Bracknell Forest Council

Bracknell Forest Council
Proposed model: Community Based intermediate care services

Index

1) INTRODUCTION

1.1) This model has been developed based on information provided by Bracknell and North Ascot CCG commissioners in the Intermediate care specification. The model encompasses the whole intermediate care offer for the residents of Bracknell Forest and not just those elements that are currently provided at the Bridgewell Centre.

This paper has been updated to include amendments as presented to commissioners on 30.11.16 to align closer to the available budget envelope.

1.2) The business case describes to commissioners how Bracknell Forest Council would deliver the specification and costings are provided to deliver the model. Consideration needs to be taken that these costings reflect the whole service offer

including existing intermediate care services delivered in people's own homes, the hospital social work team and elements of the existing intake function. The model has taken this approach to ensure that the intermediate care offer in Bracknell can be seamless to the individuals who use the service.

1.3) The business case covers:

- The specification and expected service standards
- "I statements"
- Proposed performance indicators
- Operating model and pathway
- Communication plan
- Opportunities for future developments
- Appendix (a)
- Appendix (b)

2) CONTEXT

The business case has made a number of assumptions based upon previous activity from the current intermediate care service and information available in the Joint Strategic Needs Assessment.

2.1) A range of assumptions have been made based on information available from September 2015. However, it is not possible to relate all areas of activity against the same time period, as CM2000 does not capture all necessary data. A series of spreadsheets have been developed over time, as gaps in data sets have been identified.

The business case is based upon similar activity levels as last year. With a total of 50 people in receipt of intermediate care services at any one time. With 36% as admission avoidance / crisis intervention and 60% planned discharges.

With capacity to deliver a minimum of 16,000 hours per month and a maximum of 20,000 hours per month inclusive of both community and bed based intermediate care services.

A key theme from the data period September 2015 – September 2016, was a higher level of activity between September 2015 and January 2016. It is from this point in time, where a number of care homes either closed or were red flagged (meaning no placements could be made). This equated to over 400 beds in the Bracknell locality in the last year. This has put unprecedented pressure on the system and creates a challenge for discharge planning and a burden on social care budgets as the weekly charges for placements has in some cases doubled in this period.

Under our current domiciliary care commissioning arrangements, there are also particular localities in Bracknell where there are great difficulties in sourcing care (e.g. North Ascot, Sandhurst). It is hoped that through the new domiciliary care tender due to be implemented in spring 2017, will factor in the difficulties we are currently presented with.

The Bridgewell Centre has seen an increase of readmission rates back to Frimley Park Hospital during the period January 2016 – August 2016, which latterly relates to the point at which BHFT withdrew the health component of the re-ablement service. This reflects the challenges in admissions of individuals with higher needs and the homes ability to manage higher levels of care. The fact that admissions are agreed by none clinical staff may have also had an impact on the appropriateness of referrals.

From this, we conclude that health professionals being are a critical element to provide effective intermediate care services.

More detail on this data set can be found in Appendix (A).

2.2) JSNA

As one would expect, the JSNA evidences a growth in the older person's population for the Bracknell Forest Council locality. With this comes a growth in the level of demand the health and social care system can anticipate upon services.

Currently we have:

928 people supported through CTOP&LTC
375 people supported through CMHTOA

The JSNA tells us without such intervention we can anticipate the following demands upon our services

Growth of Older person's population
Growth of **2,300** population aged 65+ by 2020
Growth of **500** population aged 85+ by 2020

Expected number of people living in a care home by 2020
People aged 65-74 in a care home = **30 people**
People aged 75 – 84 in a care home = **111 people**
People aged 85+ in a care home = **234 people**

SELF-CARE
Self Care refers to people who are unable to manage at least one self-care activity on their own. Activities include: bathe, shower or wash all over, dress and undress, wash their face and hands, feed, cut their toenails, take medicines there will be growth of **838** people by 2020.

Dementia
310 more people over the age of 65 with dementia

Falls
Increase of **655** falls in people over the age of 65 up to 2020.

Intermediate care services will be pivotal to managing the potential growth, and to support people living independently for longer. Without this we can expect to see more people needing long term care packages and an increase in care home placements. Without intervention, the likely demands will increase.

3) PROPOSED SERVICE SPECIFICATION

The proposed specification details overarching aims and service standards which are described below.

3.1) The overarching aims of the intermediate care specification are to:

- 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 be 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

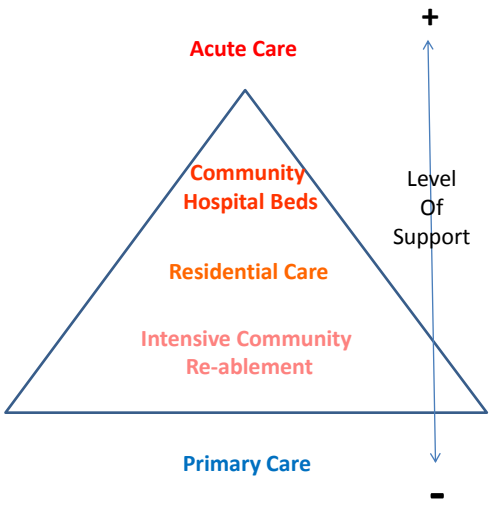
- Delivery services in partnership with health and social care, forming multidisciplinary integrated teams; including support staff, therapists, social workers, mental health, medical practitioners and nurses and the falls service.

- Deliver timely, cost effective, efficient services and nurses and the falls service

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

Table 1 illustrates the conceptual model provided by the CCG:

Conceptual Model of Community Based Intermediate Care



Location	Services
Frimley Park Hospital	Acute 24/7 hospital care
Wokingham Maidenhead Windsor	Nurse led community hospital beds – bed based nursing 24/7
Local Economy	Contracted beds supported in by MTD teams provides 24/7 care
Patient's home in community	Multi-disciplinary (MTD) teams of health and social care providing intensive care and re-ablement 8am - 10pm, 7 days a week
Primary Care	GP led including OOH, Community nursing teams, Integrated Care Teams (ICT) Home Care Packages 8-8 , Falls and Re-ablement, Falls Free 4 Life, Rapid Assessment Community Clinic, Urgent Care Centre

3.2) The service standards for the new specification ask for:

- The patients GP will receive notification (a triage report) and the outcomes (Management plan) that one of their patients has been reviewed and or treated by the service

- During operational hours each referral it to be responded to and triaged within 2 hours, and a management plan is negotiated between the service, referrer, referee and / or next of kin

- Those patients requiring community hospitalisation, referrals will be responded to and admission arranged on the same day basis, within 4 hours, whenever a bed is available

- Following triage, those patients considered most at imminent risk of hospital admission and accepted for the service, are to be offered same day support or within 24 hours of triage

- For those patients considered not at imminent risk of hospital admission and deemed appropriate for the service then an assessment will be undertaken between 48 and 72 hours

- Intensive community care and re-ablement which is provided from 8am to 10pm, 7 days per week. Where deemed appropriate telehealth / telecare will be used to support individuals during the silent hours

- The service will ensure robust data collection processes are in place to record relevant data defined in the specification. These will be communicated with the commissioner as detailed.

- Within 24 hours of discharge from the service, effective written communication is to be fed back to Primary Care and to other partners associated with the individual's on-going care. Where applicable a management plan will agree with the patient and the care co-ordinate to help with self care and prevention. Management plans will be shared with those involved in the individuals ongoing care

4) PROPOSED OPERATING MODEL AND PATHWAY

3.1) This section of the business case provides commissioners with the detail behind the proposed operating model. Beginning with the underlying principles that a person using the services should expect, presented as I statements.

- *"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 have the care and the equipment needed to keep me in my own home rather than having to move into residential care"*

- *"I will be able to stay in my own home safely with the right level of care if my needs increase"*

- *"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"*

4.3 The approach:

The intermediate care service will follow the key principles of:

4.3.1 Pace:

To achieve successful Intermediate Care it is imperative the service remains focused upon the goals that have been set, and does not stray too far into providing support similar to a classic domiciliary care service. To ensure this is the case, the team would work with a multi disciplinary approach, focusing on goal planning, reviewing and exiting for the service. This will ensure that we are able to offer the service to the greatest number of people and we do not have to turn people down for the service. Table 2 shows the proposed pathway with timescales.

