# HEALTH AND WELLBEING BOARD

## 9 SEPTEMBER 2014

| **Title:** | **Intermediate Care Consultation** |
|---|---|
| **Report of the Accountable Officer, Barking and Dagenham Clinical Commissioning Group** | |
| **Open Report** | **For Decision** |
| **Wards Affected: All** | **Key Decision: No** |
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| **Sponsor:**<br>Dr J John, Clinical Director Barking & Dagenham CCG | |


**Summary:**

This report will detail the progress made to develop and trial two new home based intermediate care community services in Barking and Dagenham.

It will detail the case for change in the model of intermediate care, informed by evidence gathered through the trial.

It will provide an overview of the consultation process currently underway and detail the preferred option of the CCG.

It will request the HWBB support the intermediate care consultation process and note the preferred option of the CCG.


**Recommendation(s):**

The Health and Wellbeing Board is asked to note and comment on:

- the outcome of the trial of the new services and case for service change
- the preferred option of the CCG
- the current consultation process

## 1. Background and Introduction

1.1 Barking and Dagenham CCG and the London Borough of Barking and Dagenham have been working with Havering and Redbridge CCGs and local authorities and NELFT through 2013/14 to develop proposals to deliver improved intermediate care community services in line with the recommendations of the Integrated Health and Social Care Commissioning Strategy including:

- Improving quality and productivity in the community rehabilitation bed base.
- Trialling the provision of home base intermediate care services - intensive rehabilitation service (IRS) and community treatment team (CTT).

1.2 In November 2013, the trial of the expanded community treatment team (CTT) and the new intensive rehabilitation service (IRS) began in Barking & Dagenham.

**Community treatment team (CTT)** - a team of doctors, nurses, physiotherapists, social workers and others who together care for people having a health or social care crisis at home so that they either don't need to go into hospital or return home from hospital sooner. It runs from 8am – 10pm, seven days a week.

**Intensive rehabilitation service (IRS)** - a team of physiotherapists, occupational therapists, healthcare assistants and others offering intensive physiotherapy and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

1.3 In June 2014, following receipt of a pre consultation business case, the Barking and Dagenham CCG governing body agreed to publically consult on the future model of intermediate care in Barking and Dagenham. Havering and Redbridge CCG governing bodies are also consulting on a new model for intermediate care.

1.4 The public consultation 'Making intermediate care better in Barking and Dagenham, Havering and Redbridge' launched on 9 July 2014 and will run until 1st October.

## 2. Case for Service Change

2.1 The pre consultation business case presents the case for service change as a result of evidence gathered through the trial, key headlines of which are as follows:

### Improved service access

2.2 There is confidence in using the new services - both CTT and IRS services have been well utilised during the trial with both services performing above activity trajectories. Over 2000 Barking & Dagenham patients have been seen by the new services to the end of June 2014.

2.3 People are able to access the services more quickly than before the trial. 2012/13 data reported an average of 5 days for patients to access community beds. Since the trial began, patients can now access IRS and community beds within 2 days on average from the point of referral. This performance is better than national averages (4.8 days for home based services and 3.4 days for bed based services). The majority of patients referred to CTT are responded to within 2 hours (faster than A&E).

**Improved patient choice**

2.4 Through provision of appropriate community based alternatives to bed based provision. The system and patients have demonstrated confidence in using the new services. 34% of referrals to CTT are from family/carers/self referral

**Improved outcomes**

2.5 CTT and IRS are demonstrating better outcomes with regard to reducing admissions to acute care when compared to bed based services - 90% of patients receiving care from CTT and IRS are supported at home and do not require admission to hospital (10% require admission). For bed based services, 84% of patients are cared for in a community setting (16% require admission). Prior to the trial 23% of patients receiving intermediate care were readmitted to the acute.

2.6 94% of patients referred to IRS demonstrated improved patient outcomes scores.

2.7 Improved recovery rates, with the average length of stay in community beds 19 days in line with best practice benchmarks (previously 29 days) and average length of treatment in IRS 9 days, providing some evidence that patients are recovering quicker at home.

2.8 83% reduction in hospital acquired clostridium difficile (C Diff) cases.

**Improved patient experience**

2.9 Patient and public engagement to date has indicated support for the new services and approach. Both CTT and IRS have consistently rated high with respect to patient experience, scoring 8.7 and 9.0 out of 10 respectively.

**Improved system performance**

2.10 During the trial we have seen a reduction in A&E attendances, non elective (emergency) admissions and delayed transfers of care.

2.11 In 2013/14 fewer community rehabilitation beds were needed to meet 'winter pressures' than in 2012/13 across the BHR CCGs. In 2012/13, 32 extra beds were commissioned October 2012 to March 2013. In 2013/14 an average of extra 14 beds were commissioned January 2014-March 2014 to meet this demand (only 9 of which were used).

**Too many community rehabilitation beds**

2.12 Productivity improvements and the trial of new services has led to 24% underutilisation of the existing community rehabilitation bed base. This means we have more beds across BHR than we need.

2.13 Activity modelling indicates the required community rehabilitation bed base will range month on month between 40-61 beds (average 50).This is significantly less than the current capacity of 104 beds across the 3 units of Heronwood & Galleon, Grays Court and Foxglove ward at King George Hospital. This modelling has been independently assured by NHS England.

## 3. Consultation

3.1 We are consulting on the future model of services provided by NELFT as follows: community treatment team (CTT); intensive rehabilitation service (IRS); required number of community rehabilitation beds and their future locations.

3.2 Five possible options were developed in partnership with key stakeholders. These options were then reviewed and assessed by the Intermediate Care Steering Group against a range of non-financial (clinical outcomes, safety and quality, patient experience) and financial criteria. Scoring criteria was weighted 60:40 (non financial: financial).

3.3 The preferred option identified by the BHR CCGs is Option 5, outlined in the consultation document:

- Member of community rehabilitation beds in line with demand (flex between 40-61 depending on the month) Continue with CTT and IRS
- Reduce our number
- Locate these beds on one site - King George Hospital

3.4 This option would mean:

- People would continue to benefit from the popular home based services (CTT and IRS) and there would still be access to rehabilitation beds for those that need them.
- The total number of community rehabilitation beds would be reduced - our evidence tells us we don't need the number of community beds we currently have as these aren't being used.
- Community rehabilitation beds commissioned by the Barking and Dagenham, Redbridge and Havering CCGs will be centralised on the King George Hospital site and community rehabilitation beds will no longer operate from Grays Court.

