nursing beds at Ackroyd, which amounts to a total of 33 nursing beds to alleviate pressures on hospital.

There are currently around 48 clients in residential/residential EMI care at Lord Hardy Court and Davies Court. Due to the increased vacancy rate in this type of beds, these clients could potentially be accommodated within the independent sector to meet needs.

Number of Permanent Admissions to Residential Care

The Council's Performance and Intelligence Team have carried out a qualitative analysis of 110 (around 54%) of all new permanent admissions to residential care. The analysis has shown that two thirds of admissions result from a short-term placement. Further reasons for admission include change of funding (previously CHC or self-funding placements) which amounts to 8%, carer breakdown (9%) and 12% where needs cannot be met with package in their own home.

The data also identified that of those admitted to residential care - 75 (68%) were already in receipt of RMBC funded services (average weekly cost prior to admission - £245)

Table 4 – Reasons for Initial Short Stay Placement in Residential Care

The table provides details around the reasons for admission to an initial short stay placement. The top 2 main reasons (which account for over 50% of the short stays identified) were planned short stays either to facilitate a hospital discharge or as a result of increased needs of the service user.

Reason for Admission to Short Stay Placements	Count of Reason for Admission
Hospital Discharge - 4 Week Short Stay	25
Planned Short Stay/Respite	22
Carer Breakdown	11
Emergency respite	4
Best interest decision - Admission to Residential Care	3
Hospital Discharge - Assessment outcome - residential admission	2
Assessment Outcome - Admission to Residential Care	1
Short stay - Safeguarding concerns	1
Respite agreed due to lack of provision in community	1
Main Carer passed away	1
Customer decision (self funder)	1
Placed by Fast Response	1
Grand Total	73

3. Current out of Scope

It is recognised that there are a number of services that have not been discussed within this report including;

- **End of Life Care**: Hospice provision (bed base and community services i.e. hospice at home including rapid response)
- **Mental Health** (bed base and community services including mental health crisis provision)

It is recognised that once specific elements of the pathway are reviewed in more detail it may be necessary to widen the scope of reviews to incorporate this provision. Service reconfiguration may include integration of elements of this provision, however the purpose of this report it to highlight the current complexities of our model and determine a future delivery model that can best meet the

needs of our population. It is assumed that this future model will deliver appropriately to all those who need reablement/rehabilitation and recovery including those with mental health and learning disabilities where appropriate.

4. Evidence Base: National and Local

The Kings Fund "Making our Health and Care Systems Fit for an Ageing Population" (2014) suggests that older people remaining in their own home would support better outcomes. However, older people require multiple health and social care services. Therefore, it is important that we have quality, responsive services with the capacity to meet those needs for people living in the community.

This includes:

- Rapid support close to home in times of crisis for them to manage their long-term health condition
- Good discharge planning and post-discharge support
- Good rehabilitation and reablement after acute illness or injury
- Timely access to equipment and adaptation provision

There is evidence that delays in addressing rehabilitation goals and community care needs can increase hospital length of stay. A quarter of hospital readmissions are due to deficiencies in discharge planning. It is estimated in Rotherham that there are approximately 15-40 patients at any one time deemed medically fit for discharge (Evidence via TRFT Sepia). Some of these patients are delayed due to blockages in community care pathways.

There is also clear evidence that high quality intermediate care services can prevent hospital admission. The Intermediate Care Audit 2017 states that "evidence from the audit demonstrates that intermediate care works with more than 91% of service users either maintaining or improving their level of independence".

Figure 6: Outcomes from National Audit of Intermediate Care Services (2017)

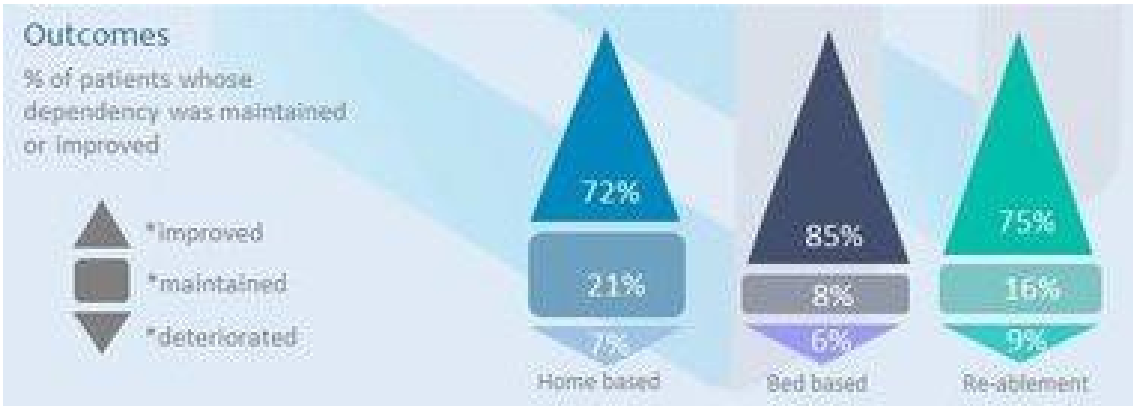
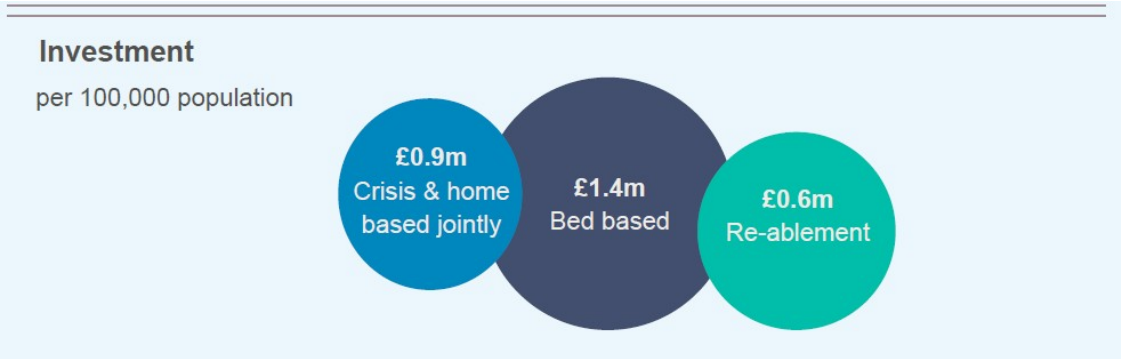


Figure 6 illustrates the % of patients whose dependency was maintained or improved according to the National Audit of Intermediate Care 2017. This shows that 93% had improved or maintained in bed based services, 91% from reablement and 93% form home based services.

In Rotherham, there has been an increase of around 8% in the number of emergency hospital admissions for people over 65 years. There is a continued upward trend for the first two quarters of 2017/18 (Secondary Uses Service SUS). This is reflected in the number and the complexity of those accessing intermediate care, particularly bed base provision.

Figure 7 & 8: NAIC 2017 Key Findings



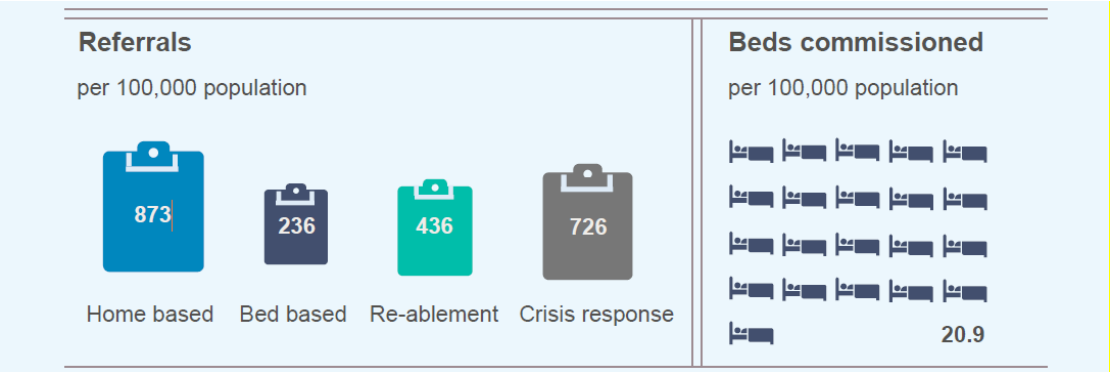


Figure 8:

Figure 7 and 8 above provides a summary of the findings from the NICA 2017. As expected a bed base model is significantly higher cost and serves a smaller population of people. Although a direct comparison is difficult to make, particularly for bed base provision (due to different purposes/specialisms) the following can be observed;

- Rotherham spends a significant amount on community bed base provision – predicted over £10M for services in scope.
- Our bed base provision including specialist provision is 51.6 per 100,000 weighted population compared to 20.9 (shown in figure 7). N.B caution needs to be taken on comparison between services nationally to locally.
- Rotherham's crisis response see's on average 714 per 100,000 population (see figure 6), the intermediate care bed base (Lord Hardy and Davies Court) see 232 per 100,000 population, this does not include the other beds within the system that are available for reablement, recovery and rehabilitation which would take this figure to more like 428 (excluding Breathing Space). Unfortunately there is insufficient annual data available for reablement and home based services (the latter is difficult to determine as services are not clearly defined in the current pathway).

4.1 Local Context

A focus on community services has helped to support the other parts of the system (acute) in dealing with the increasing demand presenting at the front door. The BCF Plan 2017-19 and the Integrated Health and Social Care Place Plan will be instrumental in supporting further initiatives to reduce attendances.

The strategic direction of reablement provision is predicated on a robust and effective front door. An interesting comparison can be drawn between development of the Care Co-ordination Centre (CCC) service and the RMBC Single Point of Access (SPA) for adult social care. Whilst the CCC have focussed on up-scaling to a 24/7 service, RMBC have focussed on up-skilling front end staff to enable more people to be divert away from services.