4.3.2 Communication:

Clear communicated with the individual and their carer about the approach, the goal planning, expected level of support, expected data of discharge. It will be clear the service is until goals have been achieved and not necessarily for 6 weeks.

4.3.3 Cognition:

People with dementia / or other cognitive impairment have traditionally not been included in the provision of Intermediate Care Services. We can see from data within the JSNA that we can anticipate an increase of 310 people over the age of 65 with dementia by 2020.

Nationally, figures suggest that someone with a cognitive impairment can stay in hospital significantly longer than someone who does not. This extended length of stay can adversely impact on the individual's ability to return to their own home, as the levels of disorientation increase in the hospital setting, as well as an increased risk of falls and infection.

Despite a view that someone with dementia 'doesn't have rehab potential', there are great opportunities to support the re-orientation of the person back into their own home, routines and familiarity. This approach can reduce the need for expensive residential placements. People with dementia can benefit from an early supported discharge into step down beds where routines and personalised care can be established

The input of a Community Psychiatric Nurse within the proposed model, will ensure that appropriate levels of support are offered and that goal planning is tailored to the needs of the individual and reflects their cognitive abilities.

4.3.4 Carers:

To provide effective intermediate care services it is imperative that our approach is collaborative. People and their circle of support need to be actively involved in decision making and participate in the programme. In order for people to be fully involved in

decisions about their care, the purpose and the journey through intermediate care needs to be clearly communicated to referrers and people using the service.

Support from the person's family and local community is essential, when the person wants it, to help them achieve their goals therefore a whole family approach needs to be adopted and they too should be involved in decision making. It is important that carers are supported in their own right in in a timely way find out if they wish to continue in their caring role and if so, enable them to maintain their health and wellbeing.

A carer's assessment will be offered for the carer in their own right. This will be discussed at each stage in the proposed care pathway.

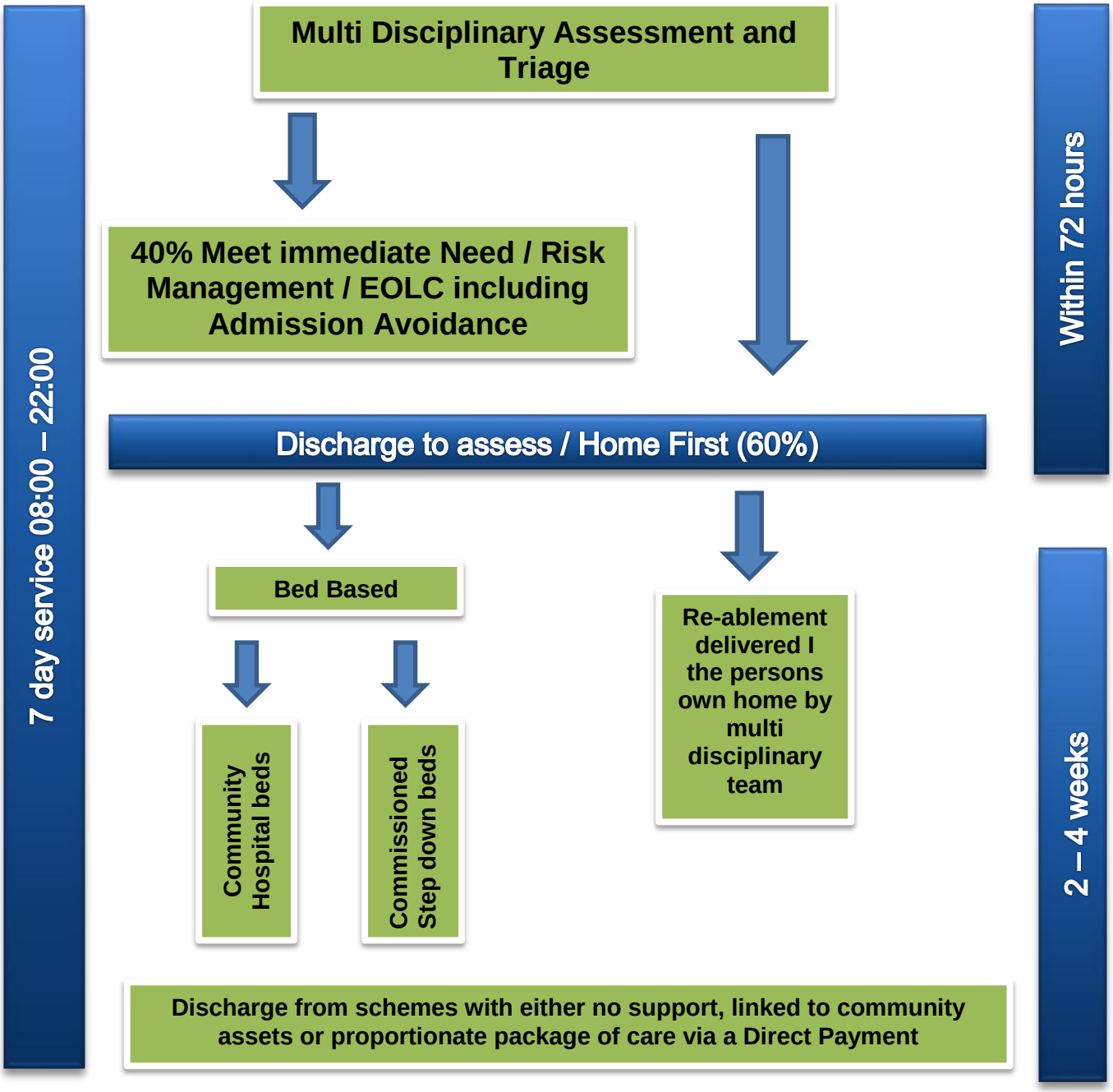
4.4) Criteria

Intermediate care services typically have criteria that can be restrictive with lost opportunities for particularly cohorts of people. This proposed model will work on a default position of services accessible to all with an 'exception criteria' in place for areas of care that would be unsafe to deliver.

E.g. a decision will be needed as to whether we will support people on IV medications / who need oxygen etc. This would need to be worked up in collaboration with health partners.

The Operating Model:

Diagram (2)



The table below identifies the proposed pathway for people in receipt of the service:

Diagram: 3

Triage		
2 hours	**4 hours**	**24 hours**
Referrals are responded to Management plan in place	Referrals to community hospitals responded to and admission arranged within 4 hours where there is a bed available	Point at which those at imminent risk of hospital admission are accepted and services offered

Timeframe	Activity	Detail
Within 72 hours *(or 3 working days if over a weekend)*	Goal plan in place Initial EDD set Escalation plan completed and shared with key professionals e.g. ambulance trust and primary care	Including risk assessments as required Carers involved in goal planning Consideration of CHC checklist

Timeframe	Activity	Detail
End of week one	Goal planned reviewed Initial EDD reviewed and communicated with the person Identify any issues that may delay discharge from the scheme Identify if carers assessment is required	Next steps discussed at MDT and communicate to the individual Discussion as to whether other clinician's / specialists need to be involved in support Carers involved in goal planning Consideration of CHC checklist

Timeframe	Activity	Detail
End of week two	Goal planned reviewed Care calls recalibrated Discuss discharge date with the individual and what plans need to be in place Identify if carers assessment is required	Identify those who required onward care and apply for funding Refer for financial assessment if required CHC Checklist?

Timeframe	Activity	Detail
End of week three	Individual discharged from the scheme	Information given on community assets GP informed of the intervention and onward care if required Long Term package of care put in place if required

There are many different tools for delivering goal plans. The team are in the process of identifying the most appropriate tool. This will be done with consideration of how the Frailty Index (where completed) can compliment this.

The re-ablement assistants currently in place will provide direct re-ablement under the supervision of the therapy staff. There will be additional re-ablement workers to be able to provide in-reach into the re-ablement bed service, and cover the added demand from reducing bed based care from 10 to 4 beds.

5) Service description

Each stage of the pathway as illustrated in diagram (2) element of the proposed model has been broken down in the next section to provide commissioners with key details of how the service would be run.