3.5 This is the best option clinically. Clinicians tell us the safest way to provide high quality care is by having bed services in one place. Running one unit would mean we could use staff much more efficiently and flexibly.

3.6 Greatest value for money and best use of resources. We will pay to keep the new services by reducing our spend on community beds and reduce the duplication of costs of running 3 sites

3.7 Consultation period and process:

- 12 week consultation – 9 July to 1 October
- Hard copy consultation documents widely distributed
- Consultation documents are on the CCG website
- Online questionnaire
- Public events will be held in each Borough. In Barking & Dagenham, we have an event scheduled Thursday 11 September at Barking Learning Centre, 4 - 7pm.
- Attending other meetings with community groups and stakeholders by request and actively engaging with key community groups

## 4. Mandatory Implications

### 4.1. Joint Strategic Needs Assessment

Barking and Dagenham expects the size of the older population to increase up to 2020 at a slower rate than England overall. Domain 3 of the NHS Outcomes Framework focuses on helping people to recover from episodes of ill health or following injury. The rate of emergency readmissions in Barking and Dagenham is higher than the London and England rate and commissioners are advised to consider developing care in the community to avoid unnecessary hospital admissions.

### 4.2. Health and Wellbeing Strategy

The Health and Wellbeing Strategy aims to deliver improved health and social care outcomes through integrated services. The new model of intermediate care
supports delivery of outcomes primarily across the theme of improvement – keeping people well and independent and ensuring that they receive the services that they need if they become unwell. We aim to prevent ill health and support people to recover from illness and stay well at home, reducing the need to access secondary care in a crisis.

### 4.3. Integration

The Barking and Dagenham, Havering and Redbridge Integrated Care Coalition has agreed a strategic plan that sets out a number of system objectives to be delivered across the health and social care economy over the next five years. The Coalition has agreed an out of hospital strategy that sets out the programme of work that will deliver improved health and social care outcomes. Developing a new model for intermediate care services is a key work stream of the out of hospital strategy.

In Barking and Dagenham, the new model of intermediate care forms one of the Better Care Fund schemes which contributes to the Better Care Fund ambitions to:

- Reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, closer to home.
- Increasing the proportion of older people living independently at home following discharge from hospital.
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and the community.

### 4.4. Financial Implications

Funding for intermediate care services is planned to be included in the Better Care Fund.

The investments reported in the consultation documentation will deliver better quality whilst also achieving a cost reduction of £929,985 for the preferred

option 5 against the previous model, across the BHR Health economy. As a result, the changes will bring about: cost reductions, improved quality and outcomes, and more patients will have access to services in the preferred model, which ultimately results in greater value for money.

Rob Adcock, Deputy Director of Finance, Barking and Dagenham CCG

**4.5. Legal Implications**

Pursuant to their statutory obligations to consult and guidance, Barking and Dagenham, Havering and Redbridge CCGs have commenced a 12 week public consultation on a new model of intermediate care. The preferred option to provide intermediate care, is set out as option 5 in the consultation paper, but no final decision on the option will be made until the conclusion of the consultation process and all views having been taken into account. The final decision will be made by each CCG governing body subject to the outcome of the consultation.

Rod McEwen, Legal and Governance Adviser, Barking and Dagenham, Havering and Redbridge CCGs

**4.6 Patient/Service User Impact**

Under the proposals more people would have access to quality care, more quickly and with better outcomes.

Patients have expressed very high satisfaction with regard to both CTT and IRS
scoring 8.7 and 9.0 out of 10 respectively.

For many people, retaining the new services will mean that people receive care within their own homes, negating the need to travel-this is an improvement.

Patients are generally transported to community rehab units by patient transport- there will be no change for patients to this.

Depending on where patients' family/friends reside there may be an impact on those family members and friends who do have to travel to visit patients at the KGH site. They won't do this for as long as they would have previously, as improved care means patients recover quicker and are discharged home sooner. There are good transport links to KGH. For visitors from:

- East of the borough very near to Romford with good travel links to KGH - several buses travel from Romford to KGH (387 bus from Dagenham Town Hall for example, takes around 40 minutes).

- South of the borough – 387 bus direct to KGH from the very south = 1 hour travel. This is an improvement in terms of travel, as travel from the very south to Grays Court, although closer, would take the same amount of time with more interchanges (walk, bus, train, bus, walk).

A stage 1 equalities impact assessment was completed as part of the evidence base underpinning the pre consultation business case which in turn informed the consultation plan.

A full equalities impact assessment will be completed during the consultation process, this will include specific engagement with cohorts of patients potentially affected by the proposals.

## 5. Non-mandatory Implications

### 5.1. Property/Assets

There is capacity for 26 community rehabilitation beds at the current sited at Grays Court Dagenham, which is owned by the London Borough of Barking and Dagenham. In addition to the above, Grays Court also accommodates 17 stroke rehabilitation beds - 10 for B&D and 7 for Havering. The Havering stroke beds were moved from St Georges Hospital in November 2012. Grays Court is leased to NELFT.

### 5.2. Contractual Issues

All services subject to the consultation are funded by the CCG and provided by North East London Foundation Trust. From 2015/16, funding for intermediate care services will be included in the Better Care Fund pooled budget. Any changes to the 2015/16 contract will be made following agreement by the commissioners with appropriate notice given to the provider.

## 6. Background Papers Used in Preparation of the Report:

Integrated Care in Barking and Dagenham, Havering and Redbridge: The Case for Change
Intermediate care briefing for stakeholders: November 2013
Intermediate care briefing for stakeholders: March 2014

## 7. List of Appendices:

Appendix 1: Making Intermediate Care Better in Barking and Dagenham, Havering and Redbridge Consultation Document

Pre consultation business case is available via:
www.barkingdagenhamccg.nhs.uk/intermediatecare

Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

# Making intermediate care better

## in Barking and Dagenham, Havering and Redbridge

# Foreword from the clinical directors

As doctors, we want to help people live as healthily as possible, making sure they get the right care, when they need it. As local GPs, we've always known what our patients need and want. Now we're also in a position to lead changes that we believe will make a real difference to local people.

We've always known that people don't want to go into hospital unless they really have to and that if they do, they want to come home again as soon as they can. We also know that they are likely to recover better outside hospital, in a familiar place, close to their family and friends - as long as they also have the right care and support from nurses, therapists and care workers. That's what we want to make happen.

