**TO: EXECUTIVE**
**9 MAY 2017**

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**PROVISION OF COMMUNITY BASED INTERMEDIATE CARE SERVICE**
**Director of Adult Social Care, Health & Housing**

## 1. PURPOSE OF REPORT

1.1. To obtain Executive support for the proposed new model of Intermediate Care provision in Bracknell Forest.

## 2. RECOMMENDATION

**2.1 That the Executive approves the model for future commissioning of Intermediate Care.**

## 3. REASONS FOR RECOMMENDATION

3.1. At its meeting of the 18 July 2016 the Better Care Fund Board considered a report outlining three options for the possible future provision of Intermediate Care in Bracknell Forest, and gave approval to develop its preferred option to a full specification and business case. The Board received the full specification and business care at its meeting of 31 October, and approved the model, noting that the final decision rests with the Council Executive. The timing of the decision was however dependent on other decisions, in particular possible uses of the Bridgewell site, and options around the development of the Heathlands site.

3.2. Intermediate Care is currently provided via a combination of bed based care at Bridgewell, and community based care provided in people's homes. Commissioners, jointly the Council and the CCG, were keen to explore whether a predominantly community based model would be successful in Bracknell Forest.

The broad outline of the preferred option was as follows:

Decommission the Bridgewell Centre and develop a community based Intermediate Care service, providing care and rehabilitation for individuals in their own homes where possible and keeping them out of hospital, using Intermediate Care teams. This care could be consultant or nurse led, with Integrated Care Teams providing both medical and social care support. People ready to be discharged from hospital would be triaged for early supported discharge into a range of different levels of support, ranging from:

- High support (provided by Community Hospital beds);
- Medium support (provided through a small block contract with private sector / nursing homes) with Community Rehabilitation teams in-reaching to provide intensive rehabilitation services;
- Medium / low levels of support – provided at home through Community Rehabilitation teams; augmented by existing services such as the Rapid

Assessment Community Clinic, Community Nursing and 24/7 support as required;

- Long term support – provided through the Reablement (Adult Social Care), Falls Service and Long Term Residential care; Integrated Care Teams, Community Nursing and Voluntary Sector.

3.3. The initial target date for implementation of the new model was to be 1st April 2017. However, the decommissioning of a bed based intermediate care service from the Bridgewell Centre presents opportunities for future use of the site, including in particular the possibility of procuring a care provider to run a dual registered EMI residential and nursing care home for a period of time, pending the redevelopment of the former Heathlands site, and opening a new home there. Separate plans are in development for seeking a potential provider of the service from Bridgewell, subject to being able to undertaking works at Bridgewell to make it fit for purpose for the interim before Heathlands is open at an affordable price.

3.4. Any future commissioning arrangements would continue to meet the requirements identified within the Intermediate Care Joint Commissioning Strategy and the outcomes of the Better Care Fund programme of work.

3.5. The changed model of care means that staff currently working at Bridgewell will be potentially at risk of redundancy. Whilst there will be opportunities in the enlarged community based team for some of those staff, and redeployment opportunities will be sought for all staff, it is considered likely that some staff will be made redundant.

## 4. ALTERNATIVE OPTIONS CONSIDERED

4.1. Three options were put before the board in July, including the one outlined above. The other two options were first to retain the status quo, i.e. continue to provide bed based Intermediate Care at Bridgewell with no nursing input, or second, to a fully integrated service delivering bed based Intermediate Care, home based reablement and a day centre for rehabilitation; all from a single new site. The first option was rejected because the current service does not support people with medium or high care or support needs, and is likely to lead to increased re-admission rates; the second option is considered unaffordable.

## 5. SUPPORTING INFORMATION

5.1 Bracknell Forest currently has a model of Intermediate Care that includes

- a team offering reablement support within people's own homes, and
- bed-based Intermediate Care at the Bridgewell Centre for those people who do not need to be in hospital but who are – for a number of reasons – unable to be supported at home through their period of reablement or treatment. Until March 2016, Bridgewell provided nursing care.

Reablement in both teams is inclusive of therapy from physiotherapists and occupational therapists.

5.2 The Bridgewell Centre is based at Ladybank in Birch Hill and shared the site with a long-stay residential facility, which closed in 2012. The intention had always been to

move the service to a more suitable location, as the building requires considerable attention.