The Single Point of Access is a key service in delivering the 'wellbeing principle' central to the Care Act, utilising 'prevent, reduce, and delay' as fundamental to driving customer focused outcomes. The front door plays a pivotal role in ensuring, what may be the customer's first experience of Adult Social Care, is a positive experience, response and intervention is timely and the right support, information and advice is received. Maximising the use of preventative services including signposting to Connect to Support, Voluntary Services, "I Age Well", maximising income and Community Assets (prevent, reduce, and delay).

The SPA as a "front door" service have a multi-disciplinary team which include, Wellbeing Advisors, Social Workers, Occupational Therapists, Occupational Therapy (OT) Assessment Officers, Independent Living Officers, Support Planners, Information Advice and Guidance Officers and a Voluntary Sector Advisor. Management support is provided across the whole service to ensure there is a prompt response to enquiries which may require management input. Towards the end of November 2017 / December 2017 the team were supporting 74% of Customers at the first point of contact. Contacts to the Locality from SPA have continued to reduce with an average of 29/30 per week actioned to each Locality for intervention. 12 months ago this was closer to 350 for both localities.

Early indications of the OT involvement are that waiting times have been significantly reduced for both new customers and those waiting for a community OT. All moving and handling assessments are now being carried out, to ensure that based on a recovery model appropriate levels of support including staffing are provided.

This approach allows the concentration of a wider range of expertise in a single location to support the holistic needs of individuals, speeding up outcomes and reducing the need for onward referrals, thereby improving the service user/carer experience and reducing referrals to statutory services. Reablement based on the 'Home First' model links to the front door and will form the next steps in prevention of reliance on long term provision via short term interventions to reduce and delay the need for ongoing care and support.

Although significant work has taken place to improve the front door of both health (Care Co-Ordination Centre (CCC) and social care (Single Point of Access) there is still work to be done to integrate these function and deliver a true single point of access. This work will coincide with the delivery of a new model of reablement through the delivery of our Place Plan priorities.

Changes to the traditional models of care have already started to gain traction. For example, in 2015/16 401 older people were permanently admitted to residential and nursing care which, reduced to 321 people in 2016/17 and 210 people during Quarters 1 to 3 in 2017/18. The number of people receiving day care has significantly reduced over the last three years from 537 adults in 2015/16, to 317 in 2016/17 and 279 people in 2017/18.

5. Case for Change: Current Model

The current system is complicated and makes it difficult for those referring into service to access the right care and support. There is insufficient flexibility within the current model to allow for patients to change pathways once in a service e.g. from Discharge to Assess to Intermediate Care. The categorisation of beds (social care, D2A, IRR, winter pressure beds) causes confusion and difficulty in

managing patient flow through the system. Patient experience is negatively affected by the physical transfer required to meet their needs i.e. transfer from hospital to discharge to assess and then intermediate care. There is risk of increased dependency on long term care within the current model and a corresponding increase in budgets (i.e. RMBC long term placements). Outcomes and quality, as demonstrated in the narrative above is mixed and in some cases is not available.

Although patient preferences are considered at times within the NHS discharge process, the complexity of the current system, the culture of an organisation and the pressure of demand mean decisions about where people go and which service they receive are more likely to be based on;

- Awareness of services
- Ease of access (to bed based)
- Past experience of those making the referral
- Capacity in the system
- Relationships with the services/understanding of the services eligibility criteria

Confusion and Duplication
A review of the service specifications and discussions with lead officers across the pathway reveal that the bed based provisions main difference is the skills that are provided by a particular team that are not available in another. For example;

- Community Unit, Waterside Grange, Athorpe Lodge and Layden Court have 24 hour nursing staff. No nurse led provision at Lord Hardy and Davies Court (community nursing support)
- Difficulties with environment and skill mix for advanced dementia at Lord Hardy and Davies Court.
- Specialism to support stroke survivors at Lord Hardy Court only
- Therapists don't work flexibly over social care assessment beds if required due to capacity
- Several social work teams input into the same bed base dependent on whether CHC or not
- Medical cover is varied, some have GP cover others community physician
- Access to Bariatric provision (equipment and bed base) is limited across provision and consideration will be needed on the demand moving forward

This insufficient flexibility and cohesive approach to multi-disciplinary working (teams with therapist, social care, nursing, GP input, community services, pharmacists) can lead to duplication and is an ineffective use of resource. There is an increased risk in this model of delays in the assessment and transfer of patients. This is a similar case for home based rapid response and reablement services that currently don't have strong connections with a multi-disciplinary approach. For example, IRR do not liaise appropriate with social care before placing people in short term residential beds and they are not integrated with reablement.

Inappropriate Placements
A small sample of the IMC referrals between 22.11.17 and 06.12.17 showed that c. 64% (11 out of 17) patients who went to IMC would have been suitable as deemed by the therapists for a home first service. This is backed up by the Newton Europe research paper 'Why not Home? Why not Today?' December 2017 which found that in the study of 3 systems across the country 60% of assessments could have taken place out of hospital. The report states that 'bed based pathways should not be the default position. Investment in intermediate care services in both health and social care, such as reablement can provide better outcomes for patients, whilst also reducing long term care needs'. In all the areas studied there were opportunities to discharge more patients to their own homes with reablement services, which reflects the position found in Rotherham.

Focus on Beds

Rotherham is an outlier when benchmarked against other areas of similar demographics for the number of community bed based provision. The National Intermediate Care Audit states that on average there are currently 20.9 beds to 100,000 weighted population. This has reduced since the last audit in 2015 when it was c. 27. Rotherham's bed base provision taking into account the specialist provision (Breathing Space/Neuro Rehabilitation/Social Care Only) is 145 which equate to c. 51.6 beds per 100,000 weighted population. Caution should be taken with this data as the NICA 2017 also states that this reducing trend rides against the increasing demand from an aging population with increasing complex and multiple long term conditions. The audit may also not take into consideration the entirety of any systems bed base provision.

The Newton Europe report also states that 'in all three areas, analysis of the data and subsequent scrutiny by frontline staff revealed that if the reablement service was supporting the appropriate volume of people and working effectively, it would lower the demand for domiciliary care to below current levels of capacity… it is important to understand how many people will require what service each week and to ensure that there is the right supply to meet the need, with a focus on the outcomes delivered in a timely fashion'.

Analysis of the current usage of the bed base outlined in this report indicates that there are approximately 1,200 people accessing services in a 12 month period (figure taken from 2016-17 usage but excludes Breathing Space), the majority of these will be step down from the hospital. This equates to c.100 per month and 23 per week. If the specialist provision (Neuro, Breathing Space, Keppel ward, Ferns, Shaftsbury) is removed from the total community bed base this reduces the total number of beds to 96, and the total number of people accessing them to approximately 1,000.

N.B Breathing Space has not been included in this figure as the pathway is slightly different and the length of stay is much shorter at an average of 5 days, meaning that approximately 960 people have access the service in a 12 month period of 2016-17.

Table 5 – Approximate Numbers Accessing Service in 2016/17

Community Bed	**Approximate Number Accessing Service (12 month period 2016-17)**
Lord Hardy and Davies Court	660
Waterside Grange	70
Community Unit (D2A and Frailty)	280
Ferns	70
Ackroyd	160
Total	**1,230**
Breathing Space	960

Taking into account the evidence locally and nationally in terms of the number of people that could have gone home rather than placed in a community beds, it is reasonable to predict that at least 40% of this bed base provision should not be required, if an effective discharge to home/home first principle was applied. The supposition is that the bed base could legitimately be reduced from 96 to 57.

It could be further argued that the number of beds for specialist provision should be reducing in line with this same principle. For example, over the winter period and due to unforeseen circumstances, 10 of the 20 beds at Breathing Space have been closed. It appears that the impact of this closure has been limited, however, further analysis would be required to understand future impact if provision was reduced.

Medical Cover
The extent to which the bed base provision is covered medically varies. General Practitioner (GP) cover is provided to some of the community bed base (i.e. Lord Hardy/Davies Court/Waterside Grange) through a formal contract with Rotherham GP practices. An alternative arrangement through the community physician is in place for other elements of the bed base provision, with limited formal cover on spot purchase beds. Any model moving forward requires a robust process for support from primary care and the community, to ensure that the health needs of the people entering services can be supported. This is also true of reablement and home based provision, there needs to be more collaborative working within localities to maintain independence and promote recovery.

Mental Health
The intermediate care facility (Lord Hardy/Davies Court) currently has input from an Occupational Therapist and Community Psychiatric Nurse from RDaSH to support people with dementia who require rehabilitation to enable them to access intermediate care services. However, this resource is limited to the residential bed base and access to provision for people with mental health/complex needs can be challenging at times. This is also the case for people with a learning disability.

Pharmacist Support
Medicines and medicine-taking are important, particularly in the context of preventing, reducing and delaying the need for long term care. Adverse drug reactions are a significant factor in avoidable hospital admissions particularly in older people. Evidence from serious incidents reported at the both intermediate care units in a 12 month period to January 2018 shows that 32 (which equates to c. 6% of those admitted – 556 admitted) were in relation to medication issues (lack of medication, wring medication, inappropriate instructions). Community pharmacists could have a role to play in providing medicines management services particularly on an urgent basis, which may improve the currently substandard communication of information relating to patients' medications between hospital, reablement/rehabilitation (home and bed based), and primary care settings.

End of Life Care
It is recognised that rehabilitation/reablement may be appropriate for end of life care if there are specific goals that could be met in a limited period of time. For example, to establish a suitable home environment or to develop specific skills that mean a person can be cared for at home. Further development of the skills to deliver this support and the appropriate links with palliative care services are required in the future model to ensure clear pathways.

5.1 The Financial Challenge

The overall cost of reablement/rehabilitation in the community is difficult to establish, budgets for elements of the provision are contained within larger service areas, some of the budgets are pooled through the BCF Section 75 arrangements and others sit within organisations.