In the past we haven't done as well as we could to provide care for people at home. We've known for some time that in other areas they do things differently and people generally recover more quickly. We wanted to learn from them and provide a different, better sort of care, but we didn't want to make any permanent changes until we knew that they really were an improvement and until we'd heard what patients thought of them. We have looked at evidence from the UK and overseas which shows better results for patients and want to implement this locally. We're pleased to see that the trials of the new community treatment team and the intensive rehabilitation service have helped more people to get care and treatment outside hospital.

We are also pleased to hear from patients and carers that they've appreciated this support at home. This success means we're now in a position to talk about what we do in the longer term.

This document explains what we want to do. Please do read about our proposals, ask us if anything's not clear and let us know what you think about what we want to do.

It's your NHS and we want you to help shape it locally.

**Dr Jagan John**, clinical director, integrated care, Barking and Dagenham Clinical Commissioning Group

**Dr Gurdev Saini**, clinical director, frail elders, Havering Clinical Commissioning Group

**Dr Mehul Mathukia**, clinical director, integrated care, Redbridge Clinical Commissioning Group

"I couldn't have got a better service if I went private."

# Introduction

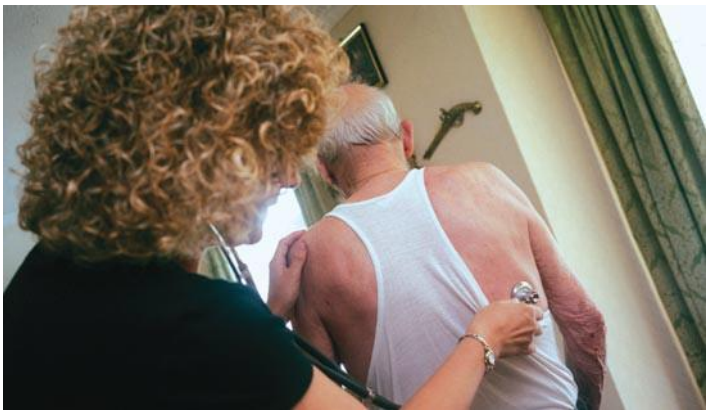
**This document talks about intermediate care in Barking and Dagenham, Havering and Redbridge. It explains what we have been doing during the past year to try out new ways of working and what we would like to do in the future to make those services better.**

We have set out different options and what we think would be the best option and why. We want to know your views, whether you agree or disagree, and if there is anything else you want us to consider.

We want to establish permanently the new intermediate care services that we have been trialling, which would mean that more people could receive care in their own homes. We also want to merge the three existing community rehabilitation units into one unit, on the King George Hospital site in Goodmayes. We believe this would result in better, more individual care that would help people to recover more quickly.

These services are currently provided by North East London NHS Foundation Trust (NELFT), and we intend for these services to continue to be provided by NELFT.

We would especially like to hear from local residents, people aged 65 years and over (as most of the people who use intermediate care services are in this age group), carers, health professionals and our partners in the community and voluntary sectors about whether they think our proposals would improve intermediate care services for local people.



**Intermediate care** means services that provide people with specialised care from nurses, therapists and other professionals, without them needing to go to (or stay longer in) hospital. These services can be provided in different places - people's own homes, community rehab units or residential homes, for example.

Our new intermediate care services are the **community treatment team (CTT)** – a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home having a health or social care crisis at home – and the **intensive rehabilitation service (IRS)**, a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's home.

**Rehabilitation** means helping people to recover after an illness or injury. **Community rehabilitation (or rehab) units** are buildings with beds for people who don't need to be in hospital any more, but can't go home because they need intensive 24 hour support and care.

# How to make your views known

**There are a number of ways in which you can give your views:**

Visit our websites and fill in the online questionnaire

Complete the questionnaire at the end of this document and send it back to us

Write a letter to
FREEPOST I Y 426
ILFORD
IG1 2BR

Email: haveyoursay@onel.nhs.uk

Call: 020 3688 1089

**All comments must be received by 5pm, Wednesday 1 October 2014.**

**Our websites:**

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

**How to find out more**

If you want to find out more about our work to improve intermediate care before you comment, you can visit the intermediate care page on our websites. Or call us and we can send information to you.

We will be out and about in Barking and Dagenham, Havering and Redbridge talking to people about our proposals – the dates and times for these events are below, and you can also find the latest information on our websites.

If you would like someone to come and talk to your community group about our proposals, please email **haveyoursay@onel.nhs.uk** or call **020 3688 1089**.

**Barking and Dagenham –** Thursday
11 September, 4-7pm
Barking Learning Centre
2 Town Square
Barking IG11 7NB

**Havering** – Thursday 21 August, 4-7pm
Romford Central Library
St Edwards Way
Romford RM1 3AR

**Redbridge –** Thursday 31 July, 4-7pm
Redbridge Central Library
(formerly Ilford Central Library), Clements Road
Ilford IG1 1EA

# Background to the proposals

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) have been working together with the local councils and local health service providers to improve health and social care services for local people. We want to make services more joined up with each other and focused on what individual people need, not on what is convenient for the services.

We need to improve people's experience of care and make sure it's the best quality, so we know we are delivering the right care, in the right place, at the right time.

We need to make sure the health and social care system is 'future proof'. We know the population is growing and getting older. We need a system that will care better for people now and can also care for more people in years to come.

We must ensure that services are efficient and deliver value for money.

**As part of this work, we have been focusing on improving local intermediate care services.**

"This is an outstanding brilliant service, what you have done in 21 days is unbelievable. My mum was in hospital for 13 weeks and was nowhere near where she is today with her walking. My mum is now able to walk which I never thought would happen."

# So what is intermediate care?

Intermediate care helps people get better quicker without needing to go to hospital, and also helps get people out of hospital and back home, sometimes after a stay in a community rehab unit.

These services are most often needed by older people, for example if they have a fall and hurt themselves which makes them less mobile and less able to care for themselves. They can also be needed by younger people, though, if they have an ongoing health problem that sometimes flares up making them unwell and needing help. We do not include specialist care for people who have had a stroke when we talk about intermediate care.

Historically, local people needing this kind of care have generally been cared for in beds at community rehab units when they could have been cared for at home, if the right services were in place to help them. This means that there are more intermediate care beds across our area compared with other areas.