And financial information can be found in Appendix (b)

5.1)

Multi Disciplinary Assessment and Triage

The operating model will work on the concepts of "meeting immediate needs then assess" for community referrals and a '***discharge to assess***' concept for referrals received from the hospital as decisions about rehabilitation and long term needs are better made when the person is in a settled and or familiar environment. The referrals will come into the multi-disciplinary triage service and the multi-disciplinary team will determined the onward care decision. We will work with health partners in the acute setting to ensure incoming referrals concentrate on levels of function and medical interventions rather than a recommendation by the acute sector on what service needs to be delivered. The MDT Triage service will ensure that onward care is delivered in the most appropriate setting in the most appropriate way.

This may include accessing services beyond the confines of the intermediate care service across the health and social care economy, for example a sensory needs referral. The diagram below describes potential services that are available within Bracknell and can be accessed through the intermediate care journey.

Diagram 4:

As the hospital sector will be a central part of the work we do, the hospital social work team will be included into the team. (it currently sits outside of this). The social work team will be extended to include a 7 day function. A key nursing role which is invaluable in supporting the links and relationships between the hospital, social care and the clusters is the Supported Discharge Community Matron as well as identifying people who could be discharged from A+E and EDOU.

The enhancement to the current model includes the addition of a mental health practitioner. This will enable the intermediate care service to support a larger cohort of individuals. At present 30 – 40% of hospital delays can be attributable to a primary diagnosis of dementia or related cognitive impairment. These delays are typically the ones with greater length of stay, as the pathway is less clear.

The specification outlines the need for a 7 day service. The model has highlighted the types of staff required to run an effective 7 day Intermediate Care Service. It should be noted that the model provides a proportionate 7 day response, which reflects the current health and

social care economy, but may wish to grow as the acute trust and external providers improves its 7 day offer particularly around discharges.

The patients GP will receive notification (a triage report) and the outcomes (Management plan) that shows the intervention provided by the Intermediate care team.

The out of hour therapy service will concentrate on both admission avoidance and discharges. With a focus on goal planning, providing equipment and completing risk assessments for new people who have joined intermediate care over the weekend as well as signing off support plans for those who no longer need to use the service.

Table (2) describes the out of hour's service level:

Post	Hours of work	Days of the week	Comment
Social Work cover	10:00 – 15:00	Saturday and Sunday	To work in Frimley Park Hospital to: Meet with families Undertake new assessments, Restarts of care packages Support people home form A&E / CDU
Weekend OT cover	10:00 – 15:00	Saturday and Sunday	Urgent assessments in persons own home Assessing new people onto the service Provide in-reach to bed based service
Physiotherapy cover	10:00 – 15:00	Saturday and Sunday	Reviewing support plans Assessing new people onto the service Provide in-reach to bed based service
Community Nursing		Saturday and Sunday	Cover to respond to clinical reviews / assessments
Permanent Discharge Coordinator post	09:00 – 17:00	Monday - Friday	Role is due to be piloted for a 6 month period through BCF funds
Management Cover (on call)	10:00 – 15:00	Saturday and Sunday	To enable decision making
Support available weekends for ICS service	Friday 17:00 – Monday 09:00	Friday to Monday	Resolve any queries

The 7 day aspect of the intermediate care service will require a different governance arrangements than on weekdays. It will be necessary to set up rapid interventions the community and to agree packages for discharge from hospital.

Weekend workers will be encouraged to work adopt an earned autonomy, whereby they can spend against budgets up to an agreed level. Where there are risks of a need for professional support, back up can be provided by current out of hour's services, namely the Health Hub and the Emergency Duty Service (EDS). These back up functions can also provide the lone working monitoring.

Structure charts and staff costings can be found in appendix (b)

5.2)

Meet immediate Need / Risk Inc. Admission Avoidance 40%

The proposed model focuses not just on our work on Delayed Transfers of Care, but equally importantly a focus on admission avoidance work to enable people to receive care outside of the hospital setting. This may be for people previously unknown to the local system, or for those with a long term condition whose condition has deteriorated due to issues such as a UTI, COPD, Pressure ulcers, falls and fluctuation of need due to a long term condition, or an unexplained deterioration in need.

It is proposed that 40% of the Intermediate Care Service is focused on admission avoidance, managing immediate need and right sizing care.

Physiotherapy, Occupational Therapy and re-ablement support will provide within a 2 hours window from referral over an extended period each day during the week (08:00 – 20:00), and between 10:00 – 16:00 at weekends. The service will be available for up to 5 days and will need to be supported by the individuals GP. Not only will this reduce the number of non elective admissions into hospital, but also not place unnecessary pressure on external care providers and adult social care budget pressures as any increase in care is likely to be temporary.

Integrated support planning will be essential and likely to involve a greater spectrum of professionals and specialities. This will reflect the cluster model of service design and risk assessment. A plan will be put in-place that can be communicated with the ambulance trust and the GP.

The service will continue to be offered to people at the End of Life to avoid unnecessary admission into hospital and to enable people to die in their preferred place if this is home. Currently the service provides an end of life service to between 2 – 4 people per month with a maximum of 5 people at any one time. It is anticipated that this number will grow in the future due to the predicted growth of the older persons' population in Bracknell and the service needs to be able to flex accordingly and any growth monitored. At present BFC are commissioned £50,000 to provide the End of Life service, but in reality the level of service provision costs £245,000.

There needs to be an infrastructure to manage the care particularly over night and at weekends. Equipment, Telecare and Telehealth will be central for the success of rapid response services and immediate access to equipment would need to be established with both Forest Care and Nottingham Rehab Services (NRS) to ensure same day delivery. Commissioners can anticipate an increase to equipment spend as the number of same day deliveries increase.

Intermediate care support workers within Bridgewell House currently support primary care by undertaking observations on people who use the service. This is done routinely on the day that the GP visits and also when a specific person requires a GP visit. This has proved helpful in monitoring the individual's vital signs and has also supporting ambulance service if they need to attend.

We will need to work with the hospital to ensure that on discharge we have clear information of the observations that require monitoring and what is within the normal range for that person. The community nurse attached to the triage service would be able to monitor the recorded observations.

We are currently working with BHFT to ensure that competency levels of intermediate care support workers are regularly monitored. With a proposal to develop the admission avoidance area of the service, it would be advantageous to extend this skill base to the community team.

For some people it may be necessary to provide a night call, to turn, toilet, medicate or offer reassurance to the individual and / or their carer and as such the service will need to be able to respond to this. Or to provide informal carers the training to be able to do some care tasks out of hours where they wish to do so. It is recommended that the intermediate care service commission Forest Care to deliver these night time calls. Details of the service available can be found in appendix C, and the proposed costings in appendix d.

5.3)

Discharge to Assess / Home First 60%

The Integrated intermediate care team will determine the onward care journey for someone leaving hospital using a 'discharge to assess' model. The focus will be on 'home first' practicing the philosophy that everyone has a bed, and intermediate care is best delivered in the persons own home.

Discharge to Assess reflects the fact that the hospital environment is not the most appropriate place to determine long term needs. There is an element of institutionalisation in the hospital setting and the environment is not conducive to identify strengths and goals to achieve independence.

Where there is a night time need, due to high risk of falls and thus readmission, or a cognitive impairment that requires a high level of monitoring, it is advised that a bed based resource is available for a small cohort of people.

Irrespective of destination, the team will work with the individual to determine clear and measurable re-ablement goals **within 72 hours** of the service commencing. Within this period the **Expected Date of Discharge (EDD)** will be set. (as detailed in Diagram 3).

It is anticipated that the general length of stay on re-ablement will be 3 weeks. The service needs to invest in adequate resource of Physiotherapy and Occupational Therapy to ensure that the length of stay does not stray from this unnecessarily.

Continuing Health Care check list will be completed in the community where appropriate with a view that the hospital is not the most appropriate setting to assess the onward health needs.

A tracker tool will be developed and updated by the lead professional to be able to monitor peoples movement through the system and address any issues.

Due to the high number of people moving through the acute setting, it is not possible for therapist in the acute sector to undertake home access visits with either the individual or by themselves. Where there is a very complex situation this will be undertaken. It is important that the therapy staff listen to the individual and informal carers to understand the home environment and whether there are any challenges that may impact on discharge.

It is good practice for the therapy team to meet the individual in their own home on day of discharge. To enable this to happen it is advised that discharges from hospital are early in the day to enable and OT visit on the same day and any equipment issued and installed.

5.4

Bed based step down services

To deliver against a new model of bed based care would not only include investment into the actual care and lodgings but also a requirement to invest into the community re-ablement and triage services as well as the commissioning of a bed based service. In decommissioning the service at Bridgewell there will be a financial liability to the local authority due to redundancy payments. This figure is not known at this time.

This model recommends a bed based step up / step down service using 4 beds (a reduction of 6 beds). Bed based services will be provided either within the community hospital setting, or via commissioned beds within the Bracknell locality (based upon a cost of £800p/w). By making the assumption that re-ablement will be provided for no longer than 3 weeks, with a void factor of 21 days per annum, one can assume there will be capacity for 16 episodes of intermediate care in each bed. The total capacity for 4 beds would be 65 episodes / individuals through the scheme per annum.

Costings for this can be found in appendix C. The service will be provided in an independent care facility with the support of the community service. This will include support from the therapy staff to develop goal plans and monitor progress against them. Provide appropriate

equipment, and provide the care home with clinical nursing support to ensure that people with moderate levels of medical support can be managed within the facility. It will be necessary for the nursing staff to play a pivotal role in the triaging of individuals to the most appropriate placement and also to support the home in the ongoing nursing support whilst they remain in the homes care.

This will be essential to provide the care home with the level of assurance they require for their registration purposes and to reduce the likelihood of readmissions into hospital. (The current levels of readmissions from the Bridgewell Centre currently is particularly high). This will need to be over a 7 day period.

The current take up of community hospital beds in the Bracknell Forest Council location is lower than in the two other East of Berkshire localities. Although we would not wish to encourage unnecessary admission in to community hospital, it appears that the hospitals are not making referrals. The future model will ensure that the triage function will determine onward care rather than referrals directly from the acute setting.

5.5)

Discharge from service

The operating model focuses on the need for timely, goal focused care. When an individual comes to the end of their intermediate care services the exit from the service needs to reflect the same pace, and delays at this point will impact on the whole service / system. (At the time of writing there are 270 hours of unallocated care with brokerage awaiting a care provider. Some of which will include hospital discharges and people receiving care from ICS who no longer have active goal plans.

The new domiciliary care contract is due to be in place in the Spring of 2017. It will be imperative that the new contract addresses the current capacity issues, and be able to pick up care across the whole of the Bracknell Forest Council geography.

Work will also be required with the residential and nursing home market. Firstly to raise their confidence in managing situations which current results in an avoidable hospital admission, such as End of Life care, and secondly to be able to take on new placements over the weekend. Work will be required to build confidence and relationships between the care home and the acute trusts.

A proportion of people who use the service will have no onward care needs. It will be the responsibility of the lead professional to ensure that the person has been signposted to service they may wish to get in contact with.

At the end of the involvement a letter detailing discharge from the scheme will be sent to the GP we will work with GPs to ensure the content is helpful.

The intermediate care re-ablement team structure is provided in Appendix (C). The structure includes the addition of a deputy to the registered manager to ensure that there are is resilience to make decisions on new cases and ensure pace and safety is maintained

6) PROPOSED PERFORMANCE INDICATORS:

6.1) To monitor the effectiveness of the service, a range of performance indicators have been suggested.

- 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 LOS in ICS 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 GP's who receive a discharge summary

The delivery group will also design a range of reporting tools to enable commissioners to scrutinise activity levels and service outcomes.

6.2) Recording mechanism will be put in place and contract monitoring arrangements will need to be put in place by commissioners.

7) Finances

The following assumptions were made in developing the costings for the proposed model:

- - Physiotherapy posts are shown as on a Health Grade
- - All posts (Council and Health staff) are shown on the mid-point of the grade
- - Assuming all posts are in the Local Pension Scheme (Council Staff)
- - Assuming that Health have the same on-costs as the Council (23%)
- - Assuming £1,000pa mileage costs for staff whose majority of time is spent out of the office - £500pa for other staff (exc. admin)
- - £30,000 for additional equipment plus £6,000 for urgent deliveries
- - Assuming that weekend working will be an additional half time per hour on Saturday and an extra time per hour on Sunday
- - CPN costs at band 6
- - Forestcare costs as suggested by Forestcare

The total cost of the proposed service is **£2,455,356** against a current budget of **£2,436,818**.

This is an obvious increase in costs of **£18,538**.

Additionally, as this work has developed it has transpired that the EOLC service is under funded by the CCG's to a total of £195,000. (see section 5.2). If this were to be invested into the ICS service, the current level of EOLC can be continued.

Detail can be found in appendix (c)

This figure does not account for potential redundancy costs as a result of the decommissioning of the Bridgewell Centre. This financial risk has yet to be calculated. Equally, the costs of disposing of the Bridgewell Centre have not been included in these calculations.

8) IMPLEMENTATION:

8.1) Workforce:

Despite the workforce being in place already, there will be a need for consultation if the working hours and days of week change for social workers and therapists as well as potential redundancy costs associated with Bridgewell.

Staff would be involved in the development of processes, and training would be required to ensure workforce is fully appraised of the new ways of working. This will include the development of a training needs analysis which will need to be costed.

8.2) Communication:

Due to the complex landscape within the health and social care economy it will be imperative to ensure that all partners are aware of changes to the operating model. A draft communication's plan can be found in Appendix (C).

8.3) Operational delivery

An operational group will be set up to manage the delivery of this specification and to trouble shoot issues as they arise.

Multi disciplinary meetings will be held twice a week to discuss cases, problem solve and to ensure that all individuals using the service move through the pathway in a timely way.

9) FUTURE OPPORTUNITIES

- Earned autonomy in place for practitioners
- Holistic health and social care roles to reduce duplication of tasks
- Role of psychology in service for those with long term conditions
- Connected care will have an advantageous impact on information sharing and communication
- Potential for using Wokingham Community Hospital beds rather than St Marks Community hospital beds in Maidenhead

- Overnight not in the spec, to move away from any bed based resource a community night service would be required
- Approach neighbouring local authorities to see if there is scope to offer reciprocal arrangements where there are care needs on the boarder, or a lack of capacity.

APPENDIX (A)

Activity data:

Table 1: Data referencing number of hours, number of hours and average length of visits between September 2015 and September 2016.

Month	Hours	Visits	Average length of visits (mins)
Sept 15	20258	33016	36.8
Oct 15	20524	33670	36.6
Nov 15	18652	31170	35.9
Dec 15	18274	30568	35.9
Jan 16	18503	31038	35.8
Feb 16	17228	28202	36.7
Mar 16	17897	29594	36.3
Apr 16	17348	28489	36.5
May 16	17273	29037	35.7
Jun 16	16717	27967	35.9
Jul 16	17087	28455	36.0
Aug 16	17118	27421	37.5
Sept 16	15871	26701	35.7

Table 2: Further detail, January 2016 – August 2016

Month	Number of people on service	EOLC	Right Sizing	Hours at start	Hours at end	Waiting on POC	Admitted to hospital	Returned to pervious levels	Currently still receiving ICS
Jan 16	34	5	4	7.00	3.50	1	9	14	1
Feb 16	37	8	6	8.50	0.50	0	4	16	3
Mar 16	37	5	6	11.00	1.00	2	5	14	5
Apr 16	41	3	19	23.50	1.00	0	4	18	16
May 16	33	6	9	15.00	1.75	1	5	11	11
Jun 16	42	9	14	18.25	1.75	0	7	2	9
Jul 16	34	1	8	9.50	3.50	1	8	4	3
Aug 16	48	1	14	19.50	-	1	-	-	-

Table 3: Number and percentage of people in receipt of services from January 2016 to 13th October 2016 by source of referral

	Community	Bridgewell	Community Hospital	Acute Hospital
End of Life Care	31	0	0	12
% End of Life Care	**72**	**0**	**0**	**28**
Reablement	97	7	29	180
% Reablement	**31**	**2**	**9**	**58**
Total	128	7	29	192
% Total	**36**	**2**	**8**	**54**

Intermediate Care - Bridgewell				
	Community	Community Hospital	Acute Hospital	Total
Reablement	4	6	48	58
% Reablement	**7**	**10**	**83**	

End of Life Care costings	
The average number of hours a person receives a service Generally all end of life care is double up care	4.5 2
Average length of stay on service is 3 weeks (21 days)	21
Cost of service per hour is £25	25
Total cost per person (£)	**4725**
Number of People using ICS from 1 Jan 16 to 13th Oct 16	43
Total cost 1 Jan 16 to 13th Oct 16 (£)	203,175

Table 3: Bridgewell Centre data

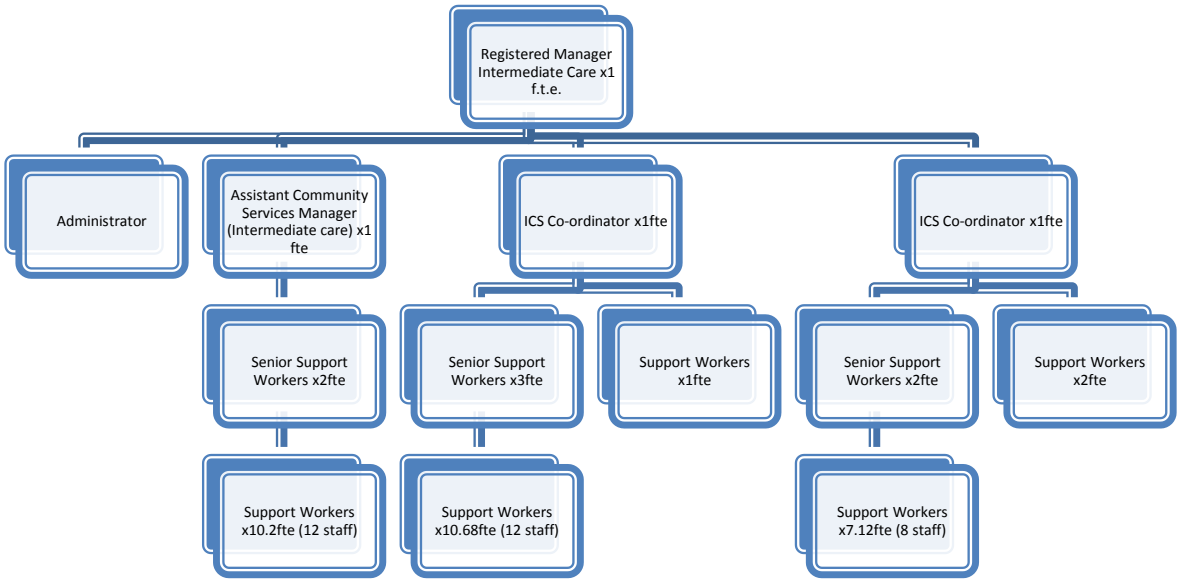
	Apr 15 – Jun 15	Jul 15 – Sep 15	Oct 15 – Dec 15	Jan 16 – Mar 16	Apr 16 – Jun 16
No. of referrals received	40	47	43	36	42
Ref accepted	31	19	27	15	24
Ref withdrawn	-	-	3	8	13
% accepted	77.5%	40.4%	62.8%	41.7%	57.1%

Appendix (b)

Intermediate Care Supervisory Structure Chart

Staffing levels based on x50 people on the service at any one time. 7 day a week service.

ICS Support Worker Structure
Supervisory ratio of 4:1 and 3 week rolling rota.
The full time equivelent of support workers is 35. However there are 39 staff. Therefore the ratio of supervisors to support workers is 3.56 fte but this equates to 4 staff.



Staffing Requirements

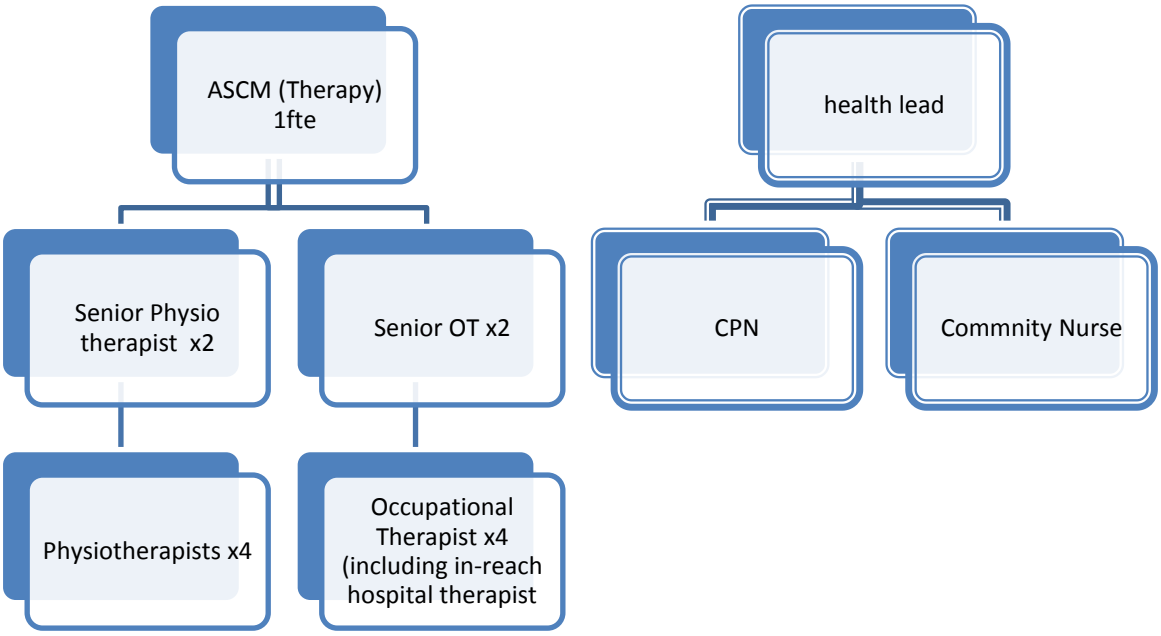
Staff grade	FTE	Numbers
Registered Manager	1	1
Administrator	1	1
Assistant Community Services Manager	1	1
ICS Co-ordinators	2	2
Senior Support Co-ordinators	7	7
Support Workers	35	39
Total costs		

Therapy Structure

Assumptions

Only one senior therapist will need to be on out of hours with one therapist.

Based on assumption that there needs to be low numbers (no more than 10 for OT/PT and 5 for each senior) of people on case load but turn-over high.

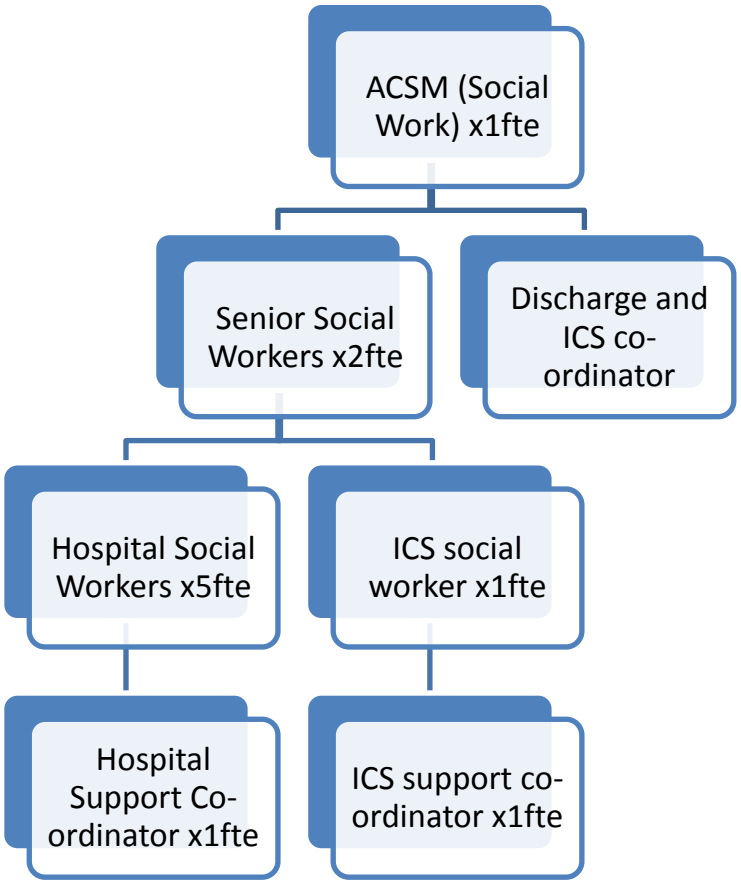


Staffing requirements

Staff grade	**FTE**
Assistant Community Services Manager	1
Senior PT	2
Senior OT	2
Occupational Therapist	4
Physiotherapist	4
Community Psychiatric nurse	22
Community nursing	Nurses - band 7 x 1, band 6 x 1, band 5 x 1
Total	

Social Work Structure

This includes Hospitals (excluding Prospect Park) work for CMHT OA.



Staff grade	FTE
Assistant Community Services Manager	1
Hospital and ICS Social Workers	6
Support co-ordinators	2

Bed Based service

Bed based support based on figures from commissioners:

£800 per week x 52 weeks £41,600 per annum, per bed
£41,600 x 4 (beds) = £166,400

Plus the of intermediate care element

Assumptions made for activity in step up / step down bed

52 weeks per year
- 3 weeks (21 nights) for voids due to turn around of rooms, periods of low demand
= 49 weeks per annum
= 16 episodes of re-ablement per bed per year
= 65 episodes of bed based re-ablement per annum

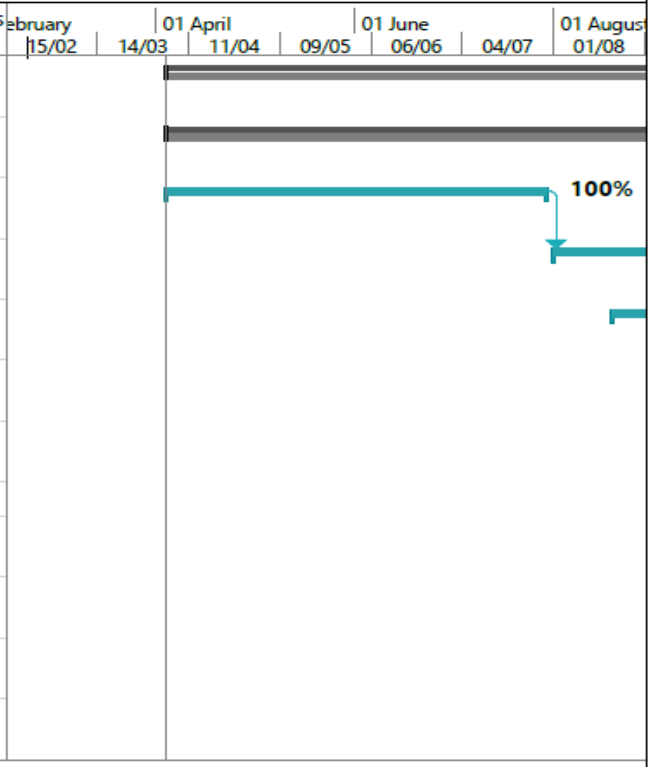
Appendix (C)	FTE	Weeks	Grade	SCP	Salary	LW	On-Costs	Lump Sum	Mileage	Total Costs
Registered Manager	1		D	51	45,256	579	10,542	963	500	57,840
Administrator	1		I	20	19,238	579	4,558	963	0	25,338
Assistant Community Services Manager	1		E	45	39,660	579	9,255	963	500	50,957
ICS Co-Ordinators	2		H	27	47,870	1,158	11,276	1,926	1,000	63,230
Senior Support Co-Ordinators	6		H	27	143,610	3,474	33,829	5,778	6,000	192,691
Support Workers	29		I	20	557,902	16,791	132,179	31,779	29,000	767,651
					853,536	23,160	201,640	42,372	37,000	1,157,708
Assistant Community Services Manager	1		E	45	39,660	579	9,255	963	500	50,957
Senior Physio	1		HEALTH	BAND 7	36,250	1,813	8,754	963	1,000	48,780
Senior Physio	1		HEALTH	BAND 6	30,357	1,518	7,331	963	1,000	41,169
Senior OT	2		F	40	70,186	1,158	16,409	1,926	2,000	91,679
Occupational Therapist	4		G	34	119,416	2,316	27,998	3,852	4,000	157,582
Physiotherapist	4		HEALTH	BAND 5	101,192	5,060	24,438	3,852	4,000	138,541
					397,061	12,443	94,186	12,519	12,500	528,709
Assistant Community Services Manager	1		E	45	39,660	579	9,255	963	500	50,957
Hospital & ICS Social Workers	6		G	34	179,124	3,474	41,998	5,778	6,000	236,374
Support Co-Ordinators	2		H	27	47,870	1,158	11,276	1,926	2,000	64,230
					266,654	5,211	62,529	8,667	8,500	351,561
CPN	1		HEALTH		29,333	0	5,867	0	0	35,200
Community Nursing	1		HEALTH	BAND 7	36,250	1,813	8,754	963	1,000	48,780
Community Nursing	1		HEALTH	BAND 6	30,357	1,518	7,331	963	1,000	41,169
Community Nursing	1		HEALTH	BAND 5	25,298	1,265	6,109	963	1,000	34,635
					121,238	4,595	28,062	2,889	3,000	159,784
On-Call Allowance @ £140 per weekend		52			7,280	0	1,674	0	0	8,954
4 Beds per week @ £800 pbpw					0	0	0	0	0	166,400
Additional costs for delivery of equipment					0	0	0	0	0	36,000
Forestcare costs					0	0	0	0	0	5,900

Weekend Working:										
- Senior Physio (Band 7)	1	9	HEALTH	BAND 7	1,882	0	433	0	0	2,315
- Senior Physio (Band 6)	1	9	HEALTH	BAND 6	1,576	0	363	0	0	1,939
- Senior OT	2	18	F	40	3,634	0	836	0	0	4,470
- Occupational Therapist	0	34	G	34	0	0	0	0	0	0
- Physiotherapist	0	34	HEALTH	BAND 5	0	0	0	0	0	0
- Hospital & ICS Social Workers	0	52	G	34	0	0	0	0	0	0
					14,373	0	3,306	0	0	225,979
Discharge Co-Ordinator	1		H	27	23,935	579	5,638	963	500	31,615
					1,676,797	45,988	395,361	67,410	61,500	2,455,356

Appendix (e)

Intermediate Care Project Plan v1.3.mpp

ID	Task Mode	Task Name	Duration	Start	Finish	Predecess
1		**Community Based Intermediate Care**	**477 days?**	**Mon 04/04/16**	**Tue 30/01/18**	
2		**Planning**	**247 days**	**Mon 04/04/16**	**Tue 14/03/17**	
3		Options Appraisal	85 days	Mon 04/04/16	Fri 29/07/16	
4		Development of Business Case	65 days	Mon 01/08/16	Fri 28/10/16	3
5		Development of Spec with Partners	51 days	Fri 19/08/16	Fri 28/10/16	
6		Comms Plan	27 days	Thu 22/09/16	Fri 28/10/16	
7		Breakout Budgets of existing services	124 days	Thu 22/09/16	Tue 14/03/17	
8		Develop Draft JDs	103 days	Fri 21/10/16	Tue 14/03/17	
9		**Approvals**	**23 days**	**Wed 15/03/17**	**Fri 14/04/17**	**2**
10		CMT Approval	0 days	Wed 15/03/17	Wed 15/03/17	
11		Staff Engagement	2 days	Wed 15/03/17	Thu 16/03/17	10
13		Project Approved by Execs	0 days	Tue 11/04/17	Tue 11/04/17	10,11,7



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Project Summary
External Tasks
External Milestone
Inactive Task
Inactive Milestone
Inactive Summary
Deadline

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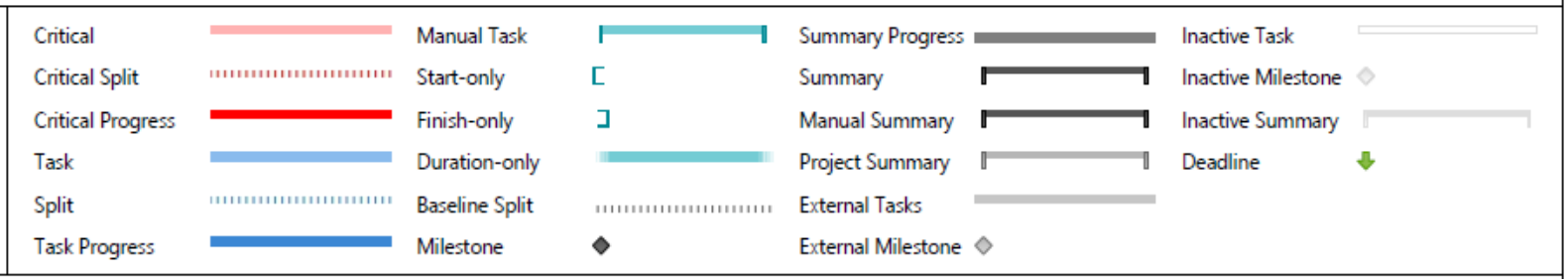
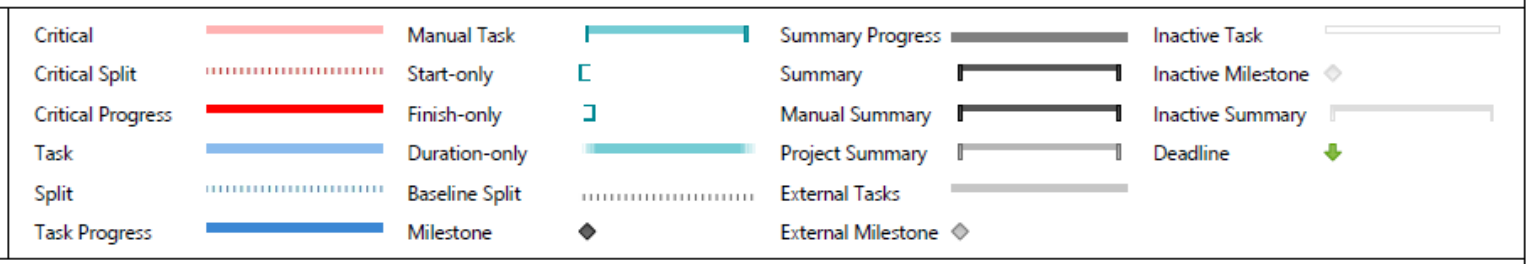
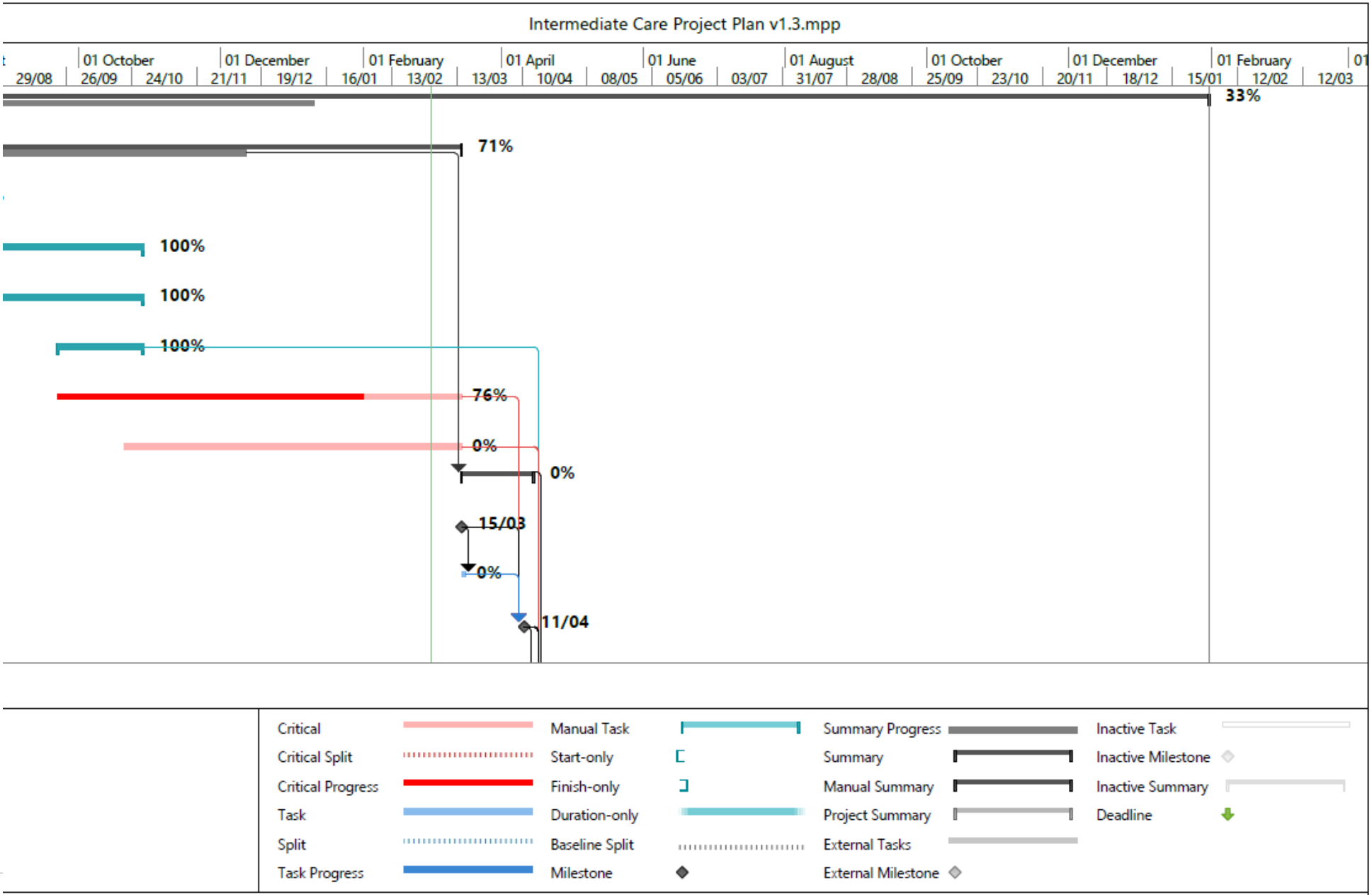
ID	Task Mode	Task Name	Duration	Start	Finish	Predecess
30		Commissioning Bed Base Capability	60 days	Mon 17/04/17	Fri 07/07/17	13
31		Decommissioning of existing service	60 days	Mon 10/07/17	Fri 29/09/17	30
17		Key Staff Recruited / Transferred	0 days	Thu 31/08/17	Thu 31/08/17	25
19		Training / familiarisation	5 days	Mon 04/09/17	Fri 08/09/17	17,29
18		Key Staff Inplace and Trained	0 days	Mon 11/09/17	Mon 11/09/17	19
32		**Go Live / Monitoring**	**102 days?**	**Mon 11/09/17**	**Tue 30/01/18**	**18**
33		Post Launch Comms (see plan)	20 days	Mon 11/09/17	Fri 06/10/17	18
34		Monitoring	65 days	Mon 02/10/17	Fri 29/12/17	18
35		Project Closure	22 days	Mon 01/01/18	Tue 30/01/18	34
36		Business as usual	0 days	Fri 29/12/17	Fri 29/12/17	34
37						



Intermediate Care Project Plan v1.3.mpp

ID	Task Mode	Task Name	Duration	Start	Finish	Predecess
12		Staff Engagement	4 days	Tue 11/04/17	Fri 14/04/17	13
14		**Service Mobilisation**	**120 days**	**Mon 17/04/17**	**Fri 29/09/17**	**9,13**
28		Comms Engagement (see plan)	99 days	Mon 17/04/17	Thu 31/08/17	6,13
15		Staff Consultation	30 days	Mon 17/04/17	Fri 26/05/17	13,8
16		Union Consultation	30 days	Mon 17/04/17	Fri 26/05/17	8,13
20		Stakeholder Consultation	56 days	Mon 17/04/17	Mon 03/07/17	13,8
21		Recruitment Gateway	0 days	Fri 26/05/17	Fri 26/05/17	15,16
22		**Staff Recruitment**	**69 days**	**Mon 29/05/17**	**Thu 31/08/17**	**21**
26		Advert and Replies	21 days	Mon 29/05/17	Mon 26/06/17	21
24		Sift and Interviews	20 days	Tue 27/06/17	Mon 24/07/17	26
23		Offers Issued / accpetance by New Staff	4 days	Tue 25/07/17	Fri 28/07/17	24
25		Notice period for new staff	24 days	Mon 31/07/17	Thu 31/08/17	23
27		Development of pathways and SOPs	56 days	Mon 03/07/17	Mon 18/09/17	20
29		TNA & Training Development	60 days	Mon 29/05/17	Fri 18/08/17	21

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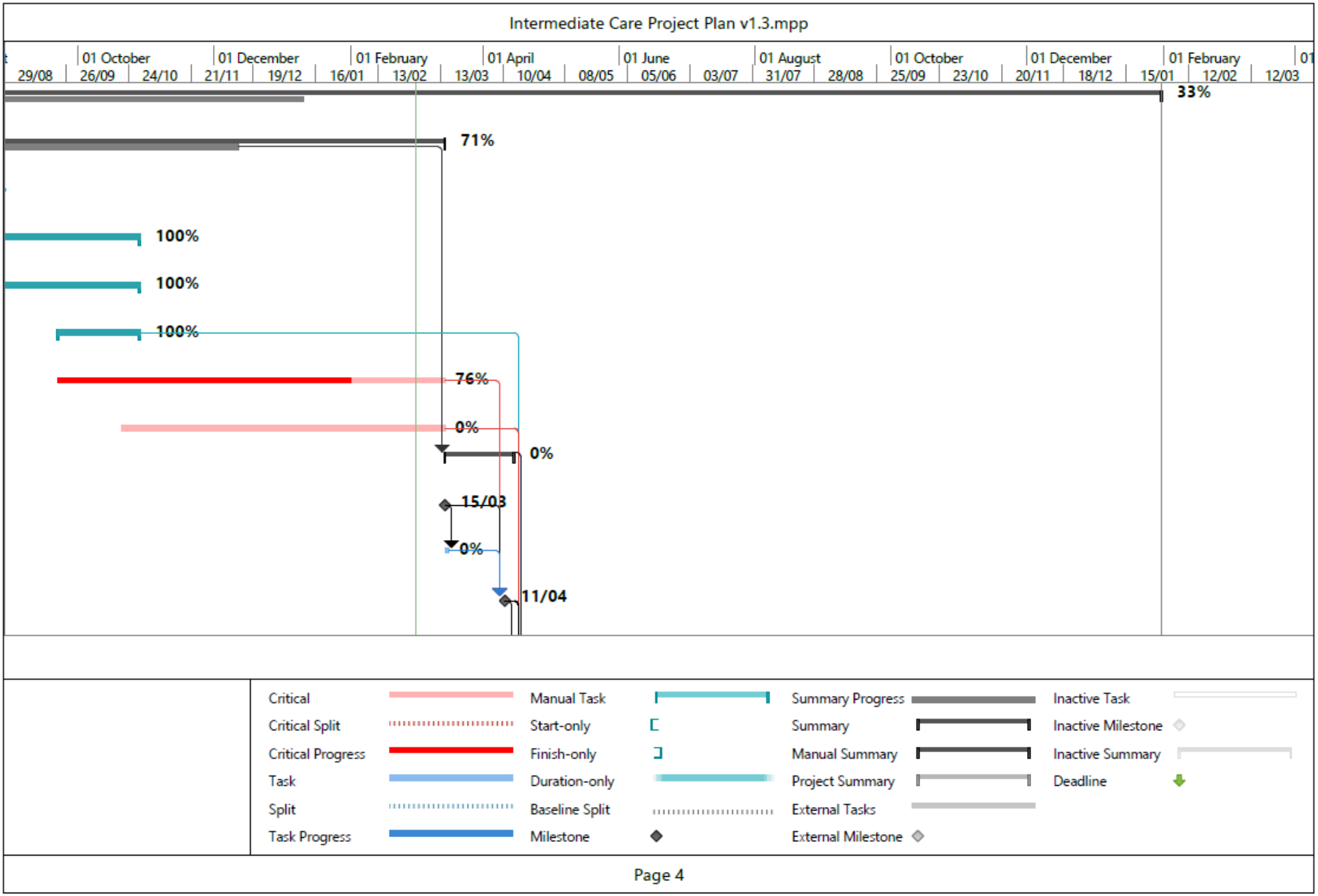
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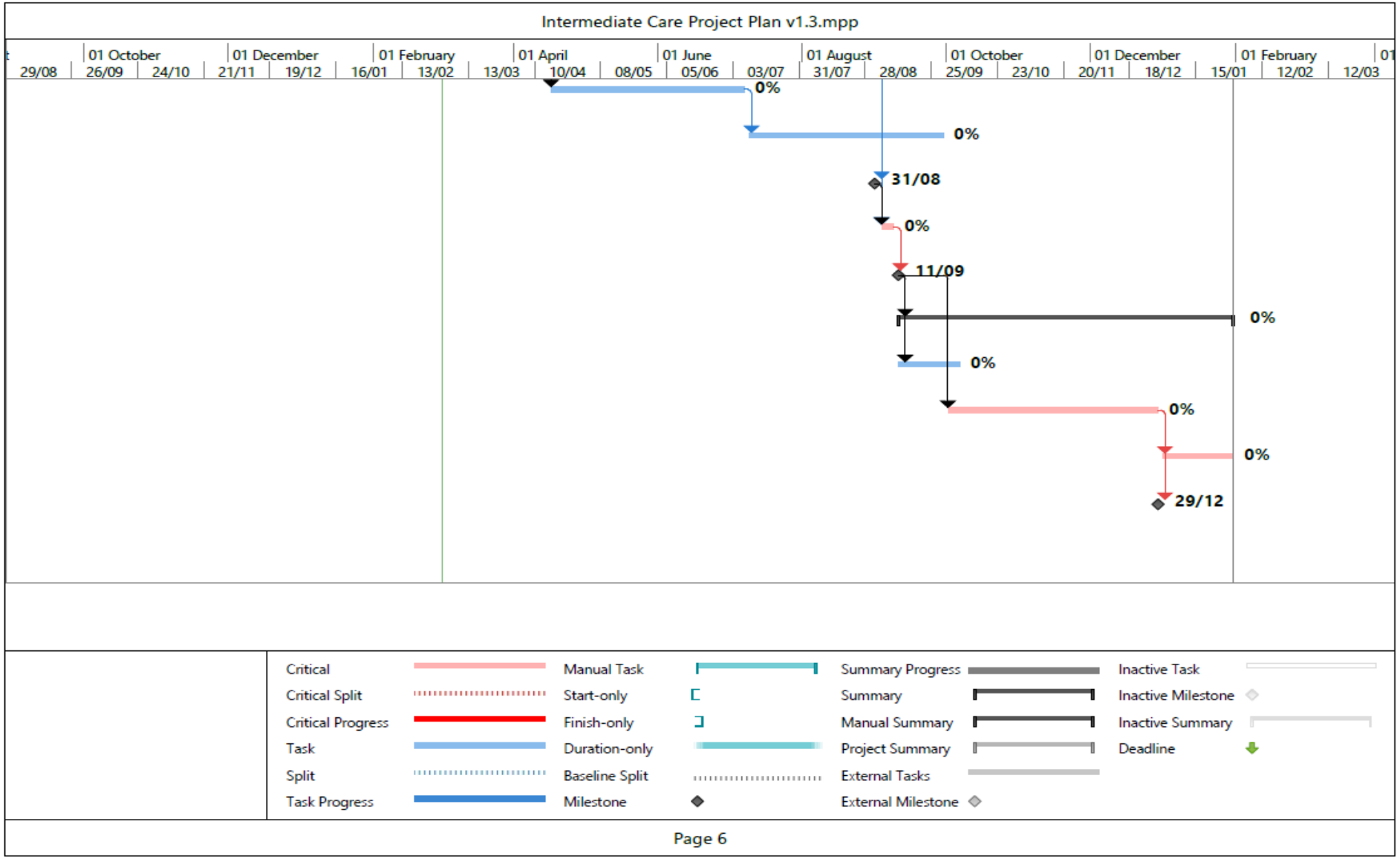
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