It is predicted that the approximate spend is as follows;

Pathway 1 Community Services

Table 6

Services	Provider	Annual Gross Cost (approximate)
Rapid Response	TRFT	£621,000
Rotherham Intermediate Care Centre	RMBC/TRFT	£382,834 plus £150,000 to £175,000 per annum = £557,834 (maximum)
Fast Response (Mears 72 hour Dom Care)	Mears	£90,000
Fast Response (Night Visiting)	Mears	£170,000
Domiciliary Care (Social Care)	Various Independent Sector Providers	£8,124,000 £8,614,000 (forecast out-turn)
Domiciliary Care (Continuing Health Care)	Various Independent Sector Providers	£1,076,915 (CCG contracted providers)
Reablement (RMBC)	RMBC	£2,258,248 £2,640,000 (forecast out-turn)
Reablement (Independent Sector) (9 months pilot)	HSG	£588.000
Spot Purchase Beds (Rapid Response use in independent sector residential and nursing)	Various Independent Sector	£100,000
TOTAL	**Based on gross costs, maximum costs and forecast out-turn**	**£14,457,749**

Pathway 2&3 Community bed base

Table 7

Services	Provider	Annual Cost (approximate)
Services	**Provider**	**Annual Cost (approximate)**
Intermediate Care – bed based	RMBC	£2,667,600
Breathing Space	TRFT	£1,660,000
Community Unit (Elderly/Frail/D2A/Neurorehab)	TRFT	£2,499,000
Waterside Grange	Horizon Care	£203,000
Ackroyd House	Hermes Care	£546,000
Athorpe Lodge (winter pressure beds – 8 week period only)	Athorpe Healthcare Ltd.	£47,280 + £35,460 (6 week extension)
Layden Court (winter pressure beds – 8 week period only)	Four Seasons	£42,552
Keppel Orthopaedic Unit	TRFT	£437,000
Ferns	RDaSH	£1,600,000
Shaftesbury House	RMBC	£57,509
TOTAL		**£9,795,401**

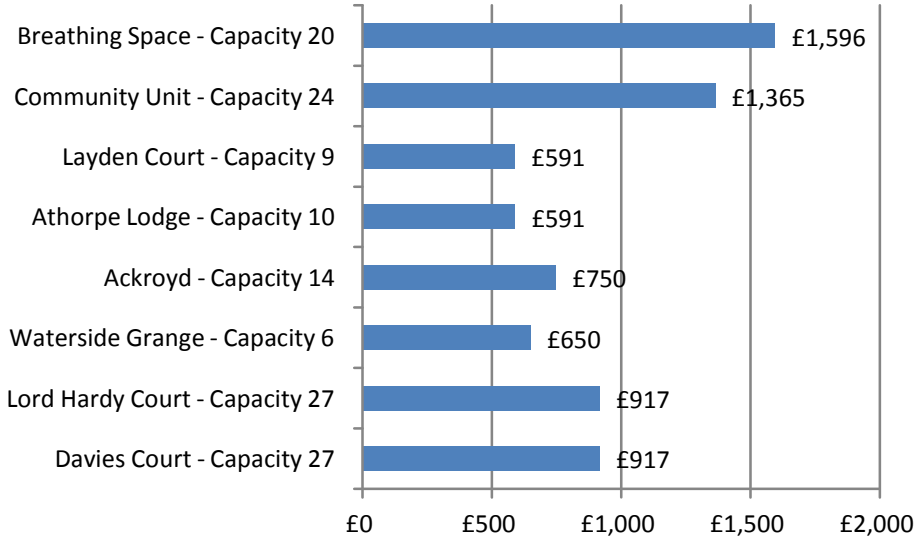
Note: The figures are estimated, there are costs such as social work, GP and therapy support that are not included in the bed base provision in particular.

Bed Base Comparison of Costings

This section explores the significant variance in current cost models for the different community bed base provision; highlighting the need to seek value for money in any future delivery model. Figures 9 and 10 show the relative cost of each of our bed base provision. Figure 5 provides a breakdown of the weekly unit cost per resident.

The weekly unit cost does not include the cost of therapy input. Therapy input into all units is delivered by Rotherham FT and provided through separate budgets. It also does not include social work input or GP cover, which varies across the bed base. Note this is not all the bed base provision costs and excludes as discussed Hospice provision, but gives an indication of variance.

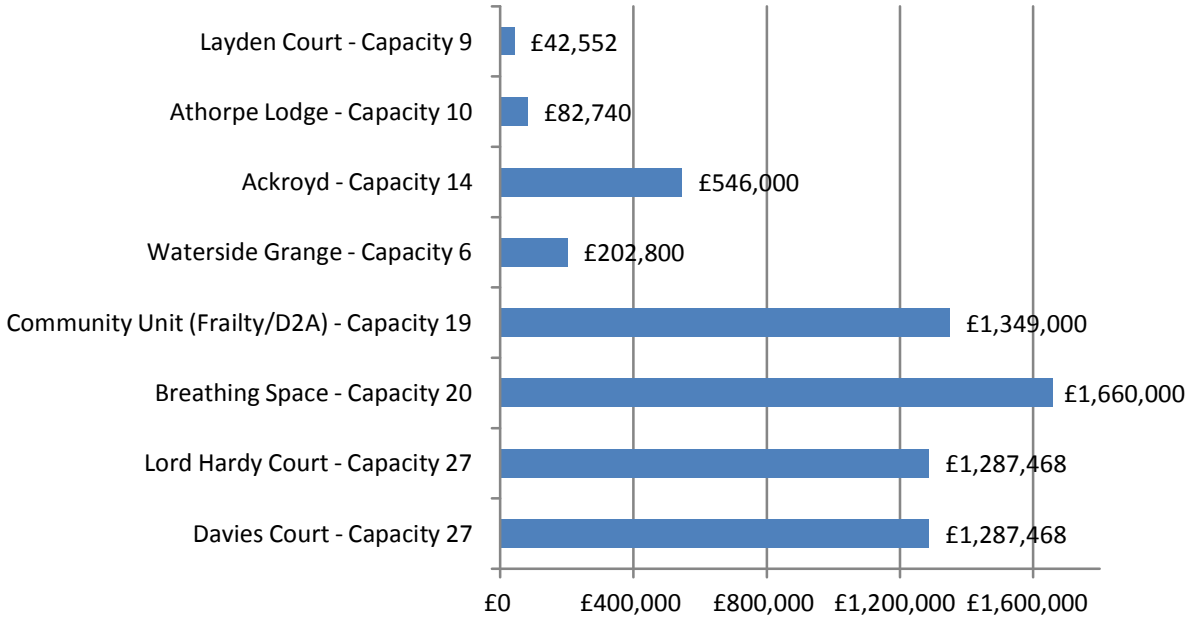
Figure 9: Weekly Cost of Intermediate Care Units per Resident



The cost of winter pressure nursing care beds at Layden Court and Athorpe is £591 per bed over the winter period, Waterside Grange is £650 per week and Ackroyd is £750 per week. This is in sharp contrast to the cost of Lord Hardy Court and Davies Court which costs approximately £917 per week for residential care. However, the most expensive provision is nursing beds at Breathing Space (£1,596).

Figure 10 provides a breakdown of the full year cost for each unit on current capacity.

Figure 10: Full Year Cost of Each Unit



The full year cost of Community Unit (D2A/Frailty Unit) is £1,349,000, Breathing Space £1,660,000 , Lord Hardy Court is £1,287,468, Davies Court £1,287,468, £202,800 for Waterside Grange, £546,000 for Ackroyd, £82,740 for winter pressure beds at Athorpe Lodge (14 week period) and £42,552 for winter pressure beds at Layden Court (8 week period).

Note this financial analysis does not include the costs of social work input, therapists, and the GP contract with some bed base provision or the mental health CPN for the bed base provision. It also does not show the current costs of our home based support services. However, it is evident that a significant proportion of both health and social care budgets are currently spent in this area, cost effective and outcome focused services are essential for the whole system.