This is an old-fashioned way of providing care and it does not take into account people's individual needs. The results for patients are generally not quite as good as if care was provided in other ways. For example, it often takes longer for people to recover fully. Being in a bed makes patients more likely to get an infection and to lose their independence.

People tell us they want to be cared for and supported in their own homes. We know people locally have been spending longer in community rehab units than people do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have a good experience of care.

To find out more about the evidence behind this, visit our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

By caring for people at home where possible we would prevent most people from having to go into a community rehab unit.

Of course, there are times when people *do* need to stay in a community rehab unit – for example they're not mobile enough to go home – and we would make sure that they can do this and the care they get there is excellent.

By improving the way we look after people in a community rehab unit and making sure they get personalised, focused care, with access to a range of therapies, patients would need to spend less time there.

To be clear, both the care at home and the care in a bed at a community rehab unit are intermediate care.

# What are the new services we have been trialling?

We have been trialling two new services to help people to stay at home.

**Community treatment team (CTT)**
This is a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home so that they either don't need to go into hospital or return home from hospital sooner.

The CTT started in Barking and Dagenham and Havering in January 2013, where it ran from 8am - 8pm, seven days a week. In November 2013, the service was expanded to include Redbridge, and the hours across the three boroughs were extended for an additional two hours a day, until 10pm.

**Intensive rehabilitation service (IRS)**
This is a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

**What do patients think of these services?**
Patient satisfaction rates for both the new services have been consistently high across the three boroughs since the trials began. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. You can see some of the comments patients have made about the services throughout this document.

"The patient is getting about now and is able to go up and down the stairs, can go the length of his footpath and manage a big step with little difficulty, something he could not do previously."

# Community rehab units

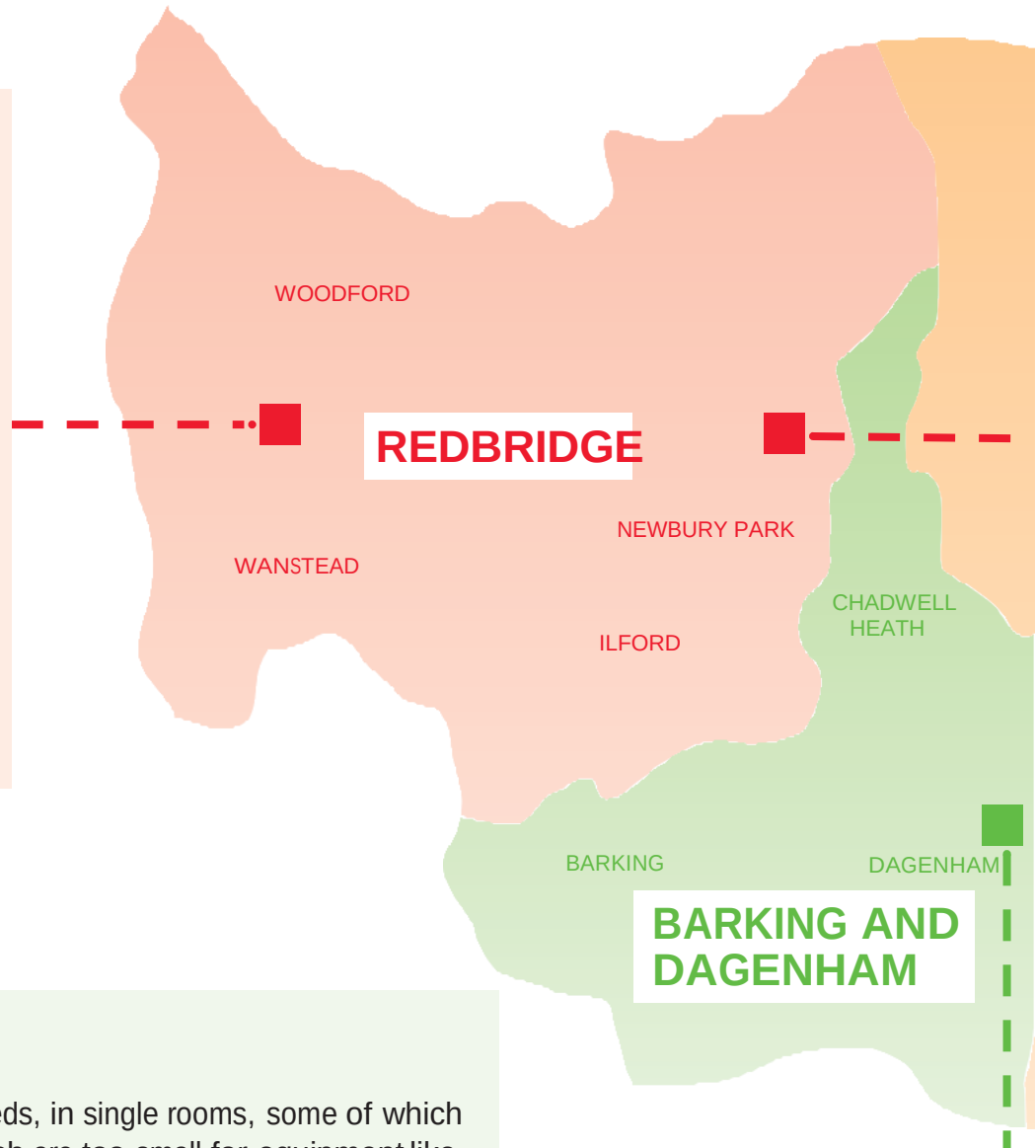
**At the moment there are three community rehab units used by people from Barking and Dagenham, Havering and Redbridge.**

## Heronwood and Galleon Unit in Wanstead

**Capacity and facilities:** 48 beds, in two wards. Physiotherapy gym, dining room and day room.

**Public transport:** Average links. Two bus routes are within five minutes' walk. Nearest underground station is 10-15 minutes' walk.

**Parking:** Free limited parking on site for staff and visitors. Limited parking in residential streets.




## Grays Court in Dagenham

**Capacity and facilities:** 26 beds, in single rooms, some of which have en-suite facilities but which are too small for equipment like hoists and wheelchairs. Physiotherapy gym, day rooms, dining area, consultation rooms.

**Public transport:** Poor links. Nearest bus route is 10 minutes' walk away. Nearest underground station is 20 minutes' walk.

**Parking:** Free limited parking on site, used by staff and visitors. Limited parking on residential streets.

## Foxglove Ward (King George Hospital) in Goodmayes

**Capacity and facilities:** 30 beds, in one ward (with another ward identified for expansion). Day room, physiotherapy gym on ward and access to a larger hospital gym. Access to other hospital services and facilities.

