Report No. 138/2015

Rutland Health and Wellbeing Board

Subject:	**Step Up Step Down – Integrated Prevention, Discharge and Reablement Model and IUR 2 Business Case**
Meeting Date:	**23rd July 2015**
Report Author:	**Yasmin Sidyot**
Presented by:	**Yasmin Sidyot**
Paper for:	**Comment**

Context, including links to strategic objectives and/or strategic plans:

Introduction

The Step up Step Down business case was approved by the Health and Wellbeing Board on 05.02.15. The business plan combines the 3 Better Care Fund Schemes: - Hospital Discharge (HDR1), Reablement (HDR2) and Crisis Response (IUR1). It links closely with the business plan for Integrated Health and Social Care Pathways and Service Delivery (IUR2).

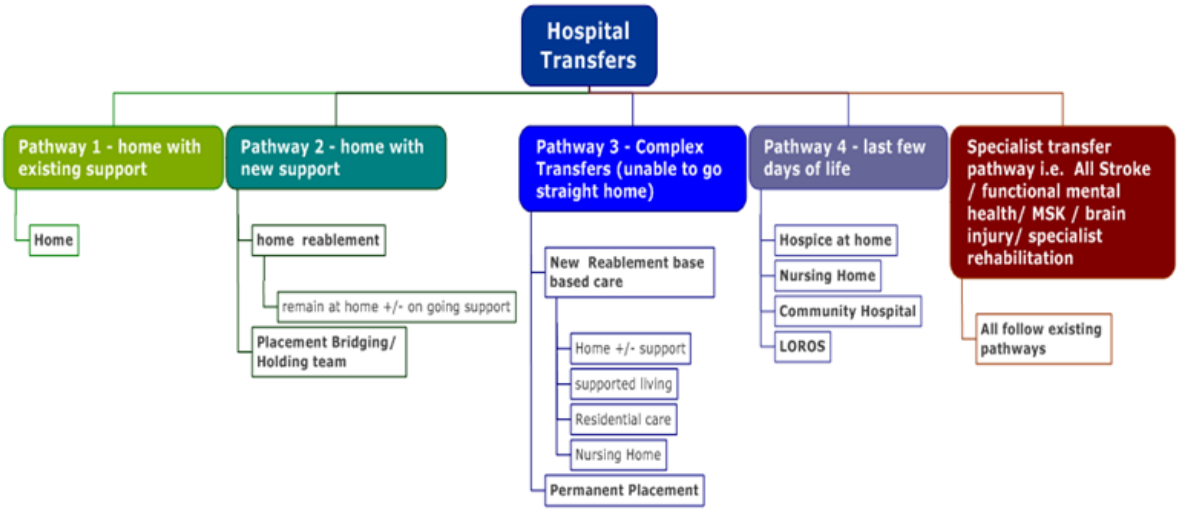
The business case for IUR 2 is attached to this report for consideration and approval. This business case outlines the work to develop a whole system response to ensure a fully coordinated and integrated service offer is available for individuals with health and social care needs in Rutland.

The Project will develop pathways, protocols and possibly co-location of health and social care teams to allow the health and social care economy to fully realise its vision of integrated care.

By bringing our resources together we aim to have an integrated pathway of home based support which can enable people to live more independently within their own homes.

One of the milestones in the business plan is to make recommendations for the future delivery model for these services.

The purpose of this report is to provide an update on the progress of the plan to date and share the 'Integrated Prevention, Discharge and Reablement Model' as developed through the Integration Executive over recent months.



Detailed above is the transfer pathway diagram to simplify transfer routes from our local NHS acute and community providers to enable the shift from the acute sector to the community and home environment as part of the redesign of our local health and care system.

This paper outlines the Rutland model to deliver the above pathways 1-3. Key objective is to provide capacity to develop an integrated team and way of working to facilitate the implementation of the transfer pathways from all hospitals. The emphasis will be on delivering 7 day services

Reablement can also help patients to stay in their own home for longer, reduce the need for home care and improve outcomes for service users.

Proposed Integrated Prevention, Transfer and Reablement model

REACH Team Manager

Unscheduled Therapy and Nurse Leads

Night ICRS

In Reach Hospital Transfer Team (Champions)

- Hospital social worker (s)
- In reach Nurse
- In reach OT

REACH Team

- Registered Manager
- Assistant Managers
- Co-ordinators
- Reablement Support Workers
- Review officer
- Broker x 1
- Pharmacy Link

Intensive Community Support Nurses and Unscheduled Nurses

- Band 6 Nurses
- Band 5 Nurses
- Health care Assistants
- Phlebotomist

Mental Health Services for Older People Link worker(s)

Therapists

- Physiotherapists
- Occupational Therapist
- Technical Instructor
- Admin Support

Who is Involved?

ICRS Night Nursing Service, Leicestershire Partnership NHS Trust (an element of the LPT Community Health Services (CHS) Unscheduled Care Team provision). The service offers a roving night team to provide home visits and overnight support incorporating nursing assessment and interventions and management of low level social care needs to ensure the person is safe at home over night.

Unscheduled Care, Nursing and Therapy Service, Leicestershire Partnership NHS Trust CHS Unscheduled Care Teams. A multidisciplinary team which provide a range of responsive nursing and therapy interventions.