6. Horizon Scanning

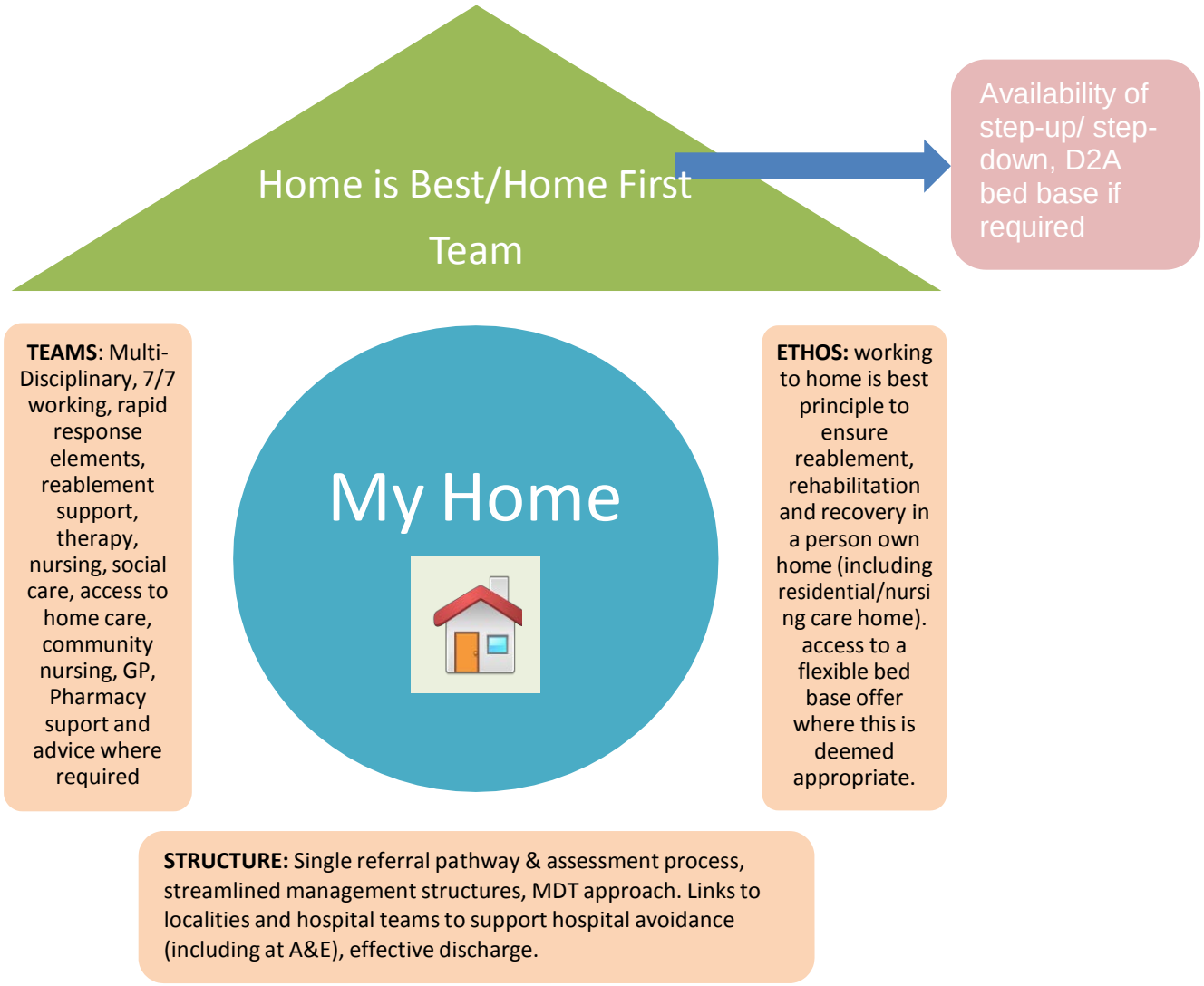
There is no one model of intermediate care, however, there are influential documents outlined throughout this report like the National Intermediate Care Audit 2017 and the Nice Guidance, Intermediate Care Including Reablement published in September 2017 that provide a sound basis to develop a picture of what 'good' looks like. Rotherham has a wealth of services that focus on reablement, rehabilitation and recovery, they are just not streamlined, the pathways do not link up and there is duplication and over supply.

Reablement must be everyone's business, with elements of focused provision for those that need additional support. Reablement and Intermediate Care models have been the focus of many health and social care systems across the country and learning from best practice is essential. For example, in 2016/17, Wakefield had an intermediate care bed base of 78 beds across three sites. Following a review of current provision, it became evident that the beds were being used to support patient flow, but that a large percentage of patients would have been better supported at home. The current service was also deemed not fit for purpose and did not promote value for money. Wakefield have now moved to a model of 55 intermediate care beds which was piloted in 2016/17, with plans to further reduce to 24 which they feel would be sufficient to meet the needs of Wakefield residents (333,759). This model of a reduced bed base is reliant on reablement as the default position, linking health and social care services including community support, therapist, nurses and social care to provide holistic support in a person centred way at home.

Commissioning have investigated models of good practice such as Glasgow and Derbyshire where they have focused on delivering home first principles through multi-disciplinary health and social care teams. Outcomes have included a reduction in ongoing home care hours provided where customers have fully completed reablement of c. 51.5% against a target of 30% in Glasgow (data based on 181 service users who fully completed reablement 2017/18). Of the 799 customers fully or partially completing a reablement programme of support this year to date, 45% required no further service. Derbyshire have invested through the IBCF funding to address delayed transfers of care, supporting system flow and hospital discharge. Occupational therapy and community care practitioners have been appointed to reduce unnecessary hospital admissions and increase post-discharge support, creating the potential for more people to be supported to live at home.

7. The Vision:

Our Rotherham Place Plan vision is for an integrated home first team (co-location and elements of virtual integration), with access to step up/step down community bed base (smaller scale/flexible model) only when needs cannot be met at home.



Intermediate care does not define a single service; it is a term that incorporates elements of reablement, rehabilitation and recovery. Our expectation in Rotherham is that reablement and recovery is everyone's business. Our services are being redesigned to deliver this principle across health and social care, such as the current remodelling of our home care provision to deliver the principles of the Buurtzorg model[2] (joint health and social care in future).

The redesign of our community reablement and rehabilitation will be focused on a 'Home First' 'Home is Best' community team providing all elements of a multi-disciplinary team (some of which will cover 24/7) through a single referral and assessment process and single or streamlined management structures.

[2] https://www.buurtzorg.com/

The Nice Guidelines, Intermediate Care including Reablement (September 2017) provide a clear vision of the model which corresponds with our local aspirations. The guidelines state that local areas should offer all 4 types of intermediate care:

- Crisis response – to prevent an avoidable admission to hospital, offering an assessment and possibly short-term care (typically up to 48 hours but up to c. 7 days) if there is an urgent increase in your health or social care needs that can be safely managed at home.
- Home-based intermediate care – services are provided at home, by a team with different specialities (therapists, nurses, equipment, and social care), that support rehabilitation and recovery and can assess for any ongoing needs including CHC.
- Bed-based intermediate care – services are delivered in a community hospital or care home, for people who do not need 24 hour consultant led medical care but need a short period of therapy and rehabilitation.
- Reablement – services are provided at home, mainly by social care professionals and specially trained social care staff. Enabling the re-learning of skills and promoting recovery to build confidence to live at home.

The Department of Health, 2005 defines Intermediate Care as; 'a range of integrated services to prevent unnecessary hospital admission, promote faster recovery from illness, support timely discharge and maximise independent living'.

Our future model will incorporate the following;

Objective	Detail
Clear eligibility criteria that is flexible to meet changing needs	Be able to meet the needs of a wide cohort (Frail elderly, Learning disability, mental health, physical health) Be targeted at people who would otherwise face: inappropriate admission to acute in-patient care; long-term residential/nursing home care; unnecessarily prolonged hospital stays Incorporate; step up, step down, discharge to assess – recovery, rehabilitation and reablement
Provided on the basis of a comprehensive person-centred assessment of need	Assessment will be completed by MDT with appropriate clinical input resulting in a structured individual care plan that, where appropriate, involves active therapy, treatment or opportunity for recovery.
Planned outcome of maximizing independence	typically enabling people to remain or resume living at home
Be short term and responsive	usually no longer than six weeks (however locally it is felt that a longer period up to 12 weeks may be required for some people with complex needs)
Cross-professional working / Multi-disciplinary working	A single point of access for all types of local intermediate care services, including a referral process that is widely understood across the whole system and a single assessment process A single assessment framework, increasingly integrated professional records and shared protocols. Ensure flexibility in how staff are deployed

Objective	Detail
Capacity will be planned across the whole system	services will work more collaboratively together to better meet needs
Shared skills and knowledge base	Joint training and induction programme for health and social care staff
Weekly multidisciplinary team meetings	attended by health and social care staff
Close collaboration with co-dependent service areas	locality teams, primary care, integrated point of contact (SPA/CCC), Home Care provision, residential and nursing care homes, mental health, learning disability services, palliative care

Whilst Rotherham's offer currently incorporates elements of what is described above, as referenced throughout the report this is fragmented and inefficient with an emphasis on bed based provision and is not always targeted at the whole population i.e. mental health, learning disabilities. There are limited opportunities for people with learning disabilities, mental health and /or physical disabilities to successfully recover through reablement/rehabilitation and recovery. Most of the current pathways excluded some or all of these customer groups.

8. Transition; Options and Key Milestones

The benefits of a fully mature, integrated health and social care system that has the right capacity in the right place, where reablement is everyone's business will ensure that people's health outcomes improve, as more people will be able to live at home for longer.

Prevention at the front door should be the first port of call, the Rotherham Place Plan identifies this as a key priority and work streams related to the development of a more co-ordinated and integrated point of contact most coincide with this work stream. However, a pathway focused on 'Home First' will mean more people are supported to recover and remain independent. This may be as prevention of a need for long term care/hospital admission/residential care placement or to support timely discharge from an acute setting. Evidence suggests that a reduced length of stay in a hospital bed due to longer-term assessments taking place in a more appropriate environment will reduce deconditioning and improve outcomes significantly, since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over the age of 80 years.

The "home first" model encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people by joint approaches through joint commissioning or joint funding arrangements. Rotherham already has these arrangements in place which leaves us in a strong position to redesign services to provide better outcomes so people can live healthy lives with an increased sense of wellbeing.
No one should be excluded from our holistic intermediate care offer on the basis of age or ethnic group, our services need to be flexible enough to adapt to a variety of needs. In future services should be available to all adults over the age of 18 who might need it (although it is likely that the majority will be over 55) and be flexible to include offers such as models of Extra Care.

The benefits of the 'home first' model include:

- Prevention of ongoing care and support needs.
- Recovery that supports self-management and independence.
- Prevention of admission to hospital.
- Timely discharge of patients admitted primarily on non-elective medical and surgical pathways.

- Improving system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in an inappropriate environment.
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.
- Sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support.

In implementing the principles of Home First, the following options need to be considered;

Option 1:

A redesign of the community offer at home to deliver these principles; integration of functions such as rapid response and reablement provision to ensure that therapy and nursing support is closely linked to reablement.