**Public transport:** Good links. Four bus routes stop in King George grounds. Nearest station is 15 minutes' walk.

**Parking:** Large on-site carpark for staff and visitors. Charges apply.


Intermediate care services used to be provided at St George's Hospital in Hornchurch, but this site was closed for health and safety reasons in October 2012 and remains closed.

Anyone who needs care in a community rehab unit is offered the next available bed in any of the three units. This might not be the one closest to where they live. This is so they can get access to rehabilitation as quickly as possible, which should help to speed up their recovery. If they prefer to wait for a bed at another unit, they can do so, but generally people want to start their rehabilitation quickly.

# Bed numbers: now and in the future

There is capacity for 104 community rehab beds across these three sites. However at the moment these beds are not all being used as there is no need for them. From looking at how the services have been operating recently and particularly since the trial of new services began, we have worked out that we would only need between 40-61 community rehab beds over a year if the home-based CTT and IRS were both running all the time. This is because most people would receive care in their own home and so would not need a community rehab bed.

When working this out, we have taken into account the fact that more beds are generally needed over the winter months.

This means if we did not reduce the numbers of available beds, at any one time during a year there would be between 43 and 64 unused community rehab beds. It costs hundreds of thousands of pounds to keep these available, whether they are occupied or not, in building upkeep, electricity and so on. We also need to duplicate staffing across the sites.

## Case study: Sunita stays in a community rehabilitation unit

**Sunita is a 77 year old woman who is unsteady on her feet and is in hospital following a fall. She also has a chest infection.** She no longer needs to be in the hospital, but she's not mobile enough to go home, and she is afraid of falling over again. CTT and IRS won't be enough for her – she needs help to move around safely, but she also needs 24 hour care. Sunita is referred to a community rehab unit. A nurse from the unit comes out to visit her, assesses her to make sure that the unit is the right place for her to go. It is and she's offered the next available bed.

While in the unit, Sunita receives 24 hour nursing care, physio and occupational therapy. The team regularly assess her and set her small but achievable goals to build her confidence and make sure she is progressing. After two and a half weeks, Sunita is feeling confident enough to go home, and the unit team supports this. They plan how she will manage after leaving. IRS staff visit her on the ward and once she's back home and develop an intensive rehab plan for her. The district nurses and the social care team also review Sunita's needs and provide the support she needs to stay at home safely, with the support of her family.

Sunita is happy to go home, pleased that she will have the support she needs to continue to recover. She is feeling stronger and more confident.

# Why we want to change the way we offer intermediate care

We want people to get better care and to recover more quickly. We want them to be able to stay at home, if at all possible, because that's what patients and their families want. Keeping people at home helps them to stay independent for longer and it reduces the risk of them picking up a new infection and becoming more unwell.

We want to make sure that we are using NHS money in the best possible way. This means spending our budget on services that would help patients the most. It means making sure that we are running services as efficiently as possible, saving money where we can so we can reinvest it in different and better services.

Since introducing CTT and IRS on a trial basis, we have found that a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. We know that for the majority of people care at home is the right thing, they do not need to go to hospital or a community rehab unit, and they recover as well, and in some cases better and quicker at home. Patients who have used the new services have told us they have had a very good experience and received high-quality care.

"Everybody wants to go home from hospital – as soon as they are ready and able to."

"I could not have managed without the support from the team."

## Case study: Reg is helped at home by the Community Treatment Team

**Reg is 55 years old. He lives on his own and he has Chronic Obstructive Pulmonary Disease (COPD) which sometimes makes it hard for him to breathe.**

Reg visits his GP a lot about his COPD because he's not confident about managing it and he's ended up in A&E in the past. His GP tells him about the local community treatment team (CTT), who can help him to manage his condition.

Reg has struggled to breathe all day but tries to manage with his existing medication. By 4pm, Reg is finding it harder to breathe and this triggers a panic attack. (Panic attacks can be very frightening and intense, but they are not dangerous and won't cause you any physical harm).

Instead of calling 999, as he would have in the past, he calls the CTT. The administrator asks him some questions and tells him how long it will be before someone calls him back. He's called back within 10 minutes as his case is a priority because it is clear he is having difficulty breathing. (The CTT will contact all patients within two hours). A senior nurse asks him questions about how he's feeling. Because of what he says, she allocates his case to a community nurse who arrives at his house within two hours. Reg is thankful that he can receive help at home as, like lots of people, he finds hospitals stressful, which generally makes him feel worse.

The nurse does various tests and notes his temperature has gone up and his oxygen levels are outside the normal range. They talk through his medical history and what medication he is on. The nurse advises Reg that he should now start taking the medication he has for when he has an attack. They discuss how he can manage his shortness of breath, and she carries out a blood test to rule out any further medical concerns. The CTT continues to monitor Reg's progress over the next two to three days and they keep his GP informed.

The nurse also refers Reg to the specialist respiratory team who will work with him in the longer term to help him manage his condition, looking in detail at the medication he's on and working with a physio and occupational therapist.

Reg feels much more confident about managing his COPD in the future, and knows he can always call the CTT if he needs them.

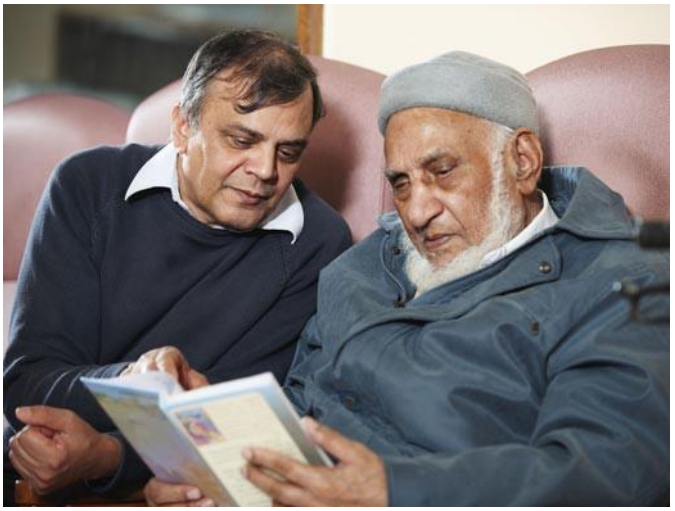
# What are the options for intermediate care?

