Report of the Executive Director Core Services and
Barnsley Clinical Commissioning Group (CCG)
to the Overview and Scrutiny Committee (OSC)
on Wednesday 12th July 2017

Barnsley's NHS Intermediate Care Service – Cover Report

1.0 Executive Summary

1.1 This short paper aims to provide the background and context to the changes in how the NHS Intermediate Care Service is delivered in Barnsley. Whilst the ask of the service isn't fundamentally different from its re-specification in 2014 it has been refined to give greater clarity about key elements required to deliver a person centred rehabilitation service in an integrated way as close to, or in the, home as possible.

1.2 Use of an Alliance of Providers and Commissioners to manage the service is pivotal to secure new ways of working and the best use of resources required to have more out of hospital care with better and demonstrable outcomes. Maintaining people's abilities to be independent in their own homes is a crucial element of Barnsley's Place Based Plan and critical to stem the rising demand on acute hospital services.

2.0 Introduction

2.1 Intermediate Care is an umbrella term often used to refer to out of hospital services but as the Service Specification (Item 4b attached) notes, failure to refine that term further can lead to inappropriate use of such services. Within Barnsley we are using the term to refer to active rehabilitation post an acute illness (with access to recuperation and reablement if or when that is appropriate) or early therapeutic intervention to prevent hospitalisation.

2.2 Whilst some forms of rehabilitation are specialist e.g. post stroke or major trauma, and are medically led, rehabilitation in the context of intermediate care is essentially therapist and nurse led. Access to medical care remains via Primary Care (GPs), where the patient's level of needs requires them to be in a 24 hour care facility (care home or step down/transition unit) for a period of time then alternative temporary GP support is organised. As our population lives longer with the ensuing complications of long term conditions and frailty intermediate care aims to:-

- Enable better use of acute hospital facilities
- Minimise hospitalisation and it's associated complications including deconditioning (reduced activity leads to muscle loss which impairs recovery)
- Promote independence and quality of life to enable people to remain in their own homes for as long as possible
- Provide care closer to home (in spirit as much as geography)

3.0 Context

3.1 Similar to other boroughs Barnsley has had an 'Intermediate Care' Service for a number of years which has been provided by South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). Back in 2014 the Clinical Commissioning Group (CCG) and Barnsley Metropolitan Borough Council (BMBC) via the Joint Commissioning Team and the then Ageing Well Programme Board undertook considerable work to re specify the service to ensure it had a clearer rehabilitation function. The new

specification was piloted in April 2015 but after a year it was clear that the delivery wasn't achieving what was envisaged which was a more seamless, integrated offer to minimise hospitalisation and maximise people's independence. The CCG therefore gave notice to SWYPFT in June 2016 indicating that a new service needed to be in place by June 2017.

3.2 Also informing this decision was the intelligence available to the system via our Care Co-ordination Centre RightCare Barnsley (RCB). RCB was set up in 2015 to provide nurse led telephonic brokerage for healthcare professionals in Barnsley to enable the right service to be utilised at the right time and place to minimise hospitalisation. RCB was set up using an Alliance Contract (more than one provider in this case SWYPFT, Barnsley Hospital NHS Foundation Trust (BHNFT) and the CCG) and was able to demonstrate admission avoidance and latterly earlier discharge both of which are key to system capacity and resilience.

3.3 By October the CCG had refined the Intermediate Care specification in the context of their 17/19 commissioning intentions which are clear about the consideration of how existing resources can be used differently. Therefore the specification (Appendix 1) emphasises the ethos of rehabilitation, person centred care and integrated working and places RCB as it's engine for effective coordination to achieve that. At a similar time the re specified Community Nursing Service (District Nursing) was implemented using a locality focus which almost mirrors the Local Area Councils and is now known as the Neighbourhood Nursing Service (NNS). SWYPFT provide the NNS and its development and implementation was steered by the CCG using a stakeholder approach that also involved GP representation, BHNFT, BMBC and the Yorkshire Ambulance Service (YAS).

3.4 Both NNS and RCB work informed the CCGs decision to pursue a process of Managed Change via an enhanced Alliance Contract (Barnsley Healthcare Federation (BHF) and BMBC joining the partners who run RBC). The way the Alliance Contract works is to focus on shared decision making re use of resources to best effect for the population we serve. The aim is that for staff to provide care that is as seamless as possible they need to feel how the actual organisation that currently employs them is working with partners to transcend organisational barriers (real and perceived) in the best interests of patients and their families. In the context of the borough's journey towards an Accountable Care Partnership this decision to pursue delivery of the service by an Alliance Contract is an ideal proof of concept and stepping stone.