This will involve the following key milestones -

Key Milestone	Detail	Timeline
Decommission Rotherham Intermediate Care Centre (RICC)	Review of provision with subsequent transfer of resource into reablement (at home) including physiotherapist and occupational therapist.	
Decommission the use of spot purchase beds in the independent residential care home sector by the IRR provision	Establish current usage and cost, outcomes for people and determine whether resource should be redirected to provision of reablement and rehabilitation	
Review of reablement pilot in the independent sector and in-house reablement	Determine a model that is fit for purpose, delivering a recovery focus. Ensure therapy is aligned/integrated to this provision.	
Review therapy services	Ensure resource is directed at the front end including reablement and rehabilitation. Identify resources that are required within the 'Home First' team.	
Redesign the rapid response element and integrate with reablement	maximise the offer	
Ensure that across the system there are appropriate professionals supporting the pathways	therapists, social workers, Mental Health, Primary Care; GPs, Community Services; District Nurses, Pharmacists, Palliative Care, Geriatricians (for assessment of need for services and Community Physicians supporting services in a joined up way.	
Increase where appropriate the length of reablement offered	support better recovery/positive outcomes	
workforce and culture	training and communication to teams regarding home first principles, wards and discharge teams ensure that they work to early discharge planning that promotes the ethos of home	

The outcome of this will be an increase rehabilitation support and assessments (where required) within the community, specifically within people's own homes, as opposed to the unfamiliar hospital or bed base environment to ensure implementation of the most appropriate care/rehabilitation plan.

Option 2:

Alongside the key milestones highlighted in option 1 to reconfigure the community services (streamline process and integrate practice), this options entails a subsequent reduction in the number of community beds (intermediate care/step up and down and discharge to assess) excluding the specialist provision (such as Breathing Space).

This will involve the additional key milestones;

- Reduce the community bed base offer significantly for example from the current 96 by 40% to 57 beds, up to a maximum of 60% (38). Based on national and local evidence of the population entering bed base services that had the potential to be supported at home.

Significant work has been undertaken to understand the current state and demand for provision, however a business case setting out in detail the actions required to reduce the bed base safely is required. Timing of key milestones is paramount to the success of the reduction in the bed base, for example, ensuring that key elements of the home first model are in place prior to full implementation of a reduced bed offer, therefore this work will be completed in conjunction with that described in option 1.

Option 3:

Option 3 would deliver key actions in both option 1 and 2 but also seek to reduce the number of specialist provision available within Rotherham. For examples services such as Breathing Space and Neurorehabilitation.

Resource: To deliver a redesign of current provision will require a dedicated project lead and sufficient resources identified across health and social care partners. Consultation will be required with key partners, professional delivering the services and in where appropriate, the public. Individual business cases and/or reports will be required through appropriate governance arrangements in order to deliver on the key milestones above and thus the overarching vision. Timelines for key actions will also be required that coincide with the other Acute and Community Place Plan Priorities.

9. Risks

Risks: there are a number of risks associated with this option that will need to be appraised as part of the project management process, including but not exclusively;

Risk	Detail
Culture and staff skills	as documented in this report there is a large piece of organisational change required across the sector to deliver the model of home is best
Discharge Planning	early discharge planning and appropriate MDT working is required within the acute to ensure that time is given to appropriately assess and plan for a discharge home.
Front Door	the front door needs to be effective to ensure the right people, get the right support at the right time.
Primary Care	capacity to support the community teams is essential to deliver care and support to people in their own home.
Resources (financial)	there remains a significant financial challenge across sectors, although this model of working should reduce the need for long term care and support and reduce reliance on acute services.
Resources (Staffing)	there are national shortage in health and social care workforce such as the ability to employ quality nursing staff and maintain a consistent care workforce (i.e. home care)
Contracting community bed base may impact on patient flow	The Better Care Fund identifies Delayed Transfer of Care as a National Conditions with a target of 3.5% or less in 2017-18. Ineffective patient flow in the hospital has a negative impact on the outcomes for the patient and can impact on the ability to deliver key performance indicators such as the 4 hour target set by NHSE at 95%.

10. Governance

The Accountable Care Partnership (now known as Integrated Care Partnership) is will need to agree the most appropriate option to pursue. Once agreed appropriate governance arrangements for the decision making process of the redesign of services is required to implement the changes necessary to develop a model focused on a Home First team.

11. Interdependencies

Success is predicated on the following interdependencies;

- Successful engagement with Primary Care
- Appropriate mapping of pathways and detailed service specifications
- Cultural shift and workforce development – principles of home first
- Early discharge planning
- Appropriate medical assessment for placement in the correct pathway
- Collaborative working arrangements with other community services (mental health/palliative care)
- Domiciliary Care (Home Care) re-commissioning; joint provision between social care and health for a recovery based model which promotes independence.
- Review of provision (independent sector pilot)
- IT and Information Governance (Shared access to health and social care records)

Appendix 2 - Service Changes

1. Integrated Discharge Team

An integrated health and social care discharge team has been established with a joint Health and Social care lead. The team is made up of nurses, social care staff and administrative support with therapies and community nursing working into the team. There is seven-day social care cover with access to nursing and therapy.

Wards are responsible for simple discharges i.e. those with no additional requirements or a restart of an existing care package. New ward co-ordinator roles have been put in place to co-ordinate simple discharges and liaise with the Integrated Discharge Team (IDT). IDT are responsible for complex discharges requiring an MDT approach. Multiple referral routes have been standardised into a single electronic referral process which is screened by IDT and allocated to the most appropriate professional to co-ordinate according to individual needs. Home is now the default pathway, with the team gatekeeping community beds (including intermediate care), winter pressure beds and discharges to Ackroyd. Joint reporting processes have been established to ensure a single version of an individual's situation and engagement and training sessions have been held to raise awareness. Continuing healthcare assessments in the acute setting have significantly reduced with a discharge to assess policy being followed.

The team also work with the Community Hospital Admission Avoidance team in Urgent and Emergency Care Centre and Acute Medical Unit to provide an MDT response to enable people with complex needs to return home who would otherwise be at risk of admission.

Benefits realised to date include:

i. DTOCs predominantly sustained within the national requirement of less than or equal to 3.5% for the hospital setting

Table 1: **Project Goal:** To achieve a sustainable monthly DTOC performance of <3.5%

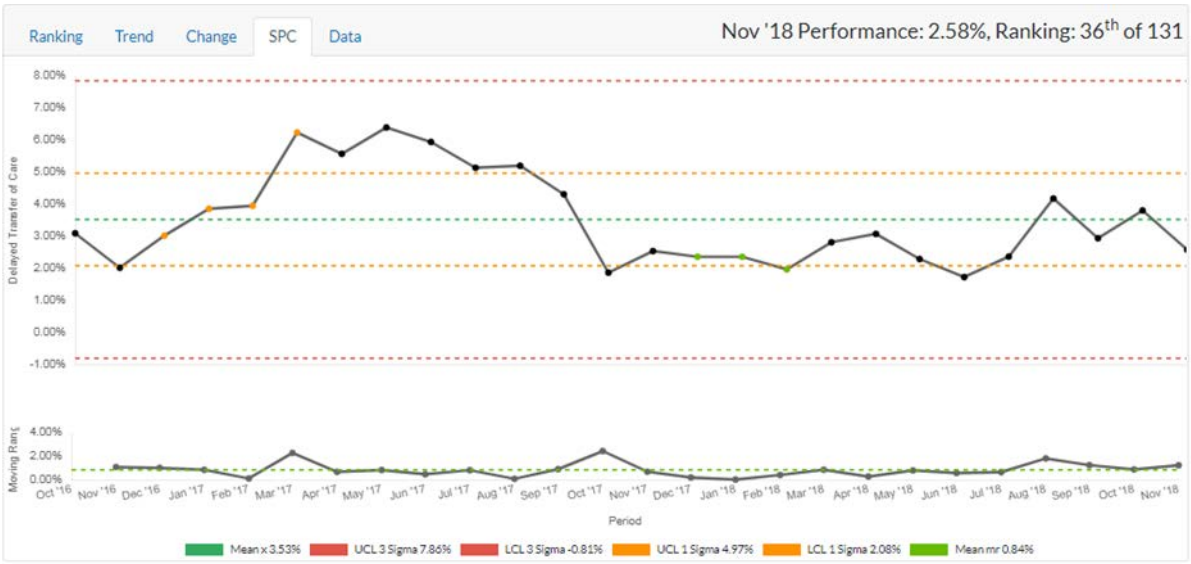
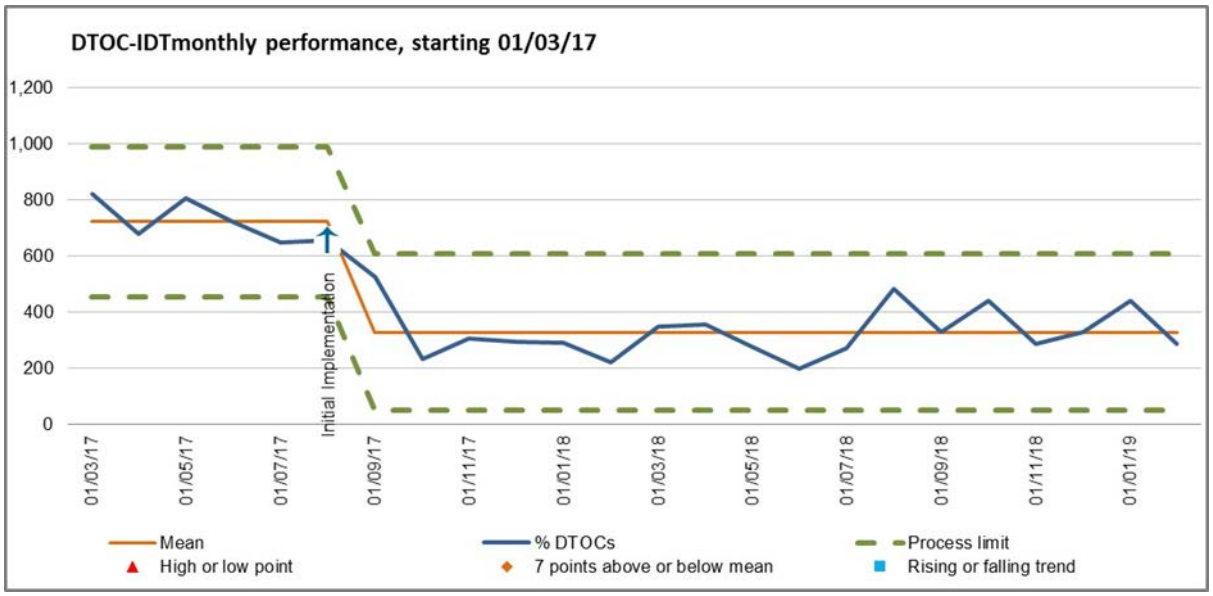
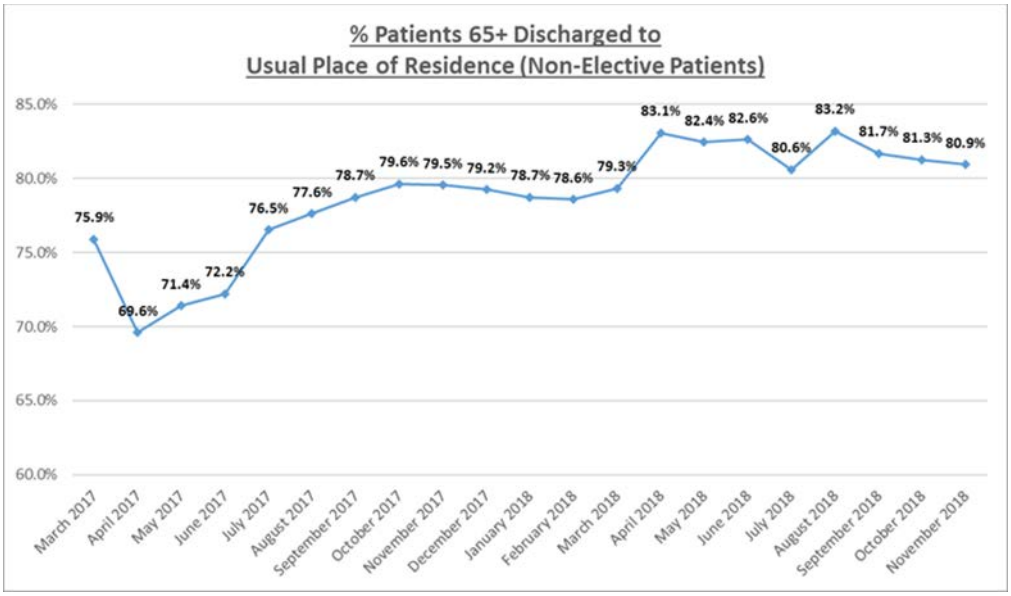