We looked at the possibilities for improving intermediate care services for local people then drew up a list of five options. We then looked at the advantages and disadvantages of each option.

- What would be best for patients and help them to recover as quickly as possible?
- What would be easiest for patients and carers to help them live their normal lives where possible?
- How well does each option fit in with all the other local health and social care services and any plans there might be to develop those in the future?
- Could we afford to pay for the services in each of the options and are some options more or less expensive than others?

We have to make sure that we spend our limited NHS money in a way that makes sure we get the most we can for local people. We do not have enough money to spend on everything that everyone wants and if we spend more on one service then we have less to spend on another. That's why it's really important that we get the balance right.

As well as thinking about how much it would cost to run the services in the future, we thought about how much it would cost to make any changes. This would include the cost of any changes that we might need to make to modernise buildings, for example.



When we evaluated the options, we took into account both non-financial and financial criteria and we weighted these 60:40, meaning the financial aspects were not as important as things like quality of care and patient experience. Detail of these processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

"Walks well now, able to walk with a stick."

**The five options we considered in detail were:**

## Option 1: Stay as they are now

CTT and IRS – same number of beds – beds on three sites

This option means things would not change from how they are now. There would be the same number of beds on the same sites and there would be the new CTT and IRS services that we have been trialling.

Under this option, patients would benefit from the popular home-based care services which help patients to recover more quickly. They would also have more choice if they needed care in a community rehab unit as there would be three community rehab units offering care.

Under this option, there would be unused beds in the community rehab units because more people would be cared for in their own homes. This means money would be wasted.

This option would not be affordable because it is the most expensive option. We would not be able to pay for the new home-based services while still running the same number of beds across three community rehab units. We managed to find additional money to pay for the trial but we cannot carry on running both home-based and bed-based services at this level in the long term.

## Option 2: Go back to before the trial

No IRS – No CTT in Redbridge and reduce CTT hours in BD and Havering – same number of beds – beds on three sites

This option means we would go back to how things were before we started trialling the new services. That means there would be no IRS in any of the boroughs and no CTT in Redbridge. The CTT in Barking and Dagenham and Havering would reduce their hours again, by two hours a day. There would be the same number of beds on the same sites.

Under this option patients in all areas would get a reduced service, particularly in Redbridge. The reduction in services would be in the home-based services that patients and carers really like and which help people to recover more quickly.

This option is not affordable in the longer term. No IRS (and no CTT in Redbridge) to support other services would mean longer waits for the services that do exist. That would make those services less productive and patients would take longer to leave hospital. That would be more expensive in the long term than what we are proposing.

"We're extremely happy with the service and have recommended to our friends already."

## Option 3: New services and three sites

CTT and IRS – fewer beds – beds on three sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs and we would still have three community rehab units. There would be fewer beds overall though because we would take out the ones that aren't needed.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would still be able to choose from the three current units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

This option is not the most affordable option because we would have to pay all the costs of keeping three community rehab units open, even if we weren't using all the space in each building.

## Option 4: New services and two sites

CTT and IRS – fewer beds – beds on two sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to two and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to choose from two units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

We considered all combinations of which two sites could stay open, but for the reasons explained above, did not feel this option would provide high quality care. For a detailed description of this process, see the pre-consultation business case on our websites:

www.barkingdagenhamccg.nhs.uk/intermediatecare
www.haveringccg.nhs.uk/intermediatecare
www.redbridgeccg.nhs.uk/intermediatecare

This option is more affordable than options 1-3, but it doesn't offer the best value for money because we would still have to run two separate units on two separate sites.

### Option 5: New services and one site

CTT and IRS – fewer beds – beds on one site at King George Hospital

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to one at King George Hospital and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to.

This option would be the most affordable because we would pay for the new services with the money that we saved by reducing bed numbers and by reducing the number of sites from three to one. It would also be the best value for money as we would reduce duplication (for example paying to run three buildings).

This is also the best option clinically – it would allow us to deliver a better service, with better results for patients. Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly and patients would have better access to specialist therapy and nursing support.

This option is our preferred option and we explain why in the following section.

**Summary of options**

| Option | Is there a community treatment team? | Is there an intensive rehab service? | How many beds overall? | How many community rehab units? |
|---|---|---|---|---|
| **1** | Yes | Yes | 104 | 3 |
| **2** | Yes, with reduced hours (Barking and Dagenham and Havering)<br>No (Redbridge) | No | 104 | 3 |
| **3** | Yes | Yes | 40-61 | 3 |
| **4** | Yes | Yes | 40-61 | 2 |
| **5** | Yes | Yes | 40-61 | 1 |

# What do we think would be best in the future?

We want to be able to continue the new services that we have been trialling – the community treatment teams in all three boroughs for 14 hours a day, and the new intensive rehabilitation service, because the trial has been very successful. We have had really good feedback from patients and carers about the services – they think they are an improvement.

As much as possible, patients have been helped to stay at home, which has helped them to get better quicker and to stay independent.

We also want to make sure that we have the right number of beds for people who do need to stay in a community rehab unit. We want those beds to have the right supporting services around them.

After thinking about the advantages and disadvantages of all the options, we think option five is the best option. This is because we think it would result in the best and safest care.

Option five would mean:

- We would continue to run the community treatment team and the intensive rehabilitation service that we have been trialling.

  This means most people would get care at home and would not need to travel or stay in hospital. They would be able to lead as normal a life as possible and stay close to family and friends. We know that helping people to stay out of hospital means they are more able to stay independent for longer. Those people who do need to go into hospital would be helped to return home more quickly than in the past. This is because people who have been helped by these services think they are much better than going into hospital.

- We would reduce the total number of beds across the three boroughs to between 40 and 61.

  This means that we would always have 40 beds and we would always be able to increase the number of beds up to a maximum of 61, depending on how many people need a bed at a time. We do not think we would ever need more than 61 beds at any one time. This is because fewer people would need a bed because they are being cared for at home and those who do need a bed for a while would not have to stay in the unit for as long.

- We would move all the beds onto one site

  Having a service in one place rather than in a number of smaller units, means patients get better more quickly. It is much easier to make sure care is of consistent quality and clinicians say this is the safest way to provide care (rather than on two or three sites).