4.0 Current and Previous Performance

4.1 As referred to in the context section the decision to undertake more work on this service relates to how it benchmarks with other similar services. The activity figures below relate to 2016/7:

- Mount Vernon Hospital (2 x 24 beds)
  - Average Occupancy 84%*, Average LOS 31 days (range 1-90)
- Hospital at Home
  - Average Occupancy 108%, Average LOS 17 days (range 0-48),
- Independent Sector Beds
  - Average Occupancy 76%, Average LOS 23 days (range 3-47)

* 89% if out of area patients included

4.2 Although improved (via use of RCB as a gate keeper) the length of stay in NHS provided beds at Mount Vernon Hospital is longer than comparators, is almost exclusively step down from BHNFT. In terms of outcomes 58% return to their own homes (of these 47% had further domiciliary rehab or re-enablement, increased use of which could enable earlier discharges), 10 % passed away, 18% were transferred to other NHS in patient units (mainly back to BHNFT) and 10% entered long term residential or nursing care (4% miscellaneous destinations). In addition the estate costs of the facility (which would require major investment to make it fit for purpose for continued future use) mean that it's cost per case is higher than other areas.

5.0 Moving Forward

5.1 The Alliance is now working at pace to have the foundations of the new service in place before the inevitable rise in demand that the winter will bring, the working implementation plan is as follows:

- Appoint Lead Practitioner (new post)
- Using RCB brand
  - Halfway Home (transition unit in BHNFT)
  - Neighbourhood Rehabilitation
    - In People's own homes
    - To patients in newly procured Independent Sector Beds

5.2 This work is not without its challenges both logistical and cultural and it is important to acknowledge that for some staff it is an anxious time. The advantages to working in the Alliance mean that there is a commitment to take a borough approach to redeploying staff at risk wherever possible. None the less the biggest risk we face is to fail to grasp this opportunity in a timely manner as it is key to stemming rising capacity pressures in the system.

6.0 Invited Witnesses

6.1 The following witnesses have been invited to today's meeting:

- Brigid Reid, Chief Nurse Barnsley CCG, Chair of the Alliance Management Team
- Jayne Sivakumar, Head of Commissioning and Transformation, Barnsley CCG
- Sean Rayner, District Director-Barnsley & Wakefield, SWYPFT
- Gill Stansfield, Community Services Manager, SWYPFT
- Bob Kirton, Executive Director, BHNFT
- Jacqui Howarth, Service Manager-Right Care Barnsley, BHNFT
- Lennie Sahota, Service Director-Adult Assessment and Care Management, BMBC
- Cllr Margaret Bruff, (Cabinet Spokesperson-People), BMBC

7.0 Possible Areas for Discussion

7.1 Members may wish to ask questions around the following areas:

- What are the key impacts changes to Intermediate Care Services will have for Barnsley?

- How will service user feedback be sought and utilised to influence the design and delivery of services?

- How involved will patients be in determining their care pathway?

- How do you determine which care/residential homes to use?

- How will you ensure a consistent and appropriate approach is applied to the step-down and step-up of cases?

- To what extent are all key stakeholders on board and engaged in ensuring the design and delivery of effective services?

- How have staff been consulted on the changes and what impact will it have on them?

- What is in place to undertake performance management of services and ensure that intelligence-led decisions are made?

- How will you ensure the effective sharing of data and intelligence across different organisations?

- If the changes to services are not effective, what impact will this have in future?

- What are the key challenges for the services during 2017/18?

- What actions could be taken by Members to support Intermediate Care Services in Barnsley?

8.0 Background Papers and Links

- Item 4b (attached) – Intermediate Care Service Specification
- National Institute for Health and Clinical Excellence (NICE) Guidelines on Rehabilitation after critical illness in adults: https://www.nice.org.uk/guidance/cg83

9.0 Glossary

BHNFT - Barnsley Hospital NHS Foundation Trust
BMBC - Barnsley Metropolitan Borough Council
CCG - Clinical Commissioning Group
RCB - RightCare Barnsley
SWYPFT - South West Yorkshire NHS Partnership Foundation Trust
OSC - Overview and Scrutiny Committee
YAS - Yorkshire Ambulance Service

10.0 Report Authors and Officer Contact

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