Table 2: **Mean DTOC Performance**



ii. Evidence of a contribution to increased numbers of discharge home



iii. Efficiency improvements through reduction of duplication and streamlining of processes. This includes:

a. refocusing of discharge pathways from 27 destinations to three pathways of home, intermediate care/community bed and DTA
b. streamlining reporting
c. implementation of a single electronic referral form, replacing seven discrete processes

IDT have taken over management of the winter pressure beds in 2018-19. Early evidence suggests that bed occupancy is down compared to 2017-18 whilst average length of stay is up (19 days to date for 2019, compared to a total average of 11 days the previous year). This reflects the greater

complexity of patients accessing the service. Delayed discharges from winter beds to date equated to 187 bed days. The reasons are an even split of pending assessment, equipment, health care plan and family choice). Discharges home are lower than the previous year 38.64% compared to 58%. Again, this may reflect complexity. It should be noted that the 2018-19 sample reflects December – mid February whereas 2017-18 is the total period of January – April.

2. Redesign of the Rotherham Intermediate Care Centre (RICC) service

The RICC service consisted of two elements within the day rehabilitation service – the first element comprised the physical rehabilitation service in order to improve safety, function and independence and the second element included the community integration service in order to maintain the physical health and well-being achieved through ongoing exercises and access to community services. Both elements (Phase 1 and Phase 2) were delivered at the Rotherham Intermediate Care Centre (RICC).

In August 2018 it was agreed that a new operating model for RICC would mean the reconfiguration of the provision of day rehabilitation services into a community setting and to become known as the "Independent and Active at Home Team" (IAHT), primarily for people who have used intermediate care and reablement services. The new team would carry out both elements of the service that was previously provided by the RICC service but within the community (in people's own homes). As the service forms part of the intermediate care offer, it is accessible for adults (all ages), including older people for those that are willing to take part in rehabilitation following a recent injury, illness or social isolation. The service is offered free of charge at point of delivery, up to a maximum of six weeks.

In summary, this enabled a similar level of service that is currently being offered, but in a more person-centred way, in a person's home, and making more use of locally available resources. It now provides individual, personalised therapy interventions for two groups of people. The service targets earlier discharge from Intermediate Care beds and hospital, to prevent delays in therapeutic intervention. This allows a more seamless transition back into the community with the aim of optimising independence and reducing the need for longer-term care packages.

Similarly, the team works closely with the reablement service to offer timely therapy assessments and interventions utilising specialist Council support staff to deliver the programmes, again to support people who may otherwise need ongoing care packages, or further intervention to establish them into their local communities.

The IAHT team started the new model of provision by delivering the service in people's own homes and local communities from 2nd January 2019. The RICC building was decommissioned in December 2018 which has generated efficiency savings for Rotherham health and social care economy.

The current IAHT service operates in isolation from the current reablement and intermediate care service offers in the community, although Council IAHT support workers have recently transferred their line management to the Reablement Team Manager.

Appendix 3

Intermediate care and reablement implementation plan
(Version 1.4)

Lead key:
PM - Project Manager
PS - Project Support
WL - Workstream Lead

RAG Status:
LILAC: Denotes scheduled activity
RED: Milestone will not be met despite mitigating actions
AMBER: Mitigating actions instigated in order to meet milestone
GREEN: Milestone on track by time and benefit
BLUE: Milestone delivered