  We could use staff much more efficiently and flexibly and we would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

  We realise that moving from three sites to one would make it harder for some people to visit a relative or friend, but we think the benefits to patients should make it worthwhile. For example, patients will go home sooner than they do now. Some people are already travelling – people in Havering travel to Redbridge to visit Foxglove ward. We think this can be offset by the majority of people being seen in their own home, and not needing to travel.

- We would locate the service on the King George Hospital site.

  This location is fairly central to the three boroughs, there are good, well-established transport links and car parking is available on the site.

  Locating the service on this site means it could link in with other health services where necessary. There is enough room here to be able to have up to the maximum number of beds that we think we might need at any one time. There is not enough room on either of the other two sites for 61 beds.

  It would mean that we would no longer need two community rehab units – Heronwood and Galleon unit in Wanstead and Grays Court in Dagenham.

  We do not own either of these sites, so we cannot make decisions about what would happen to them, but we would work with the owners and other local stakeholders to help them decide how best to use the sites.

  For information on the advantages and disadvantages of the different sites, look at the ‘Community rehab units’ section.


## Case study: Doreen goes home from hospital with the help of the Intensive Rehabilitation Service

**Doreen is an 86 year old widow living by herself. She has high blood pressure, rheumatoid arthritis and walks with a stick but is otherwise in good health.**

One day, Doreen falls down her stairs and can’t get up, so her neighbour calls 999. An ambulance takes her to Queen’s Hospital where an x-ray shows she’s broken her leg. She has her leg set under anaesthetic, and spends three weeks recovering on an orthopaedic ward.

While she is in hospital, Doreen has physiotherapy to work on her strength and mobility and an occupational therapist helps her to practise tasks like washing and dressing and moving about safely.

When Doreen no longer needs to be in hospital, instead of going to a community rehab unit, she is referred to the Intensive Rehabilitation Service (IRS). Staff from the service talk to the hospital therapists, nurses and doctors and to Doreen about her situation - how she is recovering, and what kind of care she needs to complete her recovery at home.

Once Doreen is back home, the IRS team visit her and talk to her about her goals. She wants to be able to climb her stairs safely, and walk to her neighbour’s house, so between them they work out a plan to help her achieve this.

This involves up to 21 days of intensive rehabilitation at home. She is visited twice a day every day and receives care from a physio, occupational therapist, rehabilitation assistants and a nurse. As Doreen becomes more confident moving around, the team does more with her – helping her to manage the steps in her back garden.

The team reviews Doreen’s progress throughout her rehabilitation and looks at what other help she needs. Both they and Doreen think she has recovered well, thanks to the intensive support. They let Doreen’s GP know about her progress so she can follow up and refer Doreen to other services such as district nursing. They also talk to the council’s social care team to make sure she has someone to help her do her shopping

Doreen feels safe to continue to live in her own home, with the support of NHS and council services.

# Questions and answers

### How did you decide on the preferred option?

The executive committees of the three CCGs set up a steering group with senior doctors and managers (including the nurse director and finance director) from all three boroughs. This group developed and appraised the options against a set of criteria, coming up with a recommended preferred option. The governing bodies of the three CCGs then considered what they had done, and agreed we should consult the public and other stakeholders on that preferred option.

### When would you make these changes?

If agreed, we would need to talk to Barking, Havering and Redbridge University Hospitals NHS Trust, which owns King George Hospital, to agree when we would be able to start to use more space. We'd need to take the time to make any changes properly, at minimum disruption to patients, so any move would probably take place in the 2015/16 financial year.

### Have you factored population changes into the planning?

Yes. We always use the most up-to-date population information and projections to make sure that we plan appropriately for current and future needs.

### Isn't this just all about saving money?

No. The reason we want to make changes is because we think we can make things better for patients so they recover more quickly and most of the time recover in their own homes. We have also had great feedback on the services – patients like them. This is about spending money where it will have the greatest impact and result in the best care and results for patients.

But anything we do has to be affordable. We have a limited NHS budget and if we spend more on one service then we have to cut what we spend on something else.

### What if I want to recover in a bed at a community rehabilitation unit, not at home?

If you wanted to recover in a bed at a community rehab unit, we would talk to you about why you wanted to do this. If we thought you would recover more quickly at home we would explain why. We would discuss any social care needs you might have and we would talk to you about how we could help you remain independent. Of course, anyone who is in clinical need of a bed would get a bed.

### Why can't we keep three community rehab units?

Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger community rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

### What would happen to the buildings if the decision is made to centralise services?

We do not own the sites, so we cannot make decisions about what would happen to them. We would work with the owners and other local stakeholders to help them decide how best to use the sites.

Work would also need to be done to the available space at King George Hospital. This would mean looking at the way the space is laid out so government requirements to put men and women in different areas are met. Other work, such as painting and decorating and getting IT systems set up would also be needed.

### What about the St George's Hospital site in Hornchurch?

Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre would be some way off.

### Wasn't it the plan to put the rehabilitation beds that moved off the St George's Hospital site in 2012 back into the new health centre?

The public consultation on the redevelopment of St George's supported the preferred option not to include any beds, but to ensure flexibility the CCG has made sure there is enough space in the plans for some short-term care beds (not intermediate care beds). As this is still at the planning stage, it would be some time before any new centre was up and running and we want to make these improvements more quickly.

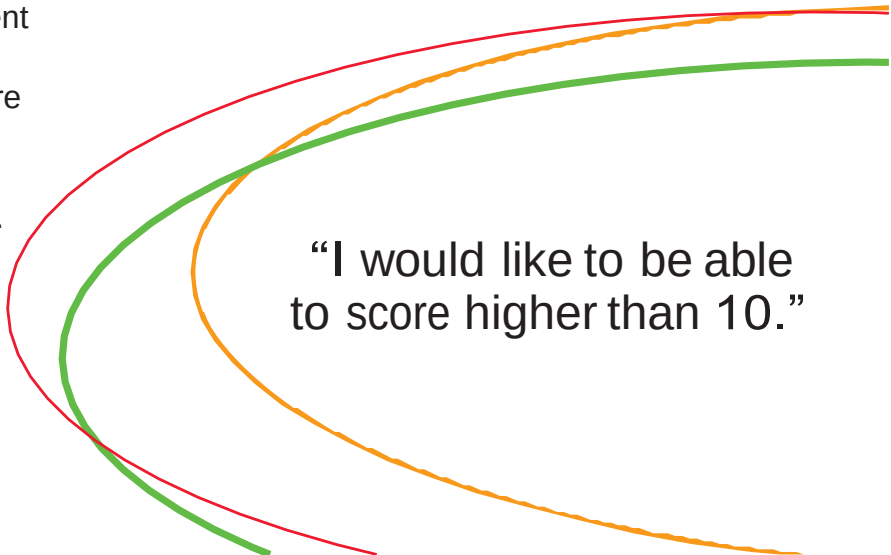
### What about involving social care and social workers?