REACH, Rutland County Council. Registered domiciliary care service providing re-ablement and social care interventions provided by Reablement Support Workers, who are supported by a management team and therapists.

Hospital Transfers
(In reach Nurse, In reach Occupational Therapist(OT), Hospitals Social Workers)
These posts will be proactive in the identification and transfer of patients to the appropriate pathways from Peterborough Hospital and the community hospitals. This builds on the discharge link nurse role that previously existed. It is proposed to make the temporary dedicated Social Worker post for Peterborough Hospital permanent. Other existing Hospital Social Workers would work closely with this Integrated team.

As reablement develops and pathways 2 and 3 progress, it is important to ensure that an experienced therapy team is commissioned on a recurrent basis to provide continuity of care and expertise that in turn will aid planning and delivery.

The focus of the reablement programme for pathways 2 and 3 is as follows:

- To provide a reabling environment and approach, where the emphasis will be on maximising independence and the primary transfer destination would always be home
- The Reablement programme will be delivered in the main by Reablement Support Workers (RSW's), under the direction of the therapists. The RSW's will be managed on a day to day basis by the REACH Registered Domiciliary Care manager and Assistant Managers and the team will work to the principles of the Health and Social Care Protocol.
- Specific Physiotherapy and Occupational Therapy and Nursing interventions will be provided to the patient in an integrated way.
- Patients/service users will have clear goals set with them within one working day of transfer which will be reviewed constantly
- Twice weekly multi-disciplinary team (MDT) meetings will occur to review progress against goals and transfer assessments/plans
- The Stepping Stones Flat will be extended for 3 months, an alternative pathway 3 option, to allow for a thorough evaluation by the 'enhanced integrated team' to establish if it could have any added value or should be discontinued.
- All assessments both health and social care required for formal discharge will be completed in the care facility rather than in the hospital setting once the person is medically stable and fit for discharge.
- Following transfer home, the patient/service user or family member/carer will be contacted:
    - At 24 hours)
    - At 7 days) review progress and determine whether packages of care are in place, suitable, timely and appropriate
    - At 4 weeks)
- The maximum reablement period is for no longer than 6 weeks. It is anticipated that patients will transfer from residential Reablement to home based Reablement during the 6 week period. In most instances, patients will not require the maximum period of Reablement.
- Therefore, it is important from the outset that goals are set and patients and their family/carers are given clear guidance as to aims and objectives for the patient and perceived timescales.

At the end of the reablement period the patient/service user would go home with any of the following:

- No formal support
- No formal care but may have assistive technology, equipment, universal services
- Self-funded package of care
- Social care package of care/ongoing planned health care.
- Joint funded package of care
- Continuing health care (CHC) funded package of care

The intention is for these groups of staff to have a co-located base and work as an Integrated Hub.

Workforce development to create a culture where roles within the teams are re-designed to make the

optimum use of team skills and knowledge and everyone is working in an integrated and person centred way is critical.

This local model needs to work closely with the Crisis Response Integrated Night Nursing Service that forms part of this BCF Step Up step down Business Plan.

Financial implications:

Costs already identified

Spend area	Value £
Reablement Team in BCF HDR2	£536,000
ICS Team in BCF IUR2	£405,000
0.5 Hospital Social Worker HDR1	£25,000
0.5 In Reach Nurse HDR1	£25,000

Cost for Proposed New posts

Spend area pay and non-pay	Value £ (FYE costs)
0.4 REACH Physiotherapy cost centre 4494a	£25,000
0.5 Hospital Social Worker	£25,000
0.5 In Reach Nurse	£25,000
0.5 In Reach OT	£25,000
Additional Band 6 Nurse	£50,000
Phlebotomist/Health Care assistant Band 2	£25,000
Additional Physio 1.3wte	£65,000 (£50,000 RCC £15,000 CCG)
0.2 wte OT – deliver ICS & REACH	£10,000
0.25 wte Technical Instructor	£10,000
1 wte reablement support worker	£30,000
1 wte admin	£20,000
1 wte Broker	£40,000
1 wte MHSOP Link worker	£50,000
ICRS/SPA contribution	£50,000
Total	**£450,00**

Funding Available

Funding Source	Value £
BCF Crisis Response IUR1	£450,000
Total	**£450,000**

Recommendations:		
(a) Notes the contents of this report (b) Support the recruitment of the proposed new posts. (c) To approve the business case for Integrated Health and Social Care Pathways (IUR2)		
Strategic Lead:	Yasmin Sidyot CCG and Mark Andrews RCC	
Time	High	Recruitment may take some time and until posts are filled the additional capacity required will delay progress. Delayed discharges continue to be a difficulty.
Viability	Medium	Recruitment may be difficult for some posts. Will need time and commitment to establish new ways of working. Having some difficulty identify a care home that is willing and able to provide the bed based options required.
Finance	Medium	Funding available within the scheme for 2015/16 but not yet clear about recurrent BCF funding but indications are that it will continue in some form.
Profile	High	Delays in hospital discharges are high profile, impact on individuals' recovery and damaging to our reputation.
Equality & Diversity	Low	No groups will be disadvantaged.