Version control: Created on 25 March by Lucy Cole

REF	Milestone	Activity	Lead		RAG Reasoning & Mitigation	Start	End
	Approvals						
A1	Organisational informal review	Informal review and comment by all partners	SRO			13/05/2019	25/06/2019
A2	Organisational business case approval	Formal approval by statutory Boards of TRFT, RMBC and RCCG	SRO			03/07/2019	30/07/2019
A3	Organisational business case approval	Business case fully approved by all partners, authority to proceed	SRO			30/07/2019	30/07/2019
	Project set-up						
PS1	Commence mobilisation	Commence implementation of Rotherham IC and Reablement project	PM			31/07/2019	31/07/2019
PS2	Establish mobilisation group	Establish implementation group across partner organisations with identified resources	PM			31/07/2019	02/08/2019
PS3	Draft project initiation document	Draft project initiation document	PM			31/07/2019	07/08/2019
PS4	Approve PID	Project Initiation Document approved by Urgent and Community Transformation Board	PM			08/08/2019	23/08/2019
PS5	Update implementation plan	Update implementation plan following OBC approval	PM			31/07/2019	07/08/2019
PS6	Risk register	Implement project risk register and risk management strategy following OBC approval	PM			31/07/2019	07/08/2019
PS7	Establish workstreams	Set-up workstream groups with leads and membership	PM /PS			07/08/2019	16/08/2019
	Workforce, HR and OD						
W1	Recruitment of additional staff	Undertake recruitment of additional staff capacity identified in the business case	SL			01/08/2019	31/10/2019
W2	GSW training programme	Undertake training and induction of staff to become generic support workers	WSL			01/11/2019	31/03/2019
W3	Double running of community capacity and bed base	Double-running of increased community capacity and full bed stock	SL			01/10/2019	31/03/2019
W4	Staff engagement (pathways and model)	Staff engagement on clincal pathway redesign and new service model	SL			12/08/2019	31/12/2019
W5	Staff consultation	Prepare staff consultation documentation and resources	WL / PM			01/11/2019	31/12/2019
W6	Staff consultation	Undertake staff consultation on changes to current roles, bases and management	SL			02/01/2020	28/02/2020
W7	Enable staff into new structure	Enable staff into new structure and roles	SL			01/03/2020	31/03/2020
W8	Embed new pathways and model	Embed new pathways and ways of working to achieve benefits of new model	SL			01/04/2020	30/09/2020
W9	New model operational	New pathways / model embedded and fully operational	SL			01/10/2020	01/10/2020
	Clinical pathway design						
CPD1	Review current state	Review existing pathways identify opportunities for reducing duplication and improve outcomes and efficiencies	WL / SL			01/08/2019	31/08/2019
CPD2	Triage process design	Develop new triage and coordination process (linked to IPC)	WL / PM			01/09/2019	31/10/2019
CPD3	Pathway redesign	Develop new home-based integrated urgent response pathway	WL / PM			01/09/2019	31/10/2019
CPD4	Pathway redesign	Develop new home-based integrated rehabilitation and reablement pathway	WL / PM			01/09/2019	31/10/2019
CPD5	Pathway redesign	Develop new bed-based integrated rehabiltiation and reablement pathway	WL / PM			01/09/2019	31/10/2019
CPD6	Identify workforce impact	Review implications of new pathways for deployment of staffing and resources	WL / PM			01/11/2019	31/12/2019
CPD7	Identify enabling requirements	Identify enabling support required to implement pathways e.g. training, IT, estates,	WL / PM			01/11/2019	31/12/2019
CPD8	Identify clinical and professional governance requirements	Identify impact on clinical and professional governance processes	WL / PM			01/11/2019	31/12/2019
CPD9	Undertake changes to clinical and professional governance	Undertake review and approve changes to clinical and professional governance	WL / PM			02/01/2020	31/03/2020
CPD10	Develop outcomes and KPIs	Identify outcomes and measures of success for each pathway and the overall service	WL / PM			01/09/2019	31/10/2019
CPD11	Finalise revised pathways	Finalise new pathways and implications for enabling workstreams	WL / PM			01/12/2019	31/12/2019
	Communication and engagement						
CE1	Engagement with service users	Healthwatch Rotherham undertake interviews with service users in community bed base	WL / PS			24/06/2019	31/07/2019
CE2	Engagement with 18-65s	Healthwatch Rotherham undertake engagement with 18-65s with LD and mental health	WL / PS			24/06/2019	31/07/2019
CE3	Engagement with BME groups	Engage with BME groups to identify barriers to accessing IC and reablement services	WL / PS			24/06/2019	31/07/2019
CE4	Review findings of engagement	Comms and Engagement workstream group reviews findings from user engagement	WL			01/08/2019	14/08/2019
CE5	Workshops with service users and carers	Workshops with service users, patients and carers to redeisgn pathways	WL			15/08/2019	31/10/2019
CE6	Primary care engagement session	Undertake primary care engagement session	PM			08/07/2019	02/08/2019
CE7	Staff briefings	Staff briefing sessions and comms on proposals (pre-document release)	SL / PS			24/06/2019	28/06/2019
CE8	Staff workshops	Workshops with staff to review and redesign pathways	WL / PM			05/08/2019	31/12/2019
CE9	Develop consultation materials	Develop materials to support staff consultation process	SL / PM			01/11/2019	31/12/2019
CE10	Develop and deliver comms to partners	Develop and deliver communications to partners about proposed changes	SL / PM			18/06/2019	31/07/2019
	IT, IG and analytics						
IT1	IT equipment to support triage	Source additional equipment to support current triage to be multi-disciplinary	WL / PS			01/08/2019	30/08/2019
IT2	S1 configuration for community unit	Configure S1 for community unit	WL / SL			02/01/2020	31/03/2020
IT3	S1 configuration for community unit	Implement S1 in new TRFT community unit	WL / SL			01/04/2020	01/04/2020
IT4	Develop outcomes framework	Develop outcomes framework to support monitoring of benefits based on clinical pathway	WL / PM			01/09/2019	30/11/2019
IT5	Baseline performance	Undertake baseline of current performance	WL / PS			01/12/2019	31/03/2020
IT6	Configure system reporting	Configure S1 and Liquid Logic to support integrated data collection	WL / SL			01/12/2019	31/01/2020
IT7	Test system reporting	Test reporting functionality in S1 and Liquid Logic	SL			01/02/2020	28/02/2020
IT8	Implement new reporting frameworks	Implement new reporting parameters in S1 and Liquid logic	WL / SL			01/04/2020	01/04/2020
IT9	Review pathways to determine IG / dating sharing needs	Review pathways and proposals for any IG / data sharing requirements	SL / PS			01/11/2019	31/12/2019
IT10	Linking RHR capabilities to IC model	Identify how the Rotherham Health Record could support integrated pathways and	WL / SL			01/11/2019	31/12/2019
	Estates (community)						
E1	Review estate requirements of the model	Review estate requirements to support new pathways and integrated model	WL / SL			01/11/2019	31/12/2019
E2	Develop estates plans	Develop estate plans to support implementation of proposed model and pathways	WL / SL			01/11/2019	31/12/2019
E3	Implement estates changes	Implement estates changes as required and link with IT workstream to ensure appropriately	WL / PS			02/01/2019	31/03/2019
	Finance, Commissioning and Contracting						
FCC1	Notice on current medical cover arrangements	Serve notice on current GP contract for provision of medical support to intermediate care	WL			01/09/2019	31/03/2020
FCC2	Notice on D2A capacity	Serve notice on independent sector D2A beds to cease end March 2020	WL			15/07/2019	15/01/2020
FCC3	Specification development	Co-produce specification for intermediate care and reablement model	WL / PM			01/08/2019	31/03/2020
FCC4	Specification development	Co-produce specification for medical cover	WL / PM			01/08/2019	30/08/2019
FCC5	Procure medical cover	Procure / commission medical cover	WL / PS			02/09/2019	31/03/2020
FCC6	Implement new specification	Implement new specification for integrated model	WL / PM			01/04/2020	30/09/2020
FCC6	Implement new specification	Specification fully implemented	WL / PM			01/10/2020	01/10/2020
	TRFT community unit re-location						
CU1	Specify estates requirements	Agree estates specification for new site	WL / SL			29/04/2019	03/05/2019
CU2	Undertake estates changes	Undertake estates changes for new site	WL / SL			05/08/2019	30/09/2019
CU3	Transfer OCU	OCU capacity transferred to new site ('lift and shift')	WL / SL			01/10/2019	01/10/2019
CU4	Baseline current OCU provision against new draft criteria	Baseline current service users against proposed criteria (OCU) and any implications for the	WL / SL			01/10/2019	31/12/2019
CU5	Support staff training programme	Existing support staff enter training programme as GSWs	WL / SL			02/09/2019	31/03/2020
CU6	Develop alternative pathways of care	Identify any new pathways required for patients not meeting the criteria for the new	WL / SL			01/10/2019	31/03/2020
CU7	Recruitment of additional staff	Undertake any recruitment required for new model	WL / SL			01/11/2019	31/12/2019
CU8	New model operational	New staff model and criteria operational	WL / SL			01/04/2020	01/04/2020
CU9	New model operational	Additional capacity opened (to 23 beds)	WL / SL			01/04/2020	01/04/2020
	Mobilisation of community capacity						
MOB1	Double running	Double running of additional community capacity with existing bed base	SRO / SL			01/10/2019	31/03/2020
MOB2	Implement enabling requirements	Implement enabling requirements e.g. equipment delivery	SL / PM			01/10/2019	31/03/2020
MOB3	New reablement model	New reablement model in place to align with NHS teams	WL			01/10/2019	31/10/2019
MOB4	Review of bed based capacity	System review to assess ability to close community bed base	SRO			02/03/2020	31/03/2020
MOB5	Close under-utilised community beds	Closure of community beds	SRO			31/03/2020	31/03/2020
MOB6	Implement new models and pathways	Implement new models / new ways of working to support efficiency gains / integrated	SL / PM			01/04/2020	31/08/2020
MOB7	Implement new models and pathways	New model of care for home-based pathways fully operational	SL / PM			01/09/2020	01/09/2020
	Project closure						
PC1	Complete lessons learned review	Undertake lessons learned review with project team	PM			01/10/2020	14/10/2020
PC2	Complete closure report	Complete closure report including lessons learned review and submit to U&CTG	PM / SRO			15/10/2020	31/10/2020
PC3	Project closed	Project closed	PM			31/10/2020	31/10/2020

Equality Impact and Engagement Assessment Form		
Complete this section **Please retain one copy, and pass one copy to both the Equalities and Engagement leads**		
Section one – Project or plan details		
1.1	**Project Title:**	
	Intermediate Care and Reablement	
1.2	**Project Lead:**	**Contact Details:**
	Claire Smith	**Claire.smith138@nhs.net**
1.3	**This activity /project is:**	
	Review and redesign of intermediate care and reablement pathways	
1.4	**Describe the activity/project**	
	The project is focused on the review and redesign of intermediate care and reablement pathways across Rotherham. The project will: • integrate a range of services across health and social care to deliver three core integrated pathways, • make an investment in the community to ensure more people are supported in their own home and • reduce the numbers of people going to a community bed when they could have been supported at home. This will enable release of resources from an under-utilised bed-base to be reinvested in community capacity in the long-term.	
1.5	**Timescales**	
	Development of outline business case – May 2019 Development of detailed proposals – July – December 2019 Implementation complete – April 2020	
2	**Equality Impact Assessment**	
2.1	**Gathering of Information:** This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty. Please add any general information here.	
	It is anticipated that the proposals will have a positive impact by improving services for the following protected characteristics: • Improving access to services for people between the ages of 18-65 who do not currently access services as much as they could • Streamlining pathways, reducing duplication and ensuring services are easier to navigate and improving outcomes for people and their carers • Improving access for people with disabilities such as learning disabilities or mental health issues, who do not currently access services as much as they could • Removing potential barriers to access for people from BME backgrounds who make up a very small proportion of the people who currently access services The impact of the proposals should have no differential impact (neutral impact) for people with the other protected characteristics.	
2.2	**Screening**	

	Please complete each area)	What key impact have you identified?			Information Source
		Positive Impact - will actively promote or improve equality of opportunity.	**Neutral Impact -** where there are no notable consequences for any group.	**Negative Impact** negative or adverse impact causes disadvantage or exclusion. **If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures.**	What action, if any, is needed to address these issues and what difference will this make? For example: *At this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess.*
	Human Rights	**N**	**Y**	**N**	**N/A**
	Age	**Y**	**N**	**N**	**N/A**
	Carers	**Y**	**N**	**N**	**N/A**
	Disability	**Y**	**N**	**N**	**N/A**
	Sex	**N**	**Y**	**N**	**N/A**
	Race	**Y**	**N**	**N**	**N/A**
	Religion or belief	**N**	**Y**	**N**	**N/A**
	Sexual Orientation	**N**	**Y**	**N**	**N/A**
	Gender reassignment	**N**	**Y**	**N**	**N/A**
	Pregnancy and maternity	**N**	**Y**	**N**	**N/A**
	Marriage/civil partnership (only eliminating discrimination)	**N**	**Y**	**N**	**N/A**
	Other relevant groups	**N**	**N**	**N**	

3 Engagement Assessment

3.1 **What is the level of service change**? – see diagram 3 above

If your project is classed as a 'significant variation' (level 3) or 'major change' (level 4) please contact england.yhclinicalstrategy@nhs.net for a preliminary discussion to support planning and agree whether the service change needs to follow the NHS England Service Change Assurance process.

The assurance process generally looks at the 'case for change' The key players in the process include overview and scrutiny teams, and the clinical senates. You can also refer to the DH guidance: (please note that level 4 changes will require considerable long term planning and this DH guidance is mandatory for all level 4 changes)
http://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/nhs_public_involvement_-hempsons_stp.pdf
DH 2013

Circle or highlight the appropriate level of service change

Level 1 Level 2 Level 3 Level 4

Add additional information and rationale for this scoring below

At this stage, the project is focused on changing individual pathways of care and reconfiguring teams to ensure that services are more integrated for the people and their carers. The proposal requires no change to the acute hospital bed base.