5.3 As the Better Care Fund progresses with local integration of health and social care, plans will progress to increase the range of care and support included in Intermediate Care. This will include greater community nursing care, which will increase the dependency and complexity of people who can be supported in the community. The potential for decommissioning Bridgewell will enable the investment in these plans.

5.4 As more extra care facilities are available, they will be able to respond to the need for overnight care, which is often the reason for people staying at Bridgewell until they are well enough not to need overnight support. Alongside this review of Intermediate Care, BFC will be reviewing accommodation support services as part of the Older People accommodation strategy. This includes support to extra care accommodation.

5.5 The Council and CCG have been working in partnership to develop a new model for Intermediate Care over the summer and Autumn of 2016. The preferred option was discussed with the provider, who worked to develop the detailed model which is attached as an Annex to this report. This outlines the specification, performance indicators, structures and care pathways.

5.6 The broad specification of the service proposed is as follows:

- Enable adults (aged 18+) to improve, maintain or manage changes in levels of independence, health and wellbeing, through a process of care, re-ablement or recuperation.

- A multi-disciplinary decision making approach providing a person-centred service collaborated carer between primary care, adult social care and voluntary sector

- Achieve better outcomes for people to remain independent and in their own homes for as long as possible

- Prevent hospital admissions and attendances through the provision of community sector based care pathways allowing patients to seamlessly step up or step down levels of care and support.

- Support the early transition from hospital for rehabilitation in the community or an individuals own home

- To reduce the high levels of dependency on long term care either at home or in a care home

- Deliver services in partnership with health and social care, forming multidisciplinary integrated teams; including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service.

- Delivery timely, cost effective, efficient services that meet an individual’s needs

5.7 The proposed operating model from the Provider is built around the following core principles, expressed as “I Statements” from the point of view of the person receiving the services:

- I will have access to the people that can help me 7 days per week
- I will decide the goals that I will achieve
- I will be informed of the way the service works and kept informed as I use the service
- I will not have to stay in hospital at the weekend if I am ready to go home
- I will be supported with my family / support networks to remain at home as long as I can
- I will be helped to build confidence to remain at home
- My carer will be supported through the process too and his / her needs taken into account

5.8 To monitor the effectiveness of the service, a range of performance measures have been proposed:

- Reduction in the number of people that remain in intermediate care services beyond 6 weeks
- Number of people with dementia in receipt of intermediate care services to improve accountability and reduce delays in the pathway
- Reduction in the number of people identified as a delayed transfer of care
- Reduction of length of stay in the acute setting
- Reduction in length of stay in Intermediate Care Services
- Increase in the number of rapid response interventions
- Reduction of people readmitted into hospital
- Reduction of the number of people admitted into residential care
- Increase in number of people who receive intermediate care services
- Increase to the number of weekend discharges
- % of GPs who receive a discharge summary

5.9 The specification outlined above will be managed within the current budget envelope, although there are some risks that the small number of beds that will be purchased in the private sector for bed based intermediate care will cost more than allowed for due to the current supply issues in the market.

5.10 There are potential redundancy costs if the proposals get implemented. The CCG will make a contribution in line with their liability. Every effort will be made to avoid redundancies.

5.11 The full specification and delivery model have been developed and are available as background papers.

## 6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 The Borough Solicitor has been consulted on these proposals.

Borough Treasurer

6.2 These proposals are expected to be delivered within the current budget envelope, although there are some risks that the purchase of private sector beds will cost more than expected due to current supply issues. The potential extra cost is potentially as high as £80,000, although is expected to be much less. This is expected to be temporary.

There are potential redundancy costs arising out of these proposals and the CCG will make a contribution in line with their liabilities.

Head of Human Resources

6.3 Any proposals affecting the employees of the Intermediate Care Service will be dealt with under the Council's Organisational Change Protocol. If the Executive accept the recommendation of this report, a 30 day consultation will need to take place with staff. At the end of that it may be necessary to put the workforce "At Risk" and this will trigger work on Redeployment and/or Redundancy. The timetable will be structured in accordance with the protocol and it will need to go to the Local Joint Committee of the Trades Unions and the Employment Committee for approval to use funds for Redundancy. Every effort would be made to redeploy as many staff as possible.

## 7 CONSULTATION

Principal Groups Consulted

7.1 The plans have been developed in partnership with the CCG. As staff in the current provider will be affected by the new model, with the possibility of staff being placed at risk of redundancy, they will need to be consulted in line with the Council's organisational change protocol.

Background Papers
None.

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