The CTT includes social care staff as well as NHS staff, so the team thinks about the patient's needs as a whole, rather than separating them out into health or social care. The IRS also has very good links with social care.

### Do local authorities and care providers support these proposals?

These proposals have been agreed by the Integrated Care Coalition (ICC), a group of health and social care partners including local councils and care providers, which was established to review and propose how health and social care services can be made better for local people.

Following an in-depth review of local services, the ICC published a 'case for change' which identified a need to improve and modernise the way intermediate care services are delivered. A strategy was developed which took into account examples of alternative models and approaches here and overseas, and involved extensive local clinical, professional and public engagement.



# We want your views

We want you to tell us what you think of these proposals. Please complete the questionnaire at the end of this booklet and send it back to us, or write to:

**FREEPOST I Y 426**
**ILFORD**
**IG1 2BR**

If you'd prefer to send an email, send it to **haveyoursay@onel.nhs.uk**

You can also call: **020 3688 1089**

**All comments must be received by 5pm, Wednesday 1 October 2014.**

## How your views will be considered

Once the consultation closes, we will review and analyse all the responses we receive.

We will use this information to write a report for each of the three CCGs' governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessments) and make a decision on the most appropriate way forward. They will also be able to see all the consultation responses in full.

If you are responding on behalf of an organisation or you represent the public (like an MP or a councillor) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your response but we may use unnamed quotes to show particular points of view.

We will put the dates of the governing bodies' decision-making meetings on our website. These are meetings held in public, so you are welcome to attend and all the reports they will look at will be published on our websites.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date with our work.

"Brilliant service, helpful, good treatment, and good communication."

# Questionnaire

**Please tell us to what extent you agree or disagree with the following statements:**

**1** The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

**2** The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

**3** The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care.

Strongly agree Strongly disagree Agree Don't know Disagree

Comments

# Questionnaire continued

**4** We believe that option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds - is the best way to organise intermediate care services in the future.

Strongly agree  Strongly disagree  Agree  Don't know  Disagree

Comments

**5** If you disagree with our preferred option (option 5) please tell us what you think we should do instead.

Option 1  Option 2  Option 3  Option 4  None of them

Comments

Use this space if you want to tell us anything else

# Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding and whether they think differently from other groups. That helps us to understand if what we want to do might have more of an impact on some groups of people than others.

You don't have to give us your name if you don't want to and we will still take your views into account.

**Name**

**Are you providing this response as a representative of a group:**

Yes No

If yes, what is the name of the group

**Would you like to be kept up to date with information about the NHS (including this consultation)**

Yes No

If yes, please give us your email or postal address

**Which borough do you live in**

Barking and Dagenham
Havering
Redbridge
Other

**Are you?**

Male Female Prefer not to say

**Are you responding as a…**

Service user
NHS staff member
Carer
Local resident
Other
Prefer not to say

**Are you employed by the NHS?**

Yes No Prefer not to say

**What is your ethnic background**

White

- White British
- White Irish
- Any other white background

Mixed

- White and Black African
- White and Black Caribbean
- White and Asian
- Any other Mixed background

Asian

- Asian British
- Indian
- Bangladeshi
- Pakistani
- Chinese
- Any other Asian background

Black

- Black British
- Black African
- Black Caribbean
- Any other Black background

Any other ethnic group

Prefer not to say

**Which belief or religion, if any, do you most identify with?**

Agnosticism
Atheism
Buddhism
Christianity
Hinduism
Islam
Judaism
Sikhism
Other
Prefer not to say

**Do you consider you have a disability?**

Yes No Prefer not to say

**How old are you?**

Under 16
16-25
26-40
41-65
Over 65
Prefer not to say

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

### English

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

### Bengali

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### Lithuanian

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### Portuguese

Este documento é acerca dos nossos planos para melhorar alguns dos serviços de saúde em Barking e Dagenham, Havering e Redbridge. Se não puder ler o documento e desejar saber mais, contacte-nos e informe-nos que tipo de ajuda necessita. Informe-nos se necessita em tamanho maior ou num formato diferente. Se não fala Inglês, informe-nos qual o seu idioma preferido.

### Punjabi

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### Romanian

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### Tamil

HGDCBA@?C=<;9765C321C0</7.,? (Barking and Dagenham)+C ,</A*5 (Havering)C321C/)('*(&C (Redbridge) B76$A#!i C 0 C A7C 6 A# !C ?=1 AD#7< C 57 .C D6(057 C =#!6$ C 57 < C HGDC BA@ D'C = 97C H$ A C .!< C # ?C ?C D7A 7 'C /=!C A ?= < +C 57 C /D<0; 9C /7<21+C 57 9 C . C DA C A21/ . C 7 57 C 57 9 C H C /=*$C 97 <C 3 C A C A A Di <C A21/ .!< C 57 0?C/D*A 57 C 57 9 CB576 Di C = C/D*$< C .!< +C 57 C . C / < 6$ C = A;7 C . C 57 0?C 57

### Urdu

(Redbridge)G/.%–7?;?><(Havering)G<2?1C(Barking and Dagenham)1FEDCBG A@G ?><D;?:9\87>:654G 37 @>=G'6!5G G#CE2G8?>654G37G <. <' ' G#C+G ?:9\'';G 1\1 D+G ?: G 6+G''5\''1:D%.6E%1;G,:+*)G*D(G';G&%$G#C+ !. +G '' @:;?4\4*+!:C;0!;¦ <3;!#C:69\#C G?><#? .;¦F:G3 9!0"5GF G .;¦ :9\1 ¦ #C0\ :0=1)G";G''D2BG*7 8+\#C+G ?:9\'';¦ = G .;¦ :9\1 ¦ '' .;¦#CE2G1 6 G#C+\A87 .2=¦ <. <¦ #C:69\#C G1@" G?:;?4\#C+¦ C+?: G. 74\' ;¦:% 1. ¦ 9\87>:654G3?1;G = #C0\''6 19G:9 ¦'5G 1;¦ <3;G#C:69\#C

This document was developed with the help of patient representatives from across our area.