3.2 **Who are your stakeholders?**
Consider using a mapping tool to identify stakeholders - who is the change going to affect and how? Complete below or attach or link to a mapping document

- People accessing current and future intermediate care services in the scope of this review

	• Workforce delivering the current and future intermediate care services including therapy staff (TRFT), nursing staff (TRFT), reablement staff (RMBC), IAHT staff (RMBC and TRFT) working in the community or from / into community bed-based sites (Lord Hardy Court, Davies Court, Oakwood Community Unit, Waterside Grange), medical staff supporting these services • Trade Unions representing staff delivering current and future services • Workforce referring to and working with current and future services including GPs, wider community services, mental health, social care, and voluntary and community sector staff • Voluntary and community sector groups and health interest groups • Rotherham Healthwatch • Elected Members (RMBC Councillors and MPs)
3.3	**What do we already know?** What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.
	In Rotherham, the general population is at its highest level at 264,242, with 52,800 older people (20%) aged 65 years and over and 6,200 people (12%) aged 85 years and over. By the year 2021, the number of older people is predicted to increase to 54,400 and the 85 years and over age group will increase to 6,800. 19,085 people aged 65 years and over lives alone, which is around 36% of people in this age group. An estimated 21,187 people over 65 (40%) need some help with domestic tasks and 17,335 (33%) need help with self-care. 18% of people over 65 years need assistance with some aspect of mobility such as walking or climbing stairs. (POPPI, 2019). 16,592 older people are living with a limiting long-term illness (31%). The health and well-being needs of the ageing population continues to increase as older people are likely to experience disability and limiting long-term illnesses and lower quality of life. Falls in older people are of a particular concern because of the risk of hip fracture and subsequent morbidity and mortality. Our reablement pathway, including intermediate care (rehabilitation/ reablement), is crucial in improving patient outcomes, providing early intervention to restore independence and prevent frailty. Therefore, it is predicted there will be a substantial increase in the number of adults with additional health and social care needs over the next five years. This prediction is made on a backcloth of substantial reductions in social care investment; increases to the NHS budget are unlikely to keep pace with the rising demand for services. If the demographic challenge is to be met it will require a joint approach to commissioning and delivering services, ensuring through early prevention and intervention at the front door to interventions are reduced further up the care pathway. The following statistics are extracted from bed-based intermediate care performance data for 2017/18. • The average age of intermediate care customers is around 82 years for intermediate care services and the potential changes to services will directly impact on them in terms of the location they receive support. • The age of customers ranges from 58 years to 100 years who were in receipt of intermediate care. • 3% of customers were aged between 59 to 64 years, 27% aged 65 to 74 years, 40% aged 75 to 84 years and 30% were over the age of 85 years. 2 people accessed the service at the age of 100 years in 2017/18. • 65% of customers are female and 35% are male. • 99.5% of customers are from a White British background, with 0.5% from other ethnic background. Consultation and analysis of the use of bed base provision indicates that around 40% of people can be supported in their own home upon discharge from hospital, instead of entering intermediate care for a

	period of around 4 weeks.
	Describe any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight? How will the insight available to you help to inform your decision?
	Existing / completed engagement work • Surveys distributed to patients across services within the scope of this project during February / March, minimal returns. Planned work to follow-up with face-to-face interviews given the low number of returns (see below). • Existing information from staff engagement events has been used to inform the proposals http://www.rotherhamccg.nhs.uk/Downloads/Engagement%20map%202017-18%20mastercopy.pdf • Feedback and comments have been reviewed from people currently accessing services through the individual service mechanisms e.g. Friends and Family Test for NHS services • Presentation and discussion with the Rotherham Patient and Public Participation Group (PPG) on 26 February 2019 to present overall objectives of the project and gain feedback to inform the work **Planned engagement work** People using services and their carers: Healthwatch Rotherham has been commissioned to undertake some more detailed engagement conducting interviews at the current community bed-based units in order to understand in more detail: • Current experience of services • Identification of what in the pathway could be improved • How a home first approach might work for them and support requirements. **See also Section 3.4 below for specific planned engagement activities with overlooked communities.** Through this engagement work and working with wide voluntary and community groups, and the Rotherham Patient and Public Participation Group, people and their carers will be engaged as participants in pathway redesign workshops, alongside the clinical and professional staff who deliver and work with these services to ensure an approach of co-production. This has been built into the implementation plan for the development and implementation of the proposals.
	Briefly describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?
3.4	**Reaching out to overlooked communities**

	Are additional arrangements for patient and public involvement required for this activity and in particular h will you ensure that 'seldom-heard' groups, those with 'protected characteristics' under the Equality Act, a those experiencing health inequalities are involved • Seldom-heard groups Yes • Nine Protected Characteristics Yes • Health inequalities Yes If yes, please provide a brief outline of your approach and objectives for any additional patient participation targeted at these groups.
	Healthwatch Rotherham has been commissioned to support engagement with service users between the ages of 18-65 with for example learning disabilities or mental health issues, which currently do not access these services regularly, to understand in more detail: • Awareness of services • Barriers to accessing services • How services and pathways could be improved or adapted to provide support to people in a wider age range, with a wider set of needs As part of the development of detailed pathways, will we engage with BME groups and users to understand any potential current barriers to accessing services and how pathways could better meet the needs of this group. The Unity Centre has been approached for support in engaging with BME groups.
	Do you need to make any of your resources accessible (i.e. for people with learning disabilities, sight impairments, or alternative languages?)
	Some of the targeted engagement with adults aged 18-65 will involve people with learning disabilities and therefore resources produced may need to be made accessible. Similarly, alternative language resources be required to support engagement with some parts of the BME community in Rotherham.
3.5	**What resources do you need for this?** Consider the sections above • The timescales • The need to reach overlooked communities • Accessible materials • Gaps in knowledge
	The timescale to undertake the next phase of work which is focused on pathway redesign in a co-produce process with patients, service users, carers and staff teams is from June 2019 – December 2019. There i requirement for formal consultation with staff teams in respect of any changes to their job roles and terms conditions which is planned for January – March 2020. Engagement with groups of service users under 65, BME communities, as well as with current service us and carers is planned for June – July 2019. The detailed pathway development work will take place follow this initial period of engagement.
4	**Feedback and Evaluation**
4.1	How will you use the feedback – who does it need to be shared with?
	Feedback will be shared with: • Project Board and Urgent and Community Transformation Group (representing health and care partners across the Borough • Directly with the current commissioning and provider organisations • Staff teams / wider workforce

	• Rotherham Patient and Public Participation Group • BCF Executive Group and BCF Operational Group • Health and Wellbeing Board
4.2	Provide a brief outline of how the information collected through patient and public participation will be used to influence the plan/activity.
	The information collected will be used in the following ways: • To support the development of new pathways within the service • Setting the outcomes and measures for success for the new service • Inform the configuration of the new service and requirements of MDT planning and working • Support wider interdependent projects in development e.g. Integrated Point of Contact (IPC)
4.3	How will the outcomes of participation be reported back to those involved?
	• Healthwatch will produce a report of its initial findings which will be shared with those involved • Opportunities to be involved in development of pathways as the project progresses • Progress reports will be made available to the Rotherham Place Board as required and papers will be published in the public domain
4.4	How will you assess the ongoing impact of the change on patients and the public after it has been completed?
	A series of outcome measures have been proposed as part of the Outline Business Case in order to asse the impact on people using services, their carers and on the wider system. Further work to develop an outcomes framework will be undertaken as part of the development of new pathways.

5	**Engagement and Equality Impact Plan**				
	Action	**Approx. Timescale**	**Lead**	**Deadline**	**Comments/ progress**
	See below				

6	Form details	
	Completed by:	Lucy Cole
	Job title:	Project Manager, Intermediate Care and Reablement
	Date	25/03/2019
	Reported to	

Section 5

Engagement and Equality Impact plan				
Action	**Approx timescale**	**Lead**	**Deadline**	**Comments / progress**
Presentation and initial feedback from Rotherham Patient and Public Participation Group	February 2019	Claire Smith / Lucy Cole	February 2019	Completed
Undertake surveys with people using current services in the scope of the review	March – April 2019	Steph Watt	April 2019	Limited returns Phone interviews to be undertaken where possible / consented to
Healthwatch interview of people currently using community beds	June – July 2019	Healthwatch Rotherham	July 2019	Targeted to understand current patient / service user journey and experience of services
Healthwatch engagement with 18-65 service user group not currently accessing services	June – July 2019	Healthwatch Rotherham	July 2019	Targeted engagement as a result of the EqIA assessment of people accessing services
Engagement with BME groups	May – July 2019	TBC	July 2019	Approached local community group Unity to access support for targeted engagement identified via the EqIA
Workshops to engage with service users, patients and carers to co-produce new pathways for the service	August – October 2019	Project Manager	October 2019	Series of workshops to seek views and redesign current pathways and services to meet people's needs.

The Rotherham NHS Foundation Trust

Annex to the Intermediate Care and Reablement Outline Business Case

The Intermediate Care and Reablement Outline Business Case (OBC) proposes three integrated pathways for home-based urgent response, rehabilitation and reablement. The bed based pathway includes a proposal for a 24 bed therapy led community unit with nursing to be provided by The Rotherham Foundation Trust (TRFT).

TRFT have been working closely with partners and key stakeholders to develop the models of care for these new pathways, including development of a service specification and key performance indicators.

TRFT's Board of Directors agreed to support the proposals outlined in the OBC at its meeting on 25 June 2019. This included the proposal for TRFT to provide the therapy led community unit with nursing. This is subject to the Board's approval of a detailed business case (including implementation plan) at the end of